



Department of  
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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin  
an Fowk Siccar**

**Independent Review Report**

**of**

**Agency Involvement with**

**Mr Arthur McElhill, Ms Lorraine McGovern**

**and their children**

**June 2008**

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## **ACKNOWLEDGEMENTS**

The Review Panel wishes to thank all those who co-operated with us during the course of our work.

The Chief Executive of the Western Health and Social Care Trust together with her Service Directors agreed at the outset to provide and did provide full co-operation throughout the course of the Review. The Trust appointed a Liaison Officer to the Review Panel and her work was of great assistance.

The Trust's staff from Social Services, Health Visiting Services, Erne House and Riverside Family Centre willingly attended extensive formal interviews at the request of the Review Panel and we are grateful to all those who attended for dealing with difficult and sometimes emotional issues.

The Review Panel met and interviewed a General Practitioner, officers from the Police Service of Northern Ireland, the Probation Board for Northern Ireland and Education Welfare Services in helpful and constructive interviews.

The Review Panel also derived insight and assistance from the principal and teachers of Sacred Heart College, Omagh and the principal of St Connors Primary School, Omagh. The Northern Ireland Children's Commissioner and the Chief Executive and a Director of the NSPCC provided invaluable assistance to the Panel.

The Tara Centre in Omagh provided tranquil circumstances for our interviews and our thanks to the management and staff of the centre.

Finally the Review Panel wishes to thank Mr Charles and Mrs Patricia McElhill and Mr Kevin and Mrs Theresa McGovern. They and their families have suffered grievous loss. We are grateful to them for their insights and thank them for their courage and quiet dignity.

**Henry Toner QC, Chairman  
Independent Review Panel  
June 2008**

# **1. INTRODUCTION AND SUMMARY**

## **Introduction**

- 1.1** On the 13 November 2007 a fire engulfed the home of Mr Arthur McElhill and Ms Lorraine McGovern at 4 Lammy Crescent, Omagh.
- 1.2** At home that night were Mr Arthur McElhill, Ms Lorraine McGovern and their children, Caroline, Sean, Bellina, Clodagh and James. All members of the family died in the fire.
- 1.3** Caroline was 13 years and 3 months old, Sean 7 years and 7 months old, Bellina 4 years and 5 months old, Clodagh 1 year and 7 months old and James was a baby in arms at 10 months old.
- 1.4** The death of an entire family is a terrible and tragic event for the relatives, friends and neighbours of the family and for their local community. Members of this Independent Review Panel (Review Panel) have met with family members and extended sympathy to them. It is the hope of the Review Panel that the publication of this report will not add to the grief of the families but rather will help them in coming to terms with what has happened to their loved ones.
- 1.5** At the time of completion of this report the tragic events which occurred at 4 Lammy Crescent on the night of the 13 November 2007 are the subject of PSNI investigation and will be the subject of a PSNI report to the Coroner. The Review Panel did not enquire into the events of that night which were outside its Terms of Reference. The detailed Terms of Reference of this Review are set out in section 2. From the outset this report was intended to be a public document and the Review Panel has therefore concentrated on the key issues which were identified during our work.
- 1.6** The United Nations Convention on the Rights of the Child was adopted by the United Nations General Council in 1980 and in 1982 was ratified by the United Kingdom government. Article 3 of the convention is specific in its terms:
  - i. "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be the primary consideration.
  - ii. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his parents, legal guardians or other individuals legally responsible for him and, to this end, shall take all appropriate legislative and administrative measures.
  - iii. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in number and suitability of their staff, as well as competent supervision."

The Review Panel therefore wishes all those concerned in the Department of Health and Social Services and Public Safety (DHSSPS), the Western Health and Social Board (the Board) and the Western Health and Social Care Trust (the Trust) to carefully read and assimilate this report and urgently implement the recommendations which we have made.

## **Summary**

**1.7** The essential work of the Review Panel was to consider the quality of the professional work of the various agencies involved with Mr Arthur McElhill, Ms Lorraine McGovern and their children particularly in the area of child protection and related matters arising from the nature of criminal offences previously committed by Mr Arthur McElhill. The Review Panel focused on two periods the first being from August 1999 to December 2000 and the second period being from June 2007 to the 13 November 2007. In the second period it was necessary also to consider the child protection case of a female teenage child (teenage child) who was not a relation of the family.

**1.8** The agencies involved were:

- Social Services in the Omagh sector of the Trust;
- Mental Health/Psychosexual Services provided by the Trust;
- Health Visiting Services provided by the Trust;
- General Practitioner Service;
- Probation Service for Northern Ireland;
- Education Welfare Services; and
- The Police Service of Northern Ireland in respect of its interaction with the agencies.

**1.9** The Review Panel found deficits in:

- Communication of information between all agencies in respect of the criminal offences committed by Mr Arthur McElhill;
- Dissemination of that information within disciplines of the Trust and other agencies and assessment of potential risks posed by Mr Arthur McElhill to teenage girls by reason of the nature of those criminal offences;

- Good practice and management within the disciplines of the Trust and other agencies.
- 1.10** In respect of all the agencies under review, the Panel has made a significant number of recommendations for improvement which are set out below. While all the agencies have received recommendations most of these relate to Social Services as the lead agency with statutory responsibility for the delivery of child protection services. It should be noted that Social Services is not the lead agency for the management of sex offenders. Many of the deficits within Social Services were acknowledged in interview by the Trust's Senior Management and the Trust has already implemented a change in four important areas which were brought to their attention by the Review Panel.
- 1.11** The Review Panel acknowledge that the Trust has been going through extensive management of change linked to the Review of Public Administration and that the implementation of the new senior management structures has taken time to put in place. Robust governance arrangements are essential in building public credibility and are underpinned by the need to have in place systems to ensure compliance with Clinical and Social Care Governance standards as outlined in the DHSSPS guidelines. More needs to be done to build up the confidence of the workforce and the other agencies and this should be given priority within the Trust's overall governance agenda and work plan. While the Review Panel acknowledges the changes implemented by the Trust to date, these steps should be regarded as the first in a process of improvement. The Review Panel encourages the Trust to do all that is necessary to provide good quality child protection services.
- 1.12** 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.
- 1.13** A chronology of the events surrounding the case are set out in section 3 and detailed findings and recommendations are set out in sections 4 to 9 of this report.

## **2. TERMS OF REFERENCE AND METHODOLOGY**

### **2.1 Terms of Reference**

**2.1.1** On 10 January 2008 the DHSSPS commissioned an Independent Review of agency involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their family.

**2.1.2** The Terms of Reference for the Review were:

- (i) to establish the history and circumstances of the case;
- (ii) to establish the extent and nature of the involvement of Mr Arthur McElhill, Ms Lorraine McGovern and their family with a range of agencies including General Practitioner services, the Trust's Social Services, Health Visiting, Mental Health Services, Education Services and others as appropriate;
- (iii) to establish the knowledge each agency had about Mr Arthur McElhill's previous convictions for sexual offences and his involvement with other agencies;
- (iv) the extent to which each agency had knowledge of Mr Arthur McElhill's past offences and other relevant information, heard it and acted upon it;
- (v) to establish how each agency identified, assessed and managed risks associated with key events in the family's circumstances and whether those actions and interventions were sufficient and appropriate;
- (vi) to identify lessons to be learned and make recommendations of appropriate action.

**2.13** The Review Panel was chaired by Mr Henry Toner QC; the Panel members were Mrs Maire McMahon (coordinator), Dr Sloan Harper, Mrs Maura Devlin and Assistant Chief Constable Harris of the PSNI. Mrs Tracy Hodgen was Executive Administrator to the Panel. (Appendix 1)

### **2.2 Methodology**

**2.2.1** In the initial stages of its work, the Review Panel met with key personnel in the DHSSPS to discuss the Terms of Reference. Introductory meetings were held with the Chief Executives of the Board and the Trust followed by a meeting with the relevant Trust Service Directors. A detailed Project Plan was developed for the work of the Review.

- 2.2.2** The Review Panel obtained copies of all relevant case files from the Trust across the entire range of disciplines. An extensive list of policy documentation was obtained from the DHSSPS, the Board and Trust. These materials were examined and analysed in detail.
- 2.2.3** Members of the Review Panel conducted interviews with forty four people in total being primarily from the various disciplines and agencies directly involved in the case and a detailed analysis was conducted on the outcomes of these interviews. Staff were interviewed from the following services:
- (i) Social Services;
  - (ii) Mental Health/Psychosexual Services;
  - (iii) Health Visiting Services;
  - (iv) Medical/General Practitioner Services;
  - (v) The Police Service for Northern Ireland (PSNI);
  - (vi) The Probation Service for Northern Ireland; and
  - (vii) Education Welfare Services.
- 2.2.4** The Review Panel met informally with Mr and Mrs McElhill and Mr and Mrs McGovern, the parents and grandparents of Mr Arthur McElhill, Ms Lorraine Mc Govern and their children.
- 2.2.5** The Review Panel met with the Northern Ireland Children's Commissioner, (NICCY) the National Society for the Prevention of Cruelty to Children (NSPCC) and also a member of the public who contacted the Panel. Members of the Review Panel also visited two schools attended by members of the family and met with the principals and a teaching representative.
- 2.2.6** Members of the Review Panel conducted an interim meeting with the Minister for Health, Social Services and Public Safety and his representatives, following the completion of the fieldwork stage of the Review.
- 2.2.7** From January to May 2008 the Review Panel met in full and in smaller groups on numerous occasions.
- 2.2.8** It should be noted that the Northern Ireland Sex Offender Strategic Management Committee (NISOSMC) commissioned a Case Management Review in relation to the Multi Agency Sex Offender Risk Assessment and Management (MASRAM) arrangements that were put in place for Mr Arthur McElhill. The Review Panel therefore did not enquire into those matters.

**2.2.9** The Review Panel has drawn together a comprehensive report on the information and analysis derived from the scrutiny of documentation and analysis of case files and the interviews with staff.

**2.2.10** The Trusts within the Board have been through major managerial and structural change over the past 18 months due to the Review of Public Administration (RPA). In the Board area Altnagelvin Hospital Trust, Foyle Health and Social Services Trust and Sperrin Lakeland Trust were merged to form the new Trust and these arrangements took effect in 2007. The issues under consideration in this report therefore span two separate managerial arrangements. In 2000 the responsibilities rested with Sperrin Lakeland Health and Social Services Trust and in 2007 with the new Trust formed under the RPA arrangements.

### **3. NARRATIVE CHRONOLOGY**

- 3.1 5 October 1971:** Mr Arthur McElhill was born.
- 3.2 22 September 1978:** Ms Lorraine McGovern was born.
- 3.3 20 September 1988:** Mr Arthur McElhill attended a Mental Health Clinic at the Tyrone and Fermanagh Hospital regarding his depression and suicidal attempts and was assessed by a locum consultant psychiatrist.
- 3.4 14 October 1988:** Mr Arthur McElhill was admitted to the Tyrone and Fermanagh Hospital following a suicide attempt. He was discharged on 20 October 1988 against medical advice and subsequently had regular contact with a mental health social worker. On 2 May 1989 Mr Arthur McElhill was discharged from the Mental Health Service.
- 3.5 October 1992:** Mr Arthur McElhill was involved in an incident when the car he was driving was shot at and his passenger wounded. He was very upset by this incident.
- 3.6 September 1993:** Arising out of events that had occurred in January 1993, Mr Arthur McElhill was convicted of aggravated burglary and indecent assault on a female who was 17 years and 10 days old at the time of the offences. Sentence was deferred for 6 months and amongst the conditions imposed on him during the deferment period were that he was to:
- attend counselling sessions at Erne House (Tyrone and Fermanagh Hospital Psycho-Sexual Clinic);
  - remain in contact with a probation officer as instructed; and
  - refrain from taking alcohol.
- 3.7 Late 1993:** Mr Arthur McElhill, then aged 22 years, met and formed an intimate relationship with Ms Lorraine McGovern, then 15 years old. Ms Lorraine McGovern became pregnant in late 1993 but did not advise Mr Arthur McElhill of her pregnancy until she was 8 months pregnant.
- 3.8 23 March 1994:** At the end of the deferment period, Mr Arthur McElhill was sentenced at Omagh Crown Court by way of a sentence of 2 years imprisonment suspended for 3 years together with the imposition of a 1 year Custody Probation Order and a condition that he attend and complete a course of psycho-sexual counselling as directed.
- 3.9 28 August 1994:** Caroline McGovern was born, her mother, Ms Lorraine McGovern then being 15 years and 11 months old. Caroline and her mother remained living with Ms Lorraine McGovern's parents in County Cavan while Mr Arthur McElhill remained living with his own parents in Omagh.

- 3.10 July 1996:** Ms Lorraine McGovern left her parents' home and moved to Omagh with Caroline where she lived with a sister of Mr Arthur McElhill. Mr Arthur McElhill remained living with his parents and was a regular visitor to his sister's house.
- 3.11 27 September 1996:** Mr Arthur McElhill committed an indecent assault on a 17 year old female. The offence was committed while Mr Arthur McElhill was intoxicated and he entered the person's own sleeping accommodation to commit the offence.
- 3.12 10 October 1996:** Referral of Mr Arthur McElhill by Probation to Erne House psychologist for psychosexual counselling
- 3.13 15 October 1996:** Letter from Probation Service to Social Services regarding Mr Arthur McElhill's pending court case regarding the alleged assault and requesting an assessment of Ms Lorraine McGovern's situation in relation to the child Caroline aged 2.
- 3.14 9 December 1996:** Joint visit by Probation Service and social worker to Mr Arthur McElhill and family. There was no further contact for 3 months.
- 3.15 28 February 1997:** Visit by social worker to the home and the case was closed. The records indicated that there were no child protection concerns noted.
- 3.16 23 May 1997:** Social work case note on file identifies the need for a case discussion but there is no record that this took place.
- 3.17 16 September 1997:** Further referral from Probation Service and social work contact was renewed on 25 September 1997.
- 3.18 14 October 1997:** Case conference held which placed Caroline's name on the Child Protection Register (the Register).
- 3.19 21 April 1998:** Mr Arthur McElhill was convicted at Omagh Crown Court of the offence referred at 3.11 above and was sentenced to three years imprisonment followed by two years Custody Probation Order. The suspended sentence in respect of his earlier offences was to be served concurrently. As a result Mr Arthur McElhill was required to comply with the Sex Offender Registration requirements for an indefinite period.
- 3.20 30 June 1998:** Caroline's name was removed from the Register as Mr Arthur McElhill was in prison.
- 3.21 23 September 1998:** Case was closed.
- 3.22 12 August 1999:** Mr Arthur McElhill was released from prison and went to live with his parents and was subject to the 2 years Custody Probation Order.

- 3.23 8 September 1999:** A further child protection case conference was held in respect of Caroline. At this time Mr Arthur McElhill continued to live with his parents and Ms Lorraine McGovern and Caroline lived with Mr Arthur McElhill's sister. Caroline's name was placed again on the Register under the category of "Potential Sexual Abuse". The probation officer attended the case conference and stated that although Mr Arthur McElhill was able to identify his own risk factors – alcohol, sexual talk amongst males and emotional stress, the psychologist's report from the prison was that he was classed "as high risk of committing sexual offences again" and that he had therefore been required to continue with further counselling.
- 3.24 17 December 1999:** A review child protection case conference took place. By this time Ms Lorraine McGovern and Caroline had moved to live at 4 Lammy Crescent. Mr Arthur McElhill and Ms Lorraine McGovern wanted Mr Arthur McElhill to live there also. Positive and negative factors in terms of risk assessment were discussed in detail at the case conference. Legally Mr Arthur McElhill was in a position to move to live at 4 Lammy Crescent provided that he complied with the Registration requirements of the Sex Offenders Scheme by notifying his probation officer and the PSNI of a change of address. The general view was that the preferred option was for all assessments to be completed before Mr Arthur McElhill moved in with Ms Lorraine McGovern and the couple agreed with this view. The decision was made to continue Caroline's registration. It was noted that Ms Lorraine McGovern was pregnant.
- 3.25 April 2000:** The case was transferred from the short term Family Intervention Team (F.I.T.) to the long term F.I.T. and there was a change of social worker.
- 3.26 18 April 2000:** Sean McElhill was born. The Social Service's programme manager directed that there was no need for a core group to meet in respect of child protection matters for Sean.
- 3.27 14 June 2000:** A further review child protection case conference took place. Written reports were available from the second social worker involved during this period and from the health visitor. The psychologist at Erne House working with Mr Arthur McElhill was of the view that his abuse of alcohol had diminished and that in the light of his offending he was a risk to older teenage girls and that there was no evidence that he was a risk to children, however, this could not be guaranteed. The psychologist indicated that he intended to continue his work with Mr Arthur McElhill and felt that more work was required with Ms Lorraine McGovern to act as protector. The therapist working with Ms Lorraine McGovern agreed. Mr Arthur McElhill stated that he wanted to move to live with Ms Lorraine McGovern, Caroline and Sean and that he had not done so since the previous case conference because he did not know whether he was permitted to do so. He advised that he intended to move in the following week but he did not. It was decided at the case conference that in view of the incomplete assessments at Erne House, Caroline's name should remain on the Register and a further case conference was set for December 2000.

- 3.28 21 November 2000:** Mr Arthur McElhill, having notified PSNI and the Probation Service, moved to live with Ms Lorraine McGovern, Caroline and Sean at 4 Lammy Crescent.
- 3.29 14 December 2000:** The review child protection case conference took place and decided that Caroline's name should be taken off the Register. Written reports were provided by the social worker and also by the health visitor who were involved during this period. Reports written for the case conference by the psychologist working with Mr Arthur McElhill and the therapist working with Ms Lorraine McGovern were not received by Social Services until 15th December 2000 and were not available for the case conference. Neither the psychologist nor the therapist were able to attend the case conference and the social worker instead reported their views as spoken to her. The social worker also reported that she had visited the family home on a regular basis and found both parents to be co-operative, although it is the view of the Review Panel that this judgment was based on four visits to the family over a five month period. The social worker also stated that the staff at Erne House had told her that they were impressed with the progress of Mr Arthur McElhill and that his attendance was excellent, whilst Ms Lorraine McGovern found it difficult to attend Erne House as she had no one to care for Sean. The General Practitioner (GP) commented that the children were making great progress with no health concerns and that the couple's care of the children was excellent. She was of the view that the family should be allowed to function as a family unit. It was agreed by all professionals present that the risks to Caroline from Mr Arthur McElhill had been significantly reduced through the work with the family and it was therefore decided that Caroline's name should be removed from the Register. It was noted that Mr Arthur McElhill would remain on probation until August 2001. The social worker was to continue to visit the family for a minimum 3 month period to provide support.
- 3.30 20 December 2000:** The last visit was made by a social worker to the family to deliver Christmas gifts.
- 3.31 April 2001:** Case closed on SOS CARE. There was no reason provided on the record.
- 3.32 11 August 2001:** Mr Arthur McElhill ceased to be subject to the probation order. He was assessed as being medium risk.
- 3.33 June 2001 to the 26 August 2004:** Mr Arthur McElhill was subject to review by the Area Sex Offender Risk Management Committee (ASORMC) having been assessed at medium risk (level 2). On the 26 August 2004 Mr Arthur McElhill was reassessed at low risk (level 1) and remained at this level until his death in November 2007, He was subject to single agency management by the PSNI through the involvement of a Designated Risk Manager.
- 3.34 26 June 2003:** Bellina McElhill was born.

- 3.35 3 September 2003:** Ms Lorraine McGovern was prescribed medication for post natal depression.
- 3.36 17 April 2006:** Clodagh McElhill was born.
- 3.37 21 January 2007:** James McElhill was born
- 3.38 December 2000 to September 2007:** There was no Social Services involvement with the family. Health visitors continued to visit the family in accordance with good practice and did not see or report anything untoward.
- 3.39 April 2007:** A teenage child and her younger sisters were entered onto the Trust's Register. The teenage child and her sisters were unrelated to the family of Mr Arthur McElhill and Ms Lorraine McGovern. The teenage child was a friend of Caroline (aged 13). Her mother was known to Mr Arthur McElhill and Ms Lorraine McGovern.
- 3.40 June and July 2007:** The teenage child was attending the Trust's Family Resource Centre and the family support worker came to know that the teenage child, with the knowledge of and by arrangement with her mother, was staying overnight from time to time at the home of Mr Arthur McElhill and Ms Lorraine McGovern. The teenage child was being collected and returned to that address by the family support worker for her sessions at the Family Resource Centre. The family support worker was concerned to find out more and on the 16 July 2007 she told the social worker assigned to the teenage child (being the first assigned social worker during this period) of her concern that the teenage child was staying at an address other than that entered on the Register.
- 3.41 9 July 2007:** The mother of the teenage child advised the social worker that the teenage child would be staying at the home of Mr Arthur McElhill and Ms Lorraine McGovern while she herself would be on holiday in early August 2007. The mother was advised by the social worker of her responsibility to check the suitability of the carers.
- 3.42 17 July 2007:** The mother of the teenage child advised the social worker that the teenage child's other siblings were also taking it in turn to spend nights at the home of Mr Arthur McElhill.
- 3.43 20 July 2007:** The assigned social worker visited the home of the teenage child but did not pursue the matters referred to immediately above.
- 3.44 3 August 2007:** The family support worker carried out a Social Services Client Administration and Retrieval Environment (SOSCARE) check and informed the Review Panel that she brought the results to the attention of the assigned social worker. The assigned social worker, in interview with the Review Panel, did not accept that assertion and informed the Review Panel that she carried out her own SOSCARE check that day.

The SOS CARE checks made on 3 August 2007 showed only that Caroline had previously been on the Register and that Mr Arthur McElhill had previously been the subject of a probation order. The SOS CARE record did not disclose the nature of the previous offending by Mr Arthur McElhill.

The assigned social worker did not seek to retrieve the original Social Services files which would have disclosed the nature of the previous offending by Mr Arthur McElhill, nor did she take any other step to find out the previous circumstances which had caused Caroline to be on the Register.

- 3.45 10 August 2007:** The family support worker informed the social worker of her concerns regarding the teenage child staying at 4 Lammy Crescent.
- 3.46 15 August 2007:** The assigned social worker spoke to the mother of the teenage child who informed her that the teenage child had stayed with Mr Arthur McElhill and Ms Lorraine McGovern from the 6 August 2007 and was refusing to return home. The assigned social worker advised that she would speak to the teenage child about her reluctance to return home.
- 3.47 22 August 2007:** The assigned social worker visited the home of the teenage child. The focus of the discussion was in respect of another matter and while the assigned social worker spoke with the teenage child, no enquiry was made by her in relation to her staying with Mr Arthur McElhill and Ms Lorraine McGovern.
- 3.48 7 September 2007:** Mr Arthur McElhill was seen by his General Practitioner. The Doctor's assessment and diagnosis excluded suicidal thoughts, nor did Mr Arthur McElhill express any intention to harm other individuals. The doctor prescribed antidepressant medication and asked him to return in two weeks but despite a reminder he did not attend.
- 3.49 11 September 2007:** The PSNI were called out by Ms Lorraine McGovern to 4 Lammy Crescent, Omagh, there having been an incident there involving the mother of the teenage child. The PSNI officers contacted the Trust's Out of Hours social work service seeking the approval of Social Services for the teenage child to remain at 4 Lammy Crescent overnight. This approval was given by the coordinator without any checks being carried out. The police officers were informed that the assigned social worker would be told of the matter.
- 3.50 12 – 17 September 2007:** Contacts were made by the family support worker with the teenage child and with the F.I.T. assigned social worker advising them of the need for police checks to be undertaken in respect of the accommodation of the teenage child at the home of Mr Arthur McElhill.
- 3.51 14 September 2007:** The assigned social worker visited the home of the teenage child and spoke to her mother. At that time the teenage child was not present as she continued to stay at the home of Mr Arthur McElhill and Ms Lorraine McGovern.

- 3.52 18 September 2007:** The assigned social worker went to 4 Lammy Crescent and spoke to Mr Arthur McElhill and Ms Lorraine McGovern. The discussion focused on the mother of the teenage child and not the accommodation arrangements for the teenage child.
- 3.53 19 September 2007:** In the late afternoon, police officers attended at 4 Lammy Crescent in relation to an incident involving the mother of the teenage child. The teenage child was at the house. The police radio communications in respect of this incident were overheard by the Designated Risk Manager who was on duty at the time. The Designated Risk Manager informed the police officers at the scene of the nature of the offending history of Mr Arthur McElhill. The police officers at the scene contacted Social Services and social workers including the assigned social worker were informed of the offending history of Mr Arthur McElhill. No steps were taken that evening by Social Services to remove the teenage child from 4 Lammy Crescent.
- 3.54 20 September 2007:** The Designated Risk Manager directly contacted the Trust's programme manager who was the Trust's representative in respect of MASRAM. As a result of that contact, the programme manager directed the immediate removal of the teenage child from 4 Lammy Crescent and she was removed by social workers later that day.
- 3.55 1 October 2007:** A group of social workers and a school representative discussed the case of the teenage child at a professional meeting convened by Social Services. It was decided to refer the case of Mr Arthur McElhill, Ms Lorraine McGovern and their children to the Gateway Team for assessment. The assessment form, Understanding the needs of Children in Northern Ireland (UNOCINI), was prepared for this referral but it did not contain the full information in respect of the offending history of Mr Arthur McElhill. The relevant social worker delivered that day to the Gateway Team the prepared UNOCINI form together with the original Social Services file from 2000.

The Gateway team manager coded the case as "orange" and placed it on the waiting list, which was the only action taken in respect of the referral. Prior to 13 November 2007 no social worker interviewed or visited Mr Arthur McElhill, Ms Lorraine McGovern or any of their children.

- 3.56 5 October 2007:** A child protection case conference in respect of the teenage child was planned for this date and was postponed that day following a challenge by Ms Lorraine McGovern. This was because of the inclusion on the UNOCINI form, in respect of the teenage child, of information about the offending history of Mr Arthur McElhill.

- 3.57 14 October 2007:** Caroline contacted the PSNI in a distressed manner about a row between her parents. Police officers promptly attended 4 Lammy Crescent and talked with Ms Lorraine McGovern who described a disagreement which had concluded. Mr Arthur McElhill and the children were not seen as they had retired to bed. The police officers did not take further action at that time but on the 25 October 2007 referred the matter to the Trust's F.I.T. On the 25 October 2007 the referral was coded "green" by the Gateway team leader and it was placed on a waiting list.
- 3.58 19 October 2007:** The child protection case conference was held in respect of the teenage child. No information was presented to the case conference about the offending history of Mr Arthur McElhill or potential risks arising from this. There was no discussion about these matters.
- 3.59 5 November 2007:** The Designated Risk Manager called at 4 Lammy Crescent. He spent over an hour in the house with Mr Arthur McElhill, Ms Lorraine McGovern, Bellina and James. He discussed MASRAM issues with both adults and also discussed with Mr Arthur McElhill a matter apparently in dispute between Mr Arthur McElhill and a member of the public. Ms Lorraine McGovern had no concerns and Mr Arthur McElhill appeared to be in good form. They described the incident of the 14 October 2007 and were of the opinion that Caroline had overreacted and that they had had a verbal disagreement and nothing more.
- 3.60 6 November 2007:** Social Services received a telephone call from a member of the public, in respect of the alleged dispute, which is referred to immediately above. This alleged dispute is the subject of police enquiry.
- 3.61 13 November 2007:** The fatal fire occurred at 4 Lammy Crescent.

## **4. SOCIAL SERVICES**

### **4.1 Professional Practice**

**4.1.1** Competent professional practice is the cornerstone of Social Services work with children and families and therefore this was an important element in the analysis of the work undertaken by the Review Panel. The social work case files of Mr Arthur McElhill and Ms Lorraine McGovern, the files associated with the social work interventions conducted with the teenage child at the Family Resource Centre and the files from Erne House were examined as a major part of this Review. In addition detailed interviews were conducted with the full range of social work staff and other disciplines involved and an analysis was made of the practice and procedural issues which emerged. The Review Panel, from the evidence obtained, has formed judgements which are critical of the way in which the cases were progressed in 2000 and over the summer of 2007.

**4.1.2** The examination of the case file for the period following the initial referral by Probation to Social Services in October 1996, highlighted weaknesses in the social work practice and records. There were long gaps in the two recorded contacts with the family and there was no evidence that an assessment of the risks associated with Mr Arthur McElhill's alleged offending behaviour had been made. Records were not kept on the case files of links made with other disciplines or of the reasons for closure of the case in 2000.

**4.1.3** There was evidence of planned therapeutic interventions in the work that was undertaken by the social work therapist at Erne House in 1997/1998 and by the F.I.T. in 1998/1999. The case files indicated that work was structured, planned and analysed with clear objectives set with the family on the safeguarding work that was ongoing. There were good communications established by the social workers with other agencies, which were used effectively to progress and review the care plan.

**4.1.4** When the case was transferred to the long term F.I.T., in early 2000, there had also been changes in late 1999 in the therapists at Erne House and the practice in both these areas weakened. The social work involvement in 2000 was weak and lacked any planning or structured interventions. The contact with the family decreased considerably from the agreed fortnightly visits, recording was poor and there was no analysis made of the interventions and levels of risk emerging. The case was not supervised and managed appropriately. Concerns emerged regarding professional practice, multi-disciplinary and interagency working and record keeping, which were weak during the period December 1999 - December 2000.

**4.1.5** The Family Resource Centre's case files also confirmed that the work undertaken by the centre over the summer of 2007 with the teenage child and her mother was also well planned and structured. Objectives were set and reviewed in terms of progress made with the family. There was also evidence of the continued attempts made by the staff at the Family Resource Centre to engage with the F.I.T. social work staff on concerns emerging in order to progress the assessment, the risk assessment and

care plan. However the F.I.T. case files did not provide any confidence that the emerging issues were acted upon. These files showed no structure or planning to the work that needed to be undertaken in the case of the teenage child. Scant details were recorded in the files, which were of a poor professional standard. Statutory requirements were not met in relation to the visits to the teenage child who was placed on the Register. There was no evidence of planned and structured work linked to the case plan. The events that occurred between 3 August 2007 and the 13 November 2007 show that competent professional practice was not followed in a number of instances particularly in responding to concerns raised and referrals made, conducting assessments, risk assessments and working with other disciplines and agencies. The professional practices of the relevant social workers were not adequately monitored, supported or challenged by senior staff and the case files were not adequately examined and monitored during this period.

### **Recommendations**

- 1. The Trust must ensure that child protection work undertaken with children and families is structured, therapeutically focused and informed by the continuing contribution, skill and expertise from all relevant professionals and agencies. This work should be evidenced through the written records.**
- 2. The social work practice and the supervision and management of this work should be appropriately audited to ensure that it meets professional standards and statutory requirements.**

## **4.2 Assessment/ Risk Assessment/ Care Planning**

**4.2.1** The standards for working with children and families and conducting assessment, risk assessment and care planning are set out in the following documents:

- Children Northern Ireland Order 1995 (Children Order Guidance and Regulations Volume 6, Cooperating to Protect Children);
- Cooperating to Safeguard Children, DHSSPS, May 2003;
- Area Child Protection Committees' (ACPC) Regional Policy and Procedures 2004;
- Draft Standards for Child Protection DHSSPS 2004. (The draft Standards for Child Protection were revised in 2007 in collaboration with all the Boards, Trusts and key agencies but they have not yet been issued by the DHSSPS);
- Our Children and Young People Our Shared Responsibility, DHSSPS 2007.

**4.2.2** Assessments should draw together all information available from the full range of disciplines and agencies involved with the child and family and provide an objective analysis, which effectively informs decisions about how best to intervene to safeguard the child and achieve the desired outcomes. There is a need for an effective risk assessment strategy for each individual child, which should be completed where there is the potential for abuse. The analysis of the evidence from the interviews and the agencies case files relating to Mr Arthur McElhill and Ms Lorraine McGovern revealed a number of failings regarding the standards required, including:

- inadequate uni-disciplinary assessment, comprehensive assessment, risk assessment and care planning in the records, across all disciplines;
- the failure on the part of the Trust to provide a strategy and procedure for conducting risk assessment on individual children and their families. This is reported in the Trust's child protection Inspection Report 2006 issued by the DHSSPS and in the Regional Inspection Report "Our Children and Young People Our Shared Responsibility" DHSSPS 2007. Specific recommendations are made in chapter 11 and at section 53, 56 and 57 of the DHSSPS report for Trusts to "ensure that each assessment of need is robust and informs the work with the child" and that "a risk management strategy is developed to support both the individual child and residential group";
- poor understanding and recognition of the skills, expertise and contributions required from the other disciplines and agencies to assess and inform the work required and to collaboratively take this forward.

## **Problems identified in the 2000 period**

- 4.2.3** There was no evidence in the file records of any structured work planning regarding visits to Mr Arthur McElhill and Ms Lorraine McGovern during 2000 or in advance of the case conferences held in June and December 2000. The file records for April – December 2000 are scant and of a poor and unacceptable quality. Objectives were not set and there was no focus to the visits or analysis of the outcome and future work needed.
- 4.2.4** There was little information in the file of work with and liaison with other disciplines and agencies during 2000 in order to make an adequate assessment of need. This was confirmed during the interviews with staff involved in 2000.
- 4.2.5** This is in contrast to the file recording by the social worker involved in the case prior to February 2000 who had recorded assessment and identification of specific areas of work to be undertaken with the family particularly safeguarding issues. There was clear evidence from the case file at this time that the work was continuing with Ms Lorraine McGovern and Caroline.
- 4.2.6** Following the transfer of the case to another social worker in February 2000 there was no assessment made of the need to continue this work and while a reference was made in the case file that it “may continue” this was not followed up by the new social worker. The frequency of contacts in the case moved from fortnightly sessions, which had been agreed at case conference as part of the care plan, to four visits between 24 July 2000 and 14 December 2000.
- 4.2.7** On the birth of Sean in April 2000, upon the direction of a senior manager, no updated assessment or risk assessment and no core group meeting was convened. There was no evidence in the file that this was based on any validated evidence or information from other sources. This direction was not in keeping with the decision of the previous case conference.
- 4.2.8** The full risks, which had been previously identified at the case conference in June 2000, were not assessed or reviewed for the case conference in December 2000. The social work report presented to the December 2000 case conference only identified one risk area and other areas of risk were not reviewed. The fact that Mr Arthur McElhill had occasionally been staying overnight at the house was not made known at the case conference.
- 4.2.9** There was an inadequate assessment by all the agencies prior to the case conference in December 2000. The effect of the move by Mr Arthur McElhill into the home of Ms Lorraine McGovern and the children, three weeks prior to the case conference, was not assessed and the need for any further assessment work was not considered.

- 4.2.10** Reports from two key professionals (who did not attend the case conference in December 2000) were received by the social worker after the case conference and these were not circulated to anyone. The information contained in these reports did not inform the assessment made by the social worker or the proposals made to the case conference. Thus the decision to remove Caroline's name from the Register was made without the benefit of these reports. The Review Panel interviewed two key professionals who attended the case conference and gave them copies of the two reports. These two professionals informed the Review Panel that had they seen the reports they would not have been in favour of removing Caroline's name from the Register at that time.
- 4.2.11** There was no evidence that the social worker discussed with the therapists the assessments which had been made or how these would influence proposals for progressing the care plan and the proposals to the case conference in December 2000. The files from Erne House did not provide up to date information or an assessment of information arising from the therapeutic consultations. Information acquired in these sessions did not inform liaisons with social services, health visiting or the nurse therapist who was working with Ms Lorraine McGovern at Erne House. The report submitted by Erne House to the case conference in December 2000, had been prepared in October 2000 for use by the Probation Service and was not what was required for the child protection case conference as it did not deal with child protection or family issues. The social worker did not request a report focused on these issues.
- 4.2.12** There were no formal core group meetings in 2000. Such meetings would have provided a mechanism to draw together information from all the various disciplines and agencies so that comprehensive assessment, risk assessment and care planning could take place.
- 4.2.13** Following the removal of Caroline's name from the Register in December 2000, there was no evidence that the situation was assessed or reviewed collaboratively by the disciplines and agencies involved or that the care plan, agreed at the case conference, was completed. The Social Services case file ended on the 20 December 2000 and the case was formally closed by social services on SOS CARE in April 2001. There was no record that an assessment was undertaken prior to formal closure, or that a review was conducted on the completion of the care plan. No other agencies were contacted as required by the Trust's procedure. Erne House finished contact with Mr Arthur McElhill in the summer of 2001 and Ms Lorraine McGovern did not return for any further sessions. Erne House were unaware of the file closure by Social Services and did not inform Social Services that contact with the family had ceased. Social Services did not make the Health Visiting Service aware of the case closure.
- 4.2.14** Evidence from interview and from case files showed inadequate supervision and monitoring by the team leader in 2000 of the processes of assessment, risk assessment and care planning. There were similar difficulties in 2007.

## **Problems identified in the 2007 period**

**4.2.15** The Review Panel interviewed Social Services staff involved with the teenage child, who stayed at the home of Mr Arthur McElhill in the summer of 2007, and examined the case files in respect of that child for the period 15 June 2007 to 13 November 2007. There was no evidence of an assessment or risk assessment of the high risk issues which were emerging. The concerns raised by the family support worker about the teenage the child staying at 4 Lammy Crescent did not trigger assessment of the levels of risk to the teenage child or Caroline. No core group meeting was held to determine what action was needed.

**4.2.16** During the summer of 2007 the teenage child, who was a friend of Caroline's, was regularly staying over at 4 Lammy Crescent. This was an arrangement initiated by the teenage child with the knowledge and approval of her mother. At the same time the teenage child was also attending the Family Resource Centre. The family support worker came to know of this arrangement and became concerned because the teenage child was on the Register. She raised her concerns in July 2007 with the social worker allocated to the teenage child. The social worker did not take the necessary steps to visit, assess and vet the arrangements so as to ensure that appropriate safeguards were in place. Also during July 2007 the social worker was advised by the mother of the teenage child that her other younger children were also taking it in turns to stay at 4 Lammy Crescent but the social worker took no steps on foot of this information. Neither the family resource worker or the social worker were aware at that time of the offending history of Mr Arthur McElhill.

However on the 3 August 2007 the family resource worker conducted a SOSKARE check on Caroline and Mr Arthur McElhill, which showed that Caroline had previously been on the Register and that Mr Arthur McElhill had been on probation. The SOSKARE computer record gave no indication as to why he had been on probation. The family resource worker told the Review Panel that she brought this information to the attention of the social worker that day. The social worker denied this to the Review Panel. However she told the Review Panel that she herself had conducted a SOSKARE check on 3 August 2007 and that it showed Caroline had been on the Register and Mr Arthur McElhill had been on probation. As with the SOSKARE check, carried out by the family resource worker, there was no indication of the nature of Mr Arthur McElhill's offending history. The social worker took no steps to find out why Caroline had previously been on the Register nor to find out why Mr Arthur McElhill had been on probation. All this information was available on the Social Services file, which was closed in 2000

It is the considered judgement of the Review Panel that on the 3 August 2007 the social worker had more than sufficient information available to her from the Family Resource Centre, the teenage child's mother and the SOSKARE records to require her to retrieve the case files from 2000. Had she done so she would have seen the nature of the offending behaviour of Mr Arthur McElhill, which should have led to immediate action to ensure that the teenage child and her siblings did not stay over at 4 Lammy Crescent. This action however did not happen until the 20 September 2007.

After the 3 August 2007 the social worker did not visit the teenage child until the 22 August when she visited the mother's home and on the 18 September 2007 when she visited her at 4 Lammy Crescent. Mr Arthur McElhill and Ms Lorraine McGovern gave the social worker detailed information about the family and circumstances of the teenage child. The social worker did not make enquiries of Mr Arthur McElhill and Ms Lorraine McGovern as to their own circumstances and background.

**4.2.17** On the 19 September 2007, in the late afternoon, police officers attended 4 Lammy Crescent in relation to an incident involving the mother of the teenage child. The teenage child was at the house. The police radio communications in respect of this incident were overheard by the Designated Risk Manager who was on duty at the time. The Designated Risk Manager informed the police officers at the scene of the nature of the offending history of Mr Arthur McElhill. The police officers at the scene contacted Social Services and social workers, including the assigned social worker, were informed of the offending history of Mr Arthur McElhill. No steps were taken that evening by Social Services to remove the teenage child from 4 Lammy Crescent.

**4.2.18** On the 20 September 2007 the Designated Risk Manager, assigned to Mr Arthur McElhill, telephoned the Trust's programme manager to advise on the immediate removal of the teenage child from the home of Mr Arthur McElhill, describing him as a "risk to teenage girls". The programme manager directed two social workers to remove the teenage child from 4 Lammy Crescent describing Mr Arthur McElhill as a "high risk to teenage girls". The previous social worker for the teenage child had moved that day to another location within the Trust area and was not involved in the removal. At the time of the removal no risk assessment was carried out either in respect of the teenage child and her siblings or in respect of Caroline and her siblings. The Review Panel were told by social workers that they had sought advice on the need for a risk assessment to be made in respect of Caroline and her siblings but were told that this was not needed as Ms Lorraine McGovern was the protector.

**4.2.19** On 1 October 2007 a professional/case strategy meeting was held in respect of the teenage child and the minutes of that meeting show that the team leader did not identify any areas of risk regarding Mr Arthur McElhill. At that meeting the decision was taken to refer Mr Arthur McElhill and his family to the Gateway team and a UNOCINI form was prepared. During the interviews held with the team leader she confirmed that this referral was made in order to determine the level of risk to Caroline but this was not on the form. The referring social worker advised that she provided all the information and the file on Mr Arthur McElhill and the family, when she passed the referral to the Gateway team. However the matter was not considered urgent by the Gateway team leader despite the removal of the teenage child on 20 September 2007 and the information regarding the offending history.

**4.2.20** A case conference was held on the 19 October 2007 but, as with the 1 October 2007 case strategy meeting, this was in respect of the teenage child who had been removed. The case conference failed to discuss the

risks posed by Mr Arthur McElhill, even though “high risk” was the reason for the removal of the teenage child. The social worker also advised the Review Panel that information about the previous offences of Mr Arthur McElhill was not included in the social worker’s report to the case conferences. The social worker said that this was because of what were regarded as concerns about data protection issues and also because of the previous difficulties created by Ms Lorraine McGovern on the 5 October 2007. Subsequently no attention was given to Mr Arthur McElhill and his family. The team leader and the case conference chair should have pursued this, particularly as there had been previous concerns and confrontations following the challenge made by Ms Lorraine McGovern before the original case conference on the 5 October 2007 and the reference to the offending history of Mr Arthur McElhill in the social worker’s report. These events and concerns were not passed to the Gateway team and therefore did not inform their assessment of the urgency of allocation. In addition the UNOCINI form completed on the teenage child who had been removed should have been passed to the Gateway team to provide details of the concerns and to progress allocation.

**4.2.21** The arrival of a notification on 25 October 2007 from the PSNI to the Gateway team about the domestic violence incident of 14 October 2007 did not trigger an urgent assessment on the risks to Caroline, which was necessary particularly as she herself had called the police.

**4.2.22** From the removal of the teenage child from the home of Mr Arthur McElhill on 20 September 2007 until 13 November 2007 there was no evidence provided in the case files that sufficient contact had been made with the teenage child. No detailed enquiry was pursued to assess the risks posed to the teenage child and her siblings.

## **Recommendations**

- 3. Trusts and agencies should review their implementation of assessment, risk assessment and care planning procedures to ensure they comply with the DHSSPS standards set and that they have fully implemented and trained their staff in:**
  - **a risk assessment protocol, procedure and format for undertaking risk assessment on individual children and their families and that this is appropriately compiled and shared with all the relevant disciplines and agencies;**
  - **the single assessment framework “ Understanding the Needs of Children in Northern Ireland (UNOCINI)” and that appropriate assessments and risk assessments are in place;**
  - **the recommendations contained in the DHSSPS reports issued to the Trust in 2004 and 2006 on the inspection of child protection services and the DHSSPS Regional inspection report “ Our**

**Children and Young People Our Shared Responsibility” 2007, in respect of assessment, risk assessment and care planning.**

- 4. The Trust should ensure that where a child makes a complaint about domestic violence that this is followed through as a matter of priority, and arrangements are made for the child to be interviewed and a full assessment made in relation to the risks.**
- 5. The DHSSPS should give priority to finalising and issuing the revised draft Child Protection Standards 2004. In finalising these standards account should be taken of;**
  - The matters highlighted in this report in relation to sex offenders.**
  - The new PSNI Public Protection arrangements which commence in October 2008.**

### **4.3 Implementation of Child Protection Procedures**

**4.3.1** From the examination of the case records and the interviews with staff there was evidence that staff are not complying with the DHSSPS, ACPC guidance on child protection and MASRAM procedures in a number of areas including: assessment, risk assessment, joint protocols, record management, case conferences and supervision.

**4.3.2** The Trust does not provide a comprehensive child care/ child protection procedural manual for staff as they advise that they operate to Co-Operating to Safeguard Children DHSSPS 2003 and the ACPC Regional Policy and Procedures 2004. While the Trust provided the Review Panel with procedures, including supervision and record keeping, there were important areas identified during the Review upon which staff require written guidance. This was particularly evident in the Omagh FIT and Gateway teams, which have a regular turnover of staff including inexperienced Assessed Year in Employment (AYE) and agency social workers. The immediate procedures requiring action in:

- a risk assessment protocol, procedure and format for assessing risks to children and families;
- procedure for managing sexual offenders/ MASRAM issues and “ a consistent approach to recording of MASRAM cases on the relevant Trust information systems” (MASRAM Guidance para 8.2);
- procedure for coding and prioritisation of cases awaiting assessment including collating ongoing information emerging and conducting the initial visit to adequately inform the assessment made regarding the level of risk;
- the procedures for conducting and recording clarification interviews and joint protocol arrangements;
- conduct of core group meetings and providing timely and accurate reports to case conference;
- procedure for managing information when a child's name is removed from the Register;
- multi-disciplinary and interagency working arrangements;
- procedure for managing cases when staff resign, leave or are on long term sick leave and allocating cases to students and trainees;
- exit strategy interviews and analysis; and
- Out of Hours coordinators' procedural manual and training.

**4.3.3** The Trust has been working collaboratively with other agencies on developing an interagency domestic violence protocol, which has been in draft form since 2006. This now needs to be reviewed, finalised and clear guidance provided to all staff on managing domestic violence referrals, ensuring a high priority is placed on responding and managing child protection concerns arising.

## Recommendations

6. **The Trust should ensure that senior management monitor and audit implementation by staff of the ACPC and DHSSPS policies and standards on child protection;**
7. **The Trust should review their current format for providing staff with information on child protection and children's services procedures and ensure that this is produced in a comprehensive manual which includes guidance on: UNOCINI procedures and risk assessment; prioritisation and coding cases; Management of Sexual Offenders/MASRAM information; responding to domestic violence referrals; clarification interviews; multi-disciplinary /Interagency working; management of cases when staff leave or are on sick leave; allocation of work to AYE and Agency staff; exit strategy interviews; updating of SOS CARE and data protection; maintenance of the Child Protection Register and de-registration; and Out of Hours procedural manual. Each member of staff should receive their own copy of this comprehensive manual in an appropriate format that can be updated.**
8. **The interagency draft Domestic Violence Protocol 2006 should be reviewed and finalised and clear guidance provided to all staff on managing domestic violence notifications, ensuring a high priority is placed on responding and managing child protection concerns arising.**

## Opening, Transferring and Closing Cases

- 4.3.4 The DHSSPS and Trust procedures were not operated for opening, transferring and closing cases in 1997/1998, 2000 and in 2007. Mr Arthur McElhill, Ms Lorraine McGovern and Caroline were not visited after the 20 December 2000, following the removal of Caroline's name from the Register. There was no evidence or record that any formal procedure was followed for the closure of the case on the SOS CARE record in April 2001. The family and other agencies were not informed. There was no review of the case to ensure that the action agreed at the child protection case conference had been achieved, before the case was closed. The child protection procedures provide clear guidance on the standards required when a child's name is removed from the Register, "de-registration should never lead to the automatic withdrawal of services help or support", para 5.79, Co-operating to Safeguard Children DHSSPS 2003. This is in effect what happened when Caroline's name was removed from the Register. During the Review interviews no explanation could be ascertained from the social worker or team leader, who was also the team leader in 2007.
- 4.3.5 The Trust procedure requires a "transfer of worker" form to be completed but there were no records of these on the file for September 2007 when the case transferred twice to other social workers, firstly on the 19 September 2007 and again on the 24 September 2007. There were no transfer records on health visiting files and lengthy periods of no visits were unexplained.

**4.3.6** The Trust procedures were also not followed by staff at Erne House for opening and closing cases and the case was not formally closed in the psychology file. A file was not opened by the nurse therapist and therefore records were not maintained and closure was not made.

### **Recommendations**

- 9. The Trust should ensure that the decisions taken on case closure and transfer are based on a full assessment of the progress of the case in collaboration with the other agencies involved and that those decisions are made in accordance with the procedures and standards set.**
- 10. When the decision is taken to remove a child's name from the Register the Trust should ensure that the care plan agreed at the case conference is actioned and reviewed with the agencies before case closure.**

#### **4.4 Understanding the Needs of Children in Northern Ireland (UNOCINI)**

**4.4.1** UNOCINI is the new assessment framework, introduced in Northern Ireland to assist professionals in identifying children and their family's needs. It provides a structure for recording information and a logical framework to assist in analysing information and developing robust plans that aim to improve outcomes for children. The UNOCINI guidance sets out the principles underpinning the framework and advises that "Using UNOCINI will ensure that children being referred come with the wealth of information that has already been collected by professionals working with them". It can be used to make referrals to family and child care and other children's services and to communicate these needs clearly and concisely to other professional colleagues, including those from outside organisations. It is also envisaged that it will be used by the organisation as "a tool to help them identify the needs of children at an earlier stage so their needs do not necessarily escalate to a point where they subsequently require further intervention". This was not the case when the UNOCINI referral was made on the 1 October 2007 by the F.I.T. to the Omagh Gateway Team. This referral was made in order that the risks to the children who had stayed at the home of Mr Arthur McElhill and the risks to his own children could be assessed and the appropriate plan put in place. No such assessment took place.

**4.4.2** The Trust had implemented the UNOCINI procedures in September 2007. The referral of Mr Arthur McElhill for assessment was made to the Gateway team on the 1 October 2007, by the social worker on the new UNOCINI format. The domestic violence referral was made to Gateway team by the PSNI on the 14 October 2007 and the Gateway team leader transferred this information onto the UNOCINI form attached to the original referral. However the two referrals then received separate codings and priorities within the format used by the Trust and this could not be explained during the interviews with staff.

**4.4.3** In examining this documentation and in discussions with staff a number of problems were identified:

- sufficient information was not included on the UNOCINI form sent to the Gateway team on the 1 October 2007 regarding Mr Arthur McElhill and important details that emerged over the following weeks were not shared to inform the decision re level of risk and case allocation. The guidance provided for staff on the implementation of the new assessment framework, Guide to UNOCINI, Preliminary assessment and referral, page 17 para 12.5.2 clearly sets out the detail required;
- there was no evidence that the content of the UNOCINI form had been discussed and agreed and monitored by the team leader. This would have been important as the social worker, who made the referral, was new to the case. This was a new social worker who was in her first term of her Assessed Year in Employment and had only been in her post 5 days when she was asked to complete this referral. In addition she had not been involved in the discussions or in the removal of the teenage child from the home of Mr Arthur McElhill and the form was not adequately checked by the team leader. This same social worker

provided a detailed and comprehensive UNOCINI report for the conference on the teenage child for the case conference on the 19 October 2007;

- at the professional meeting held on the 1 October 2007, which was convened by the F.I.T. team leader to discuss the teenage child, the end of the minute record states that Mr Arthur McElhill and the family were to be referred to the Gateway team for assessment and the newly appointed social worker was asked to do this. The Review Panel requested this minute but only received it on 28 February 2008, which was over 5 months from the date of the meeting. The minutes had only been written and had not been agreed or circulated. The minutes of this meeting did not reflect any discussion on Mr Arthur McElhill and his family and therefore did not identify the risks posed by him to other children or the potential risks he posed to his own children. The social workers, who had been involved in the removal of the teenage child and the programme manager who had made the decision, were not present at the professional meeting, nor were the PSNI who had instigated the removal of the teenage child from the home of Mr Arthur McElhill. As a result the full information was not discussed nor included on the UNOCINI referral;
- the referring social worker met with the Gateway team leader to pass over the UNOCINI form and also the file. On receipt of the UNOCINI referral there was no evidence that the family and children were seen or that an initial assessment was made regarding the levels of risk. Appropriate consultation did not take place with other professionals e.g. F.I.T. team leader, back up social workers involved (4), health visitors, GP and PSNI. The previous files, which had been passed over by the referring social worker to the Gateway team leader along with the UNOCINI form, were not read even though a full discussion had also taken place on the concerns and risks;
- the F.I.T. team leader advised that she had raised concerns in relation to the risks to Caroline as did two of the social work staff, who had been involved in the removal of the teenage child, and the family resource worker but this was not on the UNOCINI or other records and it was not acted upon;
- there was no collation of uni-disciplinary and interagency information and assessments reports to determine level of risk and immediate need as part of the UNOCINI requirements. The health visitor involved with the family and children, who had visited a month before the tragedy, was not advised by social services of the problems that had arisen over the previous months, or of the assessment referral of the 1 October 2007 or the 14 October 2007 domestic violence notification. The health visitor and other disciplines involved with the family should have been consulted as part of the gathering of information for the initial assessment and prioritisation of the case.

## **Recommendations**

- 11. Staff should be provided with the appropriate guidance, training and support in undertaking UNOCINI referrals, assessments, risk assessment and care planning. This should include training and support on the procedures to be followed from: making the UNOCINI referral to receipt of the referral, allocation and initial assessment stage; and the gathering of full and appropriate information from professionals involved to inform the initial assessment, risk assessment and action needed to ensure children are appropriately safeguarded.**
  
- 12. The Trust should ensure that all cases where there are child protection concerns, including those where there are sex offender's issues, should be immediately allocated and the children seen in line with the UNOCINI guidance on the initial assessment and Cooperating to Safeguard Children DHSSPS 2003.**

## **4.5 Communication- Interagency/multi disciplinary working**

**4.5.1** The Interagency/ multi- disciplinary working across the range of professionals and other agencies was weak, confirmed through the records examined, interviews conducted and comments received from the various agencies, both for the 2000 and 2007 periods. There was poor communication in the Omagh sector on a wide range of issues and little evidence on the case records of the communications held with other disciplines and agencies and the outcome of discussions held. Weaknesses included Social Services communication with other disciplines on:

- strategic direction and collaborative case working with children and families;
- internal senior management communication within the Trust both in 2000 and 2007 on the unresolved workforce and jobsharing problems;
- interface with other HSS disciplines, PSNI and MASRAM;
- information flow to core group meetings and case conferences in order to inform the risk assessment and care plan.

**4.5.2** In addition PSNI reported that there was inappropriate responsibility placed on PSNI to manage Out of Hours situations and to determine child protection issues and placements and other risk situations in mental health. Currently there is no dedicated person in the Social Services (Omagh Sector) to take lead responsibility for building and maintaining relationships. The NIO, in conjunction with other key agencies, are currently developing Public Protection Teams that will manage the most high risk sexual offenders and violent offenders in Northern Ireland. The secondment of Social Service staff as appropriate to these teams would allow for the ready and continual exchange of information in order to provide the most effective arrangements for managing the risk created by these serious offenders (para 6. 5). This and the opportunity for social work attachments to health centres/ GP practice as part of a work specialist commitment should be considered.

**4.5.3** The PSNI has developed and tested the Multi Agency Risk Assessment Conference (MARAC) process. This is a proven initiative to assist agencies in identifying and helping victims of domestic violence. The Minister for Health, Social Services and Public Safety has recently made an announcement regarding the funding which will now be made available for the regional rollout of MARAC. This, the action plans and the strategy will ensure a collaborative and cohesive approach to tackling and reducing sexual violence and abuse in Northern Ireland, which is commendable.

### **Recommendations**

- 13. The Trust should take immediate action to improve the poor relationships with the PSNI in the Omagh sector. Consideration should be given to identifying one key individual in the sector with lead responsibility to liaise, build and maintain relationships with the PSNI**

- 14. The Trust should set up an Interagency Review of their relationships and communication systems with other agencies including PSNI in the Omagh sector and ensure that plans are put in place to increase and improve the communication networks both informal and formal. The secondment of Social Services staff as appropriate to Public Protection Teams and attachments should be considered.**

#### **Interface with Probation**

- 4.5.4** The Review Panel examined file records, minutes of core group meetings and case conferences and met with representatives from the Probation Service in order to ascertain the levels of communication and co-operation between the organisations regarding the case examined.
- 4.5.5** It was evident from the files examined that Social Services communicated well with Probation Service during the early period of the probation sentences, on discharge from prison and for the period up until early 2000. The records and minutes of meetings confirmed regular contact and attendance at core group meetings and case conferences to progress the care plan and this continued up until early 2000 when the case transferred to the long term F.I.T. As identified earlier, the level of social work input was poor, core group meetings were not held and the level of contact between the two organisations decreased over this period. Social Services ceased contact with the family in December 2000 but did not inform any of the organisations including Probation Service, who were the main organisation involved with Mr Arthur McElhill until August 2001 when probation ended. As with the other disciplines and organisations involved in the core group and with the family, Probation Service was unaware that the case had been closed, following the removal of Caroline's name from the Register. They did not make contact with Social Services from December 2000 or with the therapists at Erne House who were to progress the work with Ms Lorraine McGovern, to ascertain the progress of the care plan and family position.
- 4.5.6** When probation ended in August 2001 Mr Arthur McElhill who was already on the sex offenders register, was graded medium risk. However, Probation Service, who were unaware of the case closure by Social Services, did not communicate with F.I.T. regarding this information.

#### **Recommendation**

- 15. The Trust and Probation Service should ensure that they continue to liaise and communicate closely on the progress of the care plan, that they seek and provide up to date assessment of the family position and share appropriate information with the relevant disciplines and agencies about risk, before deciding on case closure.**

## **Interface with Education**

- 4.5.7** The Review Panel met with representatives of the two schools attended by the children of Ms Lorraine Mc Govern and Mr Arthur McElhill and interviewed the Senior Education Welfare Officer for the Omagh area. The teachers advised that they had no cause to make contact with social services about Caroline, Sean or Bellina and also advised that they were unaware of the previous criminal offences of Mr Arthur McElhill or the fact that he was on the sex offenders register. The schools reported that good progress had been made by the children who integrated well in the schools environments, were extremely pleasant and well behaved and presented no problems.
- 4.5.8** In the interview with Education Welfare Services it was disclosed that between September and November 2007 Caroline, who had always had an exemplary school record, missed a number of days. Examination of Caroline's school attendance record indicated that a number of these absences coincided with key events highlighted in the files examined. These included: the 20/21 September 2007, following the removal of the teenage child; the 15 October 2007, following the domestic violence incident; and the 5 Nov 2007, which coincided with the PSNI visit to Mr Arthur McElhill regarding his dispute with a member of the public. Education Welfare Services did not consider that Caroline's absences were not a problem at that time and decided her attendance should be monitored.

## **4.6 Interface with Multi Agency Sex offender Risk Assessment and Management (MASRAM)**

**4.6.1** The MASRAM procedures set out the role for the Social Services representative, which includes the responsibility “to bring relevant information to the attention of the committee”. The procedures also require the Trust to put in place “a consistent approach to recording of MASRAM cases on the relevant Trust information systems” (Para 8.2 of the multi-agency sex offender risk assessment and risk management procedures). It was evident from the interviews with staff and the examination of the case files and Trust documentation, that there has been difficulty in fully implementing these procedures. A member of the Trust senior management sits on the Area Sex Offender Risk Management Committee (ASORMC) but there are no procedures or facility in place to manage the information and data arising from these meetings or to ensure that this is appropriately shared and logged on the Trust’s data system. Similarly there was no provision for Social Services to share information arising from critical issues emerging in cases and in this instance in the developments that had arisen in referring Mr Arthur McElhill and his family for assessment of the risks.

**4.6.2** There was no further communication between Social Services and the Designated Risk Manager after the teenage child was removed from Mr McElhill’s home on the 20 September 2007. The Designated Risk Manager was invited by Social Services to a professional meeting on the 1 October 2007 regarding the teenage child but did not attend as he did not know the case. There was no risk management or strategy meeting convened by Social Services to determine the potential risks posed by Mr Arthur McElhill to the other young children who had stayed at the house or to his own children. The case was instead referred to the Gateway team but it was not allocated. A risk management strategy discussion should have been convened by Social Services on Mr Arthur McElhill, which would have highlighted the urgency of the case and the need for potential allocation. The guidance Co-operating to Safeguard Children DHSSPS 2003 (Paras 7.7-7.14) and the ACPC Regional Policy and Procedure 2004 (Paras 10.8 -10.12 and 10.15) is not clear on the action that needs to be taken in convening a risk management meeting, where the identity of the offender is known to Social Services.

**4.6.3** A number of further concerns were identified:

- staff’s general lack of knowledge about sex offenders and MASRAM issues;
- key disciplines and agencies involved with the family, on a regular basis, were unaware of the previous sex offences or that Mr Arthur McElhill was on the Sex Offender’s Register. When staff were aware, they had limited knowledge of the offences and these were minimised;
- staff had little knowledge and guidance on how they could access information on MASRAM within the Trust, where this was needed and particularly during Out of Hours service;

- the procedures in 8.2 of the MASRAM guidance on the need for a “consistent approach to recording of MASRAM cases on the relevant Trust information systems” had not been implemented;
- few training opportunities had been provided to staff on sex offenders and MASRAM procedures, and training that had been provided by the Social Services team in collaboration with PSNI, was primarily targeted to social work staff. Health visitors and the GP reported limited knowledge and that no training was provided. Newly qualified, agency staff and inexperienced staff working in the frontline high risk child protection cases had been allocated sex offenders cases, yet they also had received no training in this area;
- child protection issues are not adequately addressed in the procedures in relation to the need to assess the potential risks posed by offenders to their own children.

**4.6.4** A social worker received a telephone call on the 6 November 2007 from a person in the community regarding a dispute with Mr Arthur McElhill but did not report this to the PSNI. The reason provided was that she was not the social worker allocated to the case. At that time the case had not been allocated but this was not checked nor was the information passed to the Gateway team. Such action may have resulted in case allocation.

### **Recommendations**

- 16. The Board and Trust should review the current arrangements for providing information to, and reporting back from the ASORMC meetings.**
- 17. The Trust should ensure that there is a “consistent approach to the recording of MASRAM cases on the relevant Trust system” for both current and closed cases.**
- 18. Staff should be made aware of how to access information on sex and violent offenders and this information should be available to the Out of Hours service.**
- 19. The Trust should as a matter of urgency ensure that they co-ordinate meetings and share information with the PSNI in relation to child protection concerns and sex offenders.**
- 20. The DHSSPS and the ACPC should review the current child protection guidance and ensure that there is clarity on the action that needs to be taken in convening a risk management meeting where the identity of the offender is known to Social Services.**

- 21. The Board and Trust should ensure that the training which MASRAM has made available on sexual offenders and MASRAM issues forms an integral part of the child protection training provided to Health and Social Services staff involved in child protection, General Medical Practitioners and other relevant services and agencies.**
- 22. The DHSSPS, Board, Trust and MASRAM should review their current procedures and ensure that the guidance provided for staff emphasises the importance of assessing the potential risks posed by offenders to their own children.**
- 23. The DHSSPS, in their pending review of the policy guidance Cooperating To Safeguard Children, should provide clarity on the issues contained in this report including: access to the Register, sex offenders Register and data protection. The review of the DHSSPS policy guidance should be conducted in collaboration with the ASORMC review of the MASRAM guidance to ensure that the safeguarding issues are fully clarified.**

#### **Joint protocols and clarification meetings**

- 4.6.5** The agency social worker, who over the summer of 2007, carried the case of the teenage child, and the new staff member who was allocated the case on the 24 September 2007, were not trained in joint protocols or clarification interviews. It is of concern that staff who are engaged in this high risk area of child protection work, are not trained in conducting clarification meetings and joint protocol work with the PSNI and that this work has to be allocated to other staff. There is a high level of AYE staff and agency staff in the Omagh sector and during the interviews it was reported that this additional work is regularly placed on other team members, who are already stretched and under considerable pressure. In addition there was a lack of clarity on how to conduct clarification interviews and on what social work staff could discuss with the interviewee. An example provided by a social worker during the Review interviews confirmed that some situations are not being fully explored. Staff are not provided with the level of training and support needed to handle these situations and the arrangements are not adequately monitored. A review of the procedures and training in this area is needed to ensure staff are appropriately trained to deal with these high risk situations.

#### **Recommendation**

- 24. All staff appointed to child protection teams including AYE and agency staff should be trained in clarification interviews and Joint Protocols. A review of the procedures and training provided on single agency clarification interviews is needed to ensure staff are clear about their responsibilities, are able to conduct these effectively and are appropriately supported in this area of work.**

## **4.7 Gateway Teams**

**4.7.1** The Regional Child Protection Inspection Report “Our Children and Young People Our Shared Responsibility DHSSPS 2007” identified many difficulties and failures across Trusts in the discharge of statutory functions and safeguarding procedures. The report highlighted that “there was clear evidence of repeated failures to undertake timely assessment and to provide child protection interventions, resulting in children being left at risk both at home and in residential care”. Gateway teams were established in Northern Ireland as part of the modernisation reforms and the DHSSPS Reform Implementation Team’s response to the findings and recommendations contained in the regional report. The Trust established two Gateway teams in early 2007, in the western area to cover the Enniskillen and Omagh sectors.

**4.7.2** The purpose of the Gateway Team is to provide three types of contact: information exchange; advice and guidance; and receiving referrals and completing the initial assessment, which will inform the future direction as regards the case management. One of the core principles of the service is that “all child protection referrals will receive an immediate response and the Gateway service has “a responsibility to complete the initial assessment within 10 days and to convene the initial case conference”.

This did not happen when Mr Arthur McElhill and his family were referred by the F.I.T. to the Gateway team on the 1 October 2007 for assessment and by the PSNI on the 14 October 2007 regarding the domestic violence referral. The referrals were placed on a waiting list and had not been allocated up until the tragic event on the 13 November 2007.

**4.7.3** During the scrutiny of the documentation and interviews with staff the following problems were identified regarding the structure and resourcing of the teams:

- The recruitment and retention of staff to the two teams has led to difficulties in retaining sufficiently experienced and skilled staff in this high risk front line service. As the full funding for some of the posts had not been determined temporary staff only could be appointed. This meant that as they secured permanent posts elsewhere there was a continual turnover of staff. This has resulted in the use of agency staff, trainees and AYE staff in Gateway teams. The use of AYE staff is not in line with the DHSSPS guidance and letters issued to the Trusts and the requirements as set out in the job descriptions for both AYE and team leader posts. The Review Panel were advised that the £110,000 funding was agreed by the DHSSPS and released to the Board. When allocated by the Board the Trust should be able to draw from their waiting list of staff already approved;
- The funding for the current Gateway team leader post in the Omagh sector, which has been a temporary position for the past 12 months, has now been agreed. This will enable the Trust to progress the development of this new service and to build in the stability required.

The Trust has advised the Review Panel that “extra resources have been deployed to Family and Child Care on a temporary basis to employ extra social work staff to complete home visits, and assessment and over-time has been offered to all social work staff to address the back-log of cases.”

However while this may deal with the immediate difficulties of sorting the current waiting list crisis it does not provide a strategic plan to resolving the long term problem. The Gateway teams were set up as part of the modernisation agenda to provide quality frontline services with timely responses, assessments and interventions in this high risk area of work. In order to ensure that this can be delivered on an ongoing basis the Trust need to examine the resources needed to adequately staff the Gateway teams on a long term basis and to provide a business plan setting out the funding required to the Board and to the DHSSPS.

### **Recommendations**

- 25. The Trust should ensure that the Gateway teams are equipped with the appropriate numbers of staff who have the appropriate level of skill and experience, in line with the expertise required to undertake this high risk work and the directions issued by the DHSSPS regarding AYE staff and trainees.**
- 26. The Trust should assess the resources needed to adequately equip the Gateway teams on a long term basis and provide the business case to the Board and the DHSSPS.**

### **Coding of cases**

- 4.7.4** The Trust operate a traffic light coding system of red, orange and green to determine the priority for allocation of cases to the waiting list. A written procedure and guidance for staff to assist in determining the allocation of a colour code was not available and it was therefore difficult to determine the rationale used. In examining the waiting list the colour orange was used in sex offenders and domestic violence cases and they therefore do not receive priority. The case of Mr Arthur McElhill, Ms Lorraine McGovern and their children was coded orange by the Gateway team on the receipt of the first referral on 1 October 2007 and coded green on receipt of the domestic violence referral from PSNI on the 14 October 2007. This case should have received the coding red, given the risk determined and the removal of the teenage child from the house, the previous history of sex offending and the potential risks that needed to be assessed in relation to other children and Caroline. An explanation could not be given as to why two separate codings had been applied or why the two referrals had not been brought together and a review of the position on the waiting list determined in relation to the additional risks presented. There was no written guidance on how to code and prioritise. The case had not been allocated at the time of the tragedy on the 13 November 2007.

**4.7.5** On 1 October 2007 the Social Services file for the 2000 period was given by the F.I.T. social worker to the Gateway team leader. After that there was no further communication of any kind between these two teams. In particular the Gateway team was not provided by the F.I.T. with a copy of the UNOCINI form prepared in respect of the teenage child. This form contained vital information for the Gateway team. Further, the Gateway team was not informed by the F.I.T. of the interruption by Ms Lorraine McGovern into the case conference of the 5 October 2007 and the challenge by Ms Lorraine McGovern to the information on the offending history of Mr Arthur McElhill contained in the case conference report on the teenage child.

No one in the Gateway team read the Social Services file for the 2000 period and no contacts were made with any other disciplines to gather information to make a coding or an initial assessment of risk. The Gateway team did not make the coding on the basis of the relevant information.

**4.7.6** The method of monitoring and auditing the codings of both unallocated and allocated cases was weak. Mr Arthur McElhill, Ms Lorraine McGovern and their children were on the waiting list for over six weeks, there were two referrals made and there were a series of other pieces of information emerging that should have determined and progressed this as a matter of urgency. Cases on the waiting list were reviewed by the new senior management during this period to assist staff in understanding the codings to be used. However senior management did not identify that the case had been given different codes on the two separate occasions when referrals were received by the Gateway team.

**4.7.7** The Trust has put forward a number of proposals to eliminate the current waiting list for children services. In so doing they will now want to ensure that a review of the current coding system is undertaken and a determination made on the need. However, given that all child protection cases should be allocated immediately and initial assessments undertaken within a maximum of seven days, it is not clear to the Review Panel why a coding system of the current kind is necessary.

## **Recommendations**

- 27. The Trust should conduct a review of the current coding system in order to ensure that a determination is made on the basis of need and that the coding system itself promotes compliance with the time limits set out in chapter 5, Co-operating to Safeguard Children DHSSPS 2003 and in chapter 5, ACPC Regional Policy and Procedures 2004.**
- 28. The Trust should ensure that staff making referrals to the Gateway Team provide detailed information at the referral stage and as new information emerges, to inform the judgements made.**

- 29. The decisions taken by the Gateway team should be based on the collation of appropriate information from the UNOCINI form, previous case records and professionals/agencies involved in the case.**

### **Unallocated Cases / Waiting Lists.**

**4.7.8** The Trust, as with a number of Trusts in Northern Ireland, has had a historical problem with unallocated cases and waiting lists for children's services since 2004. This was raised by the Children's Commissioner and explored by the DHSSPS at that time with all Trusts in order to be assured that there were no children awaiting assessment, where there were child protection concerns. The Trusts were required to immediately address the problem of the unallocated cases, to report to the DHSSPS on the progress made to eradicate the waiting list and to provide monthly monitoring returns on their position. While resolutions were put in place at that time there has been a reported growing waiting list in the Board area since June 2007. This is an important issue as Mr McElhill and his family were placed on the Trust waiting list on the 1 October 2007 and up until the tragedy on the 13 November 2007 they had not received a visit. They therefore did not receive an initial assessment to determine the levels of risks and action required. The problems emerging from the review of the waiting list data are:

- an examination of the information provided to the Review Panel by the Trust revealed that child protection cases had been allocated to social workers in the Gateway teams but they did not have the capacity within their case load to visit the child concerned within seven days. The effect of that arrangement was that the "waiting list" of cases appeared to be substantially reduced whereas in fact there had been no such reduction. Thus the Trust under reported the extent of the problem both to their own Board and to the DHSSPS. The Trust has advised the Review Panel that these cases are now returned to the waiting list, when a visit cannot be made by the social worker within seven days, and these cases are now included in the returns made to the DHSSPS;
- the problem of the growing list is not restricted to the Omagh sector but is across the full Board area;
- the effectiveness of the management of the information in the returns made by the Trusts to the DHSSPS is not sufficiently robust as the evidence indicates that at the time of the Review, the problem had not been dealt with even though this increase had been evident since June 2007;
- the Trust receives a large number of domestic violence notifications from the PSNI and such cases remain in the Trust's waiting lists without being prioritised. The Trust had not taken steps to deal with the need for the prioritisation of these cases.

**4.7.9** These matters were brought to the attention of the DHSSPS and the Trust, by the Review Panel, during the course of the Review. The Trust has advised on the steps they are taking to resolve the waiting list crisis which includes: “multi-disciplinary checks on all referrals to enable prioritisation which has been achieved on all referrals; extra resources have been deployed to Family and Child Care on a temporary basis to employ extra social work staff to complete home visits, and assessment; over-time has been offered to all social work staff to address back-log; summarised assessments are to be completed after visit on cases which require no further action; full UNOCINI to be completed in respect of cases that require further Intervention; extra admin staff to be employed to answer phones etc in the Omagh office to free up social work time to address back-log”. The waiting list for assessment at the time this report was prepared had been reduced to 12 cases.

**4.7.10** While the implementation of these proposals will assist the Trust in beginning to deal with the backlog of cases they will need to have additional systems in place to prevent the problem of waiting lists re-occurring. It is vital that children and families receive timely assessments and interventions and that appropriate safeguarding arrangements are in place to eliminate the risks to children.

### **Recommendations**

- 30. The Trust should explore alternative methods to immediately resolve the unallocated waiting list within children’s services and ensure that all cases, where there are child protection concerns, receive a visit and initial assessment within the timescales set in the DHSSPS policy guidance and child protection standards. Attention should be given by the Trust to the priority needed regarding sex offenders and domestic violence notifications. .**
- 31. The Trust should examine the waiting list regarding the high number of domestic violence notifications and identify solutions to the prioritisation of these cases.**
- 32. The Board should monitor the Trust’s action plan and ensure that the action proposed and taken by the Trust eliminates the waiting list and the problem with the coding and prioritisation used and the DHSSPS advised accordingly.**

## **4.8 “Job Sharing”**

- 4.8.1** In the Omagh Sector the post of team leader for the Family Intervention Team (over 11s) has been a job share for approximately eight years. This team leader was responsible for the management of the case of Mr Arthur McElhill, Ms Lorraine McGovern and Caroline in the 2000 period and also for the management of the case in respect of the teenage child in 2007. For the greater part of this period, including the last four years, one half part of this post has not been filled. Thus for substantial periods of time a part-time team leader has been responsible for ten staff members i.e. six social workers, two family support workers, a student and a trainee.
- 4.8.2** This situation had serious and adverse consequences for this team over a substantial period of time. This was acknowledged by the team leader in interview and also was apparent from the examination of the case files by the Review Panel.
- 4.8.3** The Review Panel's view as to the gravity of this situation was brought to the attention of the DHSSPS and the Trust during the course of the Review and the Trust has advised the Review Panel that, from April 2008, the post of team leader is no longer the subject of a job share and is now occupied by a single full time individual in post. This is welcomed by the Review Panel. However it became apparent during interviews that senior management staff responsible for the Omagh Sector had made several ineffectual attempts over the years to solve the problem and that it was the intervention of the Review Panel which caused senior management to react effectively in this regard.
- 4.8.4** Throughout the two periods under review the unfilled “job share” created a dangerous inconsistency in the management direction, control and supervision of staff. Junior and inexperienced staff advised that they were left at times to make their own decisions and act as best they could as crisis situations arose. It was reported that this contributed to the low morale, high sickness rate and high turnover of staff and required senior staff to “act down” in an attempt to provide the necessary support for staff. There was an absence of a consistent team leader role in the coordination of inter agency arrangements and in the development of effective communications across the various disciplines and agencies.

### **2000**

- 4.8.5** From the records examined it was clear that practice and intervention in the case during 2000 was extremely weak and poorly managed.
- 4.8.6** The social worker appointed in April 2000 had no previous experience in the child care field and little training. There was no evidence that adequate support and guidance was offered to this staff member by the team leader or that the work was sufficiently supported or challenged.

**4.8.7** The team leader who signed the case records on two occasions between April 2000 and October 2000 did not deal with the weaknesses in the social work intervention. The file records identified long gaps in visits to the family and there were no records of core group meetings. There was no checking or challenge of the implementation of the child protection plan. The team leader did not attend core group meetings or case conferences and the case was not effectively supervised or managed.

**4.8.8** Closure of the case file in 2000 was not achieved by proper process. The procedures confirmed by the team leader were that case closure could only take place with the approval of the team leader or senior manager. Any other agencies involved were to be informed. The team leader could not recall who closed the case or how it was closed and the records did not disclose any further information.

## **2007**

**4.8.9** In the summer of 2007 the social worker assigned to the teenage child was employed by the Trust through an agency recruitment service and had been trained outside Northern Ireland. In interview the social worker reported that she had received some initial induction in her first week but that she had no previous experience in child protection or knowledge of Northern Ireland legislation, protocols or procedures and that she was immediately given a full caseload. Training needs were not identified as part of the induction or continuing supervision and she was not trained in joint protocol or clarification interviews.

**4.8.10** The team leader provided a record of the supervision of the social worker over the summer period in 2007. The records were extremely brief and not fit for purpose. The team leader confirmed that she did not read the case file of the teenage child from it was allocated in mid-June until the social worker left on 19 September 2007. The team leader was therefore unaware of the poor practice recorded in the file and confirmed, having read the file for the Review interview, that there were matters for improvement.

**4.8.11** In interview the team leader advised that she did not have the capacity or time to read the social work records and that management was aware of and acquiesced in this state of affairs. She further advised that she was not available to attend case conferences or core group meetings and that she had informal permission not to attend. This caused some surprise to the Review Panel and also to Trust senior management interviewed during the Review.

**4.8.12** Upon the departure of the social worker involved in the summer of 2007 a further social worker was appointed, on 24 September 2007, to the case of the teenage child. This social worker was a new recruit to social work and was immediately allocated the entire workload of the previous social worker. There was no evidence of proper management guidance or support to the new social worker in dealing with the preparation of the relevant UNOCINI forms and in ensuring that all relevant information in respect of Mr Arthur McElhill went to the Gateway team.

**4.8.13** The supervision records did not focus on the overall management of the case workload, professional social work intervention or the competencies or appraisals of the staff. While the team leader reported that she had received training in supervision there was no evidence that the supervision was adequate or to the competency required in managing and supporting staff working in complex and high risk cases. The Review Panel were advised that the Trust has now resolved the job sharing post within the Omagh sector by appointing a full time member of staff.

**4.8.14** The Review Panel does not believe that critical management positions in child protection services should be the subject of a job share.

### **Recommendation**

- 33. The Trust should identify such critical management positions in child protection services which are “job shared” and review the effects of any such arrangements upon those services.**

## **4.9 Child Protection Case Conferences and Core Group Meetings**

### **Case conferences – December 2000 & October 2007**

- 4.9.1** The child protection case conference is constituted as a multi-disciplinary, multi-agency meeting convened to assess relevant information with a view to determining plans to safeguard children. Mr Arthur McElhill, Ms Lorraine McGovern and Caroline McElhill were the subjects of the case conference processes between the periods 1997 and 2000 when Caroline's name was twice placed on the Register following Mr Arthur McElhill's probation and prison sentences. The teenage child was also subject to the case conference process as her name was also on the Register. As a result the case conference minutes between 1997 and 2000 and in 2007 were examined as part of the Review.
- 4.9.2** The Trust introduced their new arrangements for the independent chairing of case conferences in 2007. While this was in its infancy stage during the Review a number of core problems emerged from the examination of the case files and the interviews with staff. At the commencement of the Review in February 2008, the Review Panel requested the minutes of the case conference, which was held on the 19 October 2007 in respect of the teenage child, as these were not in the file. It transpired that the minutes had not been written up and the team eventually received these on the 28<sup>th</sup> February 2008, but these had not been agreed or provided to those who attended the case conference. The Review Panel were concerned at this practice and found it impossible to justify as these case conferences are held on children who are placed on the Register and the case conference is the forum for agreeing the care plan that the disciplines and agencies will be taking forward. The DHSSPS guidance Co-operating to Safeguard Children DHSSPS 2003 specifies that they should be issued within fourteen working days.
- 4.9.3** Further examination of the case conference minutes and discussions with staff identified a long standing problem in issuing minutes, which on average were taking several months to produce and there was a back log in excess of over 900. The result of this is that the care plan agreed at these case conferences is arriving too late for this to be progressed effectively by the disciplines and agencies and by the core group and impossible for those who did not attend the case conference. The Trust advised, at the time of writing this report, that the back log of the case conference minutes has been reduced to 335.
- 4.9.4** The Review Panel has determined that staff were not compliant with regional guidance, policy or procedures. In a number of areas which include:
- Membership/representation from key and relevant organisation was poor and inconsistent.
  - The Trust introduced the new role of independent chairperson to chair the review case conference, which is convened at specified times following the initial case conference. This is not in line with the guidance contained in Co-operating to Safeguard Children

DHSSPS 2003, which recommends that this should be the same person. The case conference held on the 19<sup>th</sup> October 2007 substantiates this proposition as the chairperson was new to the case and was not in a position to challenge a number of issues emerging, and the need for a risk assessment on Mr Arthur McElhill's children was not raised.

- The team leader in 2000 and 2007 did not attend any of the case conferences or core group meetings, which she reported was due to her "job share" position.
- The reports to case conferences are not provided in advance of the meeting. They were not available for the December 2000 case conference. In particular the reports from Erne House, which were central to informed decision making, were not received until after the case conference and therefore did not inform the decision to remove Caroline's name from the Register.
- In preparation for the case conference the team leader, in 2000 and 2007, did not adequately check the content and adequacy of the social worker's reports to case conference or ensured that statutory visits had been made.
- There was a failure to check compliance with the child protection plan by the team leader or chairperson for the case conferences in December 2000 and in October 2007.
- The convening of the core group meetings and the outcome of the discussions was again not addressed by either the team leader or the chairperson as part of the case conference procedure. It is the view of the Review Panel that there was a lack of clarity regarding the role and responsibility of the team leader in monitoring the assessment, risk assessment, report and proposals made by the core group to the case conference.

## **Recommendations**

**34. The Trust should review the procedures for Independent Chair and ensure that the standards operated for case conferences are in line with those set out in Cooperating to Safeguard Children DHSSPS 2003, the ACPC Regional Policy and Procedures 2004 and the Draft Child Protection Standards DHSSPS 2004. In particular attention should be immediately given to the:**

- **completion of UNOCINI assessment and risk assessment;**
- **completion of uni-disciplinary/agency reports and their issue in advance of the case conference;**
- **team leader attendance and representation from the agencies at the core group and case conference meetings;**

- adherence to statutory functions and the agreed care plan; and
- quality assuring and auditing the full case conference process.

**35. The Trust should immediately resolve the backlog in the issue of case conference minutes and take all steps necessary to ensure that in the future minutes are provided within the timescales set out in line with Co-operating to Safeguard Children DHSSPS 2003.**

### **Core Group Meetings**

**4.9.6** The core group is an important forum and the members have a key role in developing and delivering the agreed child protection plan. The group is also responsible for the regular evaluation of progress in achieving the objectives set out in the plan. An examination of the form and function of core groups in 2000 and 2007, in the cases examined identified the following problems:

- the implementation and monitoring of the child protection plan was weak in 2000 and 2007;
- the attendance at core group meetings was not consistent nor in keeping with the delivery of and review of the child protection plan;
- there is no evidence that issues emerging from the individual agency work informed core group discussions and proposals made to case conferences. This was particularly evident in relation to the work of Erne House in 2000;
- the core group meetings as required in 2000 did not take place;
- the core group did not review progress against the child protection plan in April 2000 to determine the level of risk on the birth of baby Sean. This was determined by the chair of the case conference in isolation from other key professionals and agencies;
- during September 2007, when the level of risk to Caroline was raised by the social worker who had removed a teenage child from the home of Mr Arthur McElhill, the programme manager determined there was no risk in the absence of a risk assessment, a case conference or consultation with other relevant professionals;
- the social worker did not convene a core group meeting during the period June – September 2007 when high risk issues were emerging.

The Review Panel concludes that there is no evidence of any quality assurance, monitoring of practice and standards as they relate to core group meetings.

## **Recommendations**

- 36. The frequency of core group meetings and representation from the key agencies, as identified at the case conference, should be adhered to in order to progress and monitor the implementation of the care plan.**
- 37. The Trust should monitor and audit the quality of the work progressed by core groups.**

## **4.10 Out of Hours Social Work Service**

- 4.10.1** The Trust's Out of Hours social work service was involved with the cases on the 11 September 2007 and on the 15 September 2007, therefore the records for these two dates were examined and the staff involved were interviewed. The Out of Hours service, which is described by staff as a "life and limb" service, operates from the Out of Hours coordinator's home from 5.00pm to 9.00am weekdays and at the weekend it is a 24 hour service. The coordinators, who are social work staff, volunteer to operate this service and are paid for so doing. In addition to this the coordinator has a list of social work staff who have also volunteered to take case allocation, if they are available, and they are paid for the visits made. The coordinators have direct access to a telephone but not to the files or the Trust data base system.
- 4.10.2** A referral was made by PSNI to the Out of Hours service on the 11 September 2007 regarding the teenage child staying with Mr Arthur McElhill and his family. The police were called out to Mr Arthur McElhill's home, where there had been an incident with the mother of the teenage child. The PSNI were seeking the approval from Social Services for the teenage child to remain at 4 Lammy Crescent overnight, which approval was given. The coordinator informed the police that the designated social worker would be informed of the incident in the morning. Police personnel had been told by Mr Arthur McElhill that the teenage child was the subject of a Care Order and they so advised the coordinator. This was factually incorrect as the teenage child was on the Register. Neither the coordinator nor the police personnel involved were aware of Mr Arthur McElhill's offending history.
- 4.10.3** Irrespective of whether a Care Order was in force or not the importance of being told that the teenage child was the subject of a Care Order was not appreciated by the coordinator who ought to have made arrangements for the teenage child to be immediately seen and interviewed by a social worker. At any rate the police were left to deal with the situation on the ground as best they could.
- 4.10.4** A further referral was made on the 15 September to the Out of Hours service by an interested party. However, there was no mechanism available to check records or make the necessary links to the 11 September 2007 referral to the Out of Hours service or the ongoing issues and concerns in the case. The information is not logged on a system or held collectively by coordinators for their access. In addition there was no check made on the Register which would have provided some information on the teenage child and her family. The reason given for the no action was that an address was not available. However the information was eventually forwarded to the Omagh office but this arrived after the 20 September 2007 when the teenage child had been removed from the home.

#### 4.10.5 Problems identified with the service were:

- there are no job descriptions for staff which clearly set out the roles, responsibilities and reporting arrangements;
- staff are not appropriately recruited to ensure they are skilled to deal with issues emerging e.g. trained in child care where there are child care issues and in mental health where there are mental health concerns;
- induction and ongoing training for Out of Hours staff is not mandatory and not evident;
- the method of drawing up a list of back up social work staff to undertake the visits after hours is not sufficiently robust to ensure their availability or expertise in the areas required;
- there is no manual of guidance to assist in giving directions and support to staff;
- staff do not have access to SOSKARE and files during out of hours service or other computerised information e.g. the Register;
- responsibility for child protection cases and children who are on Care Orders, after normal working hours needs clarification with the Out of Hours service regarding statutory responsibilities;
- during and after the referral stage accurate records were not kept and there were delays in communication inside Social Services. There was a delay in providing the 15 September 2007 report as it did not arrive in Social Services until after the teenage child was removed on the 20 September 2007;
- there is a need to move from a "life and limb" approach to a professional service and the provision of appropriate and timely social work "crisis intervention" and support.

While the Review Panel were advised that the ACPC is currently reviewing the Out of Hours arrangements there is a need for a wider independent Review, which would analyse in detail the full range of the current problems, resources and research the systems and approaches elsewhere. The need to professionalise this service and to bring it up to the standard required within the modernisation agenda is critical. The appointment of a full time Out of Hours team with appropriately recruited and trained staff, clear job descriptions and structured links with other after hour's services, such as GPs and PSNI, should be considered as part of the Review.

#### **Recommendations**

- 38. The Trust should ensure that Out of Hours social work staff are clear about their statutory responsibilities regarding child protection cases, children who are on the Register or who are on Care Orders.**
- 39. The Trust should ensure that Out of Hours staff have access to records held on a 24 hour basis and the SOSKARE system in order that they can respond appropriately to situations that arise and particularly where children are on Care Orders or on the Register.**
- 40. The DHSSPS should convene an Independent Review of the**

**Out of Hours social work service in Northern Ireland in order to professionalise, modernise and upgrade this service. The Review should consider the need for a dedicated full time team located outside the coordinators own home to operate the after hours service and: provide clear job descriptions, guidance manual and mandatory training; appoint staff with the relevant training and expertise to separately cover the programmes of care in adult and children's services; and provide access to SOSKARE data base and records held on a 24 hour basis. Consideration should be given to the potential benefits of co-location with other after hours services e.g. GP services and PSNI.**

## 4.11 Work Force

4.11.1 The Trust reported that there has been an ongoing recruitment and retention problem in the Omagh sector for a number of years and this has had particular implications for the F.I.T. and Gateway teams. Some of the problems highlighted by the Review Panel were:

- frequent turnover of staff and cases left unmanaged when posts are not filled;
- the inadequate management arrangements due to the job share post, a part of this has been left unfilled for many years;
- skewed lines of accountability and reporting arrangements associated with the job share post and long term staff sickness;
- low morale and high levels of staff sickness;
- problems created by the use of inexperienced agency staff and AYE who are not trained in specialised areas of child protection work including clarification interviews and joint protocols. This places additional demands on staff working in high pressurised and high risk child protection teams;
- providing adequate induction, supervision and ongoing training needs when under resourced;
- implementing and monitoring the Codes of Practice for employers;
- conducting exit strategy interviews and implementing change needed as a result of the issues arising.

4.11.2 The Trust provided the Review Panel with their proposals to resolve some of the immediate problems in relation to the Gateway teams and the waiting lists (para 4.7.9).

### Recommendation

41. **The Trust should review their strategy and procedures regarding the recruitment and retention of staff and ensure that: appropriately qualified and trained staff are engaged in F.I.T. child protection and Gateway teams; staff are appropriately managed supported and trained in their work and exit interviews are conducted and the necessary changes implemented.**

### Codes of Practice

4.11.3 The Northern Ireland Social Care Council's Codes of Practice for social care workers sets out the standards of professional conduct required of social care workers. The Codes of Practice for Employers of social care workers sets out the responsibilities of employers in the regulation of social care workers, the purpose of which is to protect the interest of services users and their carers. Employers are responsible for ensuring that they meet the standards, provide high quality services and promote public trust and confidence in these services.

The Codes contain a number of requirements relevant to the issues arising from the Independent Review in the Trust and social workers and

employers should ensure that they are complying with the Codes particularly in relation to meeting relevant standards of practice and maintaining records.

**4.11.4** The Regulatory, Quality and Improvement Authority (RQIA) is the lead governance and regulatory body responsible for monitoring and reviewing the Trust's compliance with the codes and standards particularly regarding:

- workforce issues;
- written policies including risk assessment and record keeping; and
- supervision management and support for staff.

### **Recommendations**

- 42. The Trust should review their implementation of the Codes of Practice for Employers regarding managing the performance of staff; supervision and induction training; and providing organisational policies and procedures, including risk assessment.**
- 43. The Trust should ensure that social workers comply with their Codes of Practice including the areas of risk assessment, meeting relevant standards of practice and maintaining clear and accurate records.**
- 44. RQIA should ensure that they monitor the Trust's compliance with the Codes of Conduct for Employers, as part of their routine Governance Reviews.**

### **Supervision**

**4.11.5** From an examination of records there was evidence that the implementation of standards set by the Trust and DHSSPS for supervision were not in place. File records were not read by a team leader as an integral part of monitoring social work practice and workload. Supervision records were not audited by senior management and the qualitative nature of supervision and support in terms of workload management, therapeutic interventions and continuous professional development was missed. This compounded the difficulties for new F.I.T. staff who were not provided with adequate induction programmes.

### **Recommendation**

- 45. The Trust should ensure full compliance with the Trust and DHSSPS supervision standards which includes: providing appropriate induction and ongoing training and support for staff involved in high risk child protection services; reading, agreeing and signing case files regarding the therapeutic interventions provided; and**

**conducting audits of the supervision files to ensure such full compliance.**

## **Training**

**4.11.6** There are a range of training issues emerging from the review of case files and the interviews with staff and these are contained in the detail of this report. In collaboration with the other agencies and GPs, the Board and Trust will need to urgently ensure that interagency training is provided on:

- MASRAM, sex offender's issues and procedures for all staff engaged with children and families;
- joint protocols and clarification interviews;
- multi- disciplinary and interagency working;
- UNOCINI and completion of initial referrals;
- assessment, risk assessment and comprehensive assessment;
- preparing reports for case conference and conducting core group meetings;
- record management;
- data protection;
- Out of Hours co-ordinators guidance manual.

**4.11.7** The Northern Ireland Social Care Council is currently undertaking a Review of the degree in social work which will assist in ensuring its effectiveness in preparing students for social work practice.

## **Recommendations**

- 46. Interagency training should be urgently provided on: sexual offenders and MASRAM issues; clarification interviews and joint protocols; interagency working; completion of referrals to UNOCINI, initial assessment and risk assessment; conduct of core group meetings; preparing reports for case conferences; record management; data protection; and mandatory training for all Out Of Hours coordinators.**
- 47. The Northern Ireland Social Care Council, in undertaking the Review of the degree in social work, should ensure that the curriculum for undergraduate and post qualifying requirements adequately addresses the training needed for social work staff on child protection, the interface with sex offenders and MASRAM process.**

## **4.12 Data Protection**

**4.12.1** There is recognition that effective information sharing is essential in safeguarding children and the DHSSPS has provided clear guidance to staff in this area. However in the interviews conducted with staff there was confusion around the areas of data protection and human rights. The examination of the documentation and case conference minutes identifies areas which the Trust should clarify in their guidance and training for staff including:

- the procedure for the removal of information and destruction of child protection records when a child's name is removed from the Register;
- the retention of information relating to children previously on the Register and the removal of the information from SOS CARE;
- information sharing at case conferences on the risks associated with individuals who are on the sex offenders register.

**4.12.2** SOS CARE is the universal database for Social Services in Northern Ireland and is the key to appropriate and timely access to relevant information. A number of difficulties were identified in relation to the storage and removal of information. The SOS CARE record did not contain information about the reasons why Caroline's name had been previously entered on the Register and did not contain any information about the nature of the offending behaviour of Mr Arthur McElhill. There was no information logged about the fact that Mr Arthur McElhill was on the sex offenders register or subject to MASRAM processes. Staff could not easily access relevant information about individuals previously known to Social Services.

### **Recommendations**

- 48. Clear guidance should be provided for staff on data protection regarding information sharing at case conferences on the risks associated with individuals who are on the sex offenders register.**
- 49. The Trust should ensure that data logged on SOS CARE includes appropriate information on MASRAM and names previously placed on the Register. Staff should be able to access SOS CARE information on a 24 hour basis.**

## 4.13 Record Keeping

**4.13.1** “Good record keeping is an essential part of a professional’s responsibility and is vital to good child protection practice.” Chapter 8 of Cooperating to Safeguard Children DHSSPS 2003 and Chapter 11 of the ACPC Regional Policy and Procedures 2004 provide guidance on the standards required. There were examples of good records of practice in the social work files during the period when the short term F.I.T. were involved with Mr Arthur McElhill and Ms Lorraine McGovern, in the file records of the social work therapist at Erne house and in the file records at the Family Resource Centre. These indicated that work was structured, planned and analysed with clear objectives set with the family on the safeguarding work that was ongoing. However the recording in the social work files for the period in 1996/1997, 2000 and the summer of 2007 was poor and there was no analysis made of the interventions and levels of risk emerging. Records were not maintained in an orderly manner and they were not comprehensive. There was an absence of:

- chronology of events;
- records of all contacts;
- objectives set and a plan of work, which was outcome focussed;
- analysis and summary of intervention;
- evidence and rationale for case transfer and case closure;
- evidence of statutory visits and working to the timeframe specified in the child protection plan;
- evidence of communication with other disciplines and agencies and informed reports to case conferences;
- copies of core group meetings and case conference minutes;
- formal closure of cases and evidence of links with other disciplines and agencies as required by the Trust procedure;
- senior management audit and signing of records.

### Recommendation

- 50. The case records should be kept up to date and in order. They should contain: clear records on opening and closing the case; a chronology of events, the objectives set for the work plan; all case reports and case conference/ core group minutes; an analysis and summary of the interventions provided; and an outline of the future work programme. The maintenance of records should be audited to ensure that they comply with the standards set by the DHSSPS, and professional codes.**

## **5. MENTAL HEALTH SERVICES**

- 5.1** Mr Arthur McElhill first came into contact with the Board's mental health services in September 1988 when he was suffering from depression and was admitted to Erne hospital following a suicide attempt in October 1988. On discharge he received follow up intervention from the community mental health services until his discharge in May 1989. He was further referred in March 1993 by his GP. At that time he was diagnosed as suffering from Post Traumatic Stress Disorder and continued to be reviewed at the mental health out patient clinic. As part of the conditions of the 6 month deferment of the sentence in September 1993, for the aggravated burglary and indecent assault, he was required to attend Erne House psycho- sexual Clinic for counselling in relation to his offending behaviour. He was referred again following his prison sentence for his second offence in 1999 and attended until his discharge from probation in August 2001. We know from the GP records that he attended his GP in September 2007 and was prescribed anti-depressant medication.
- 5.2** Erne House is based at the Tyrone and Fermanagh hospital site and is a board wide facility, which provides a range of therapeutic services. These include: the Programme for Prevention of Sexual Abuse (PPSA); psychosexual dysfunctioning services; and services to adult survivors of sexual abuse. The PPSA is provided to perpetrators and their families and its goal is to prevent sexual abuse, break the cycle of abuse within families and prevent future mental health difficulties. The psychosexual department is a specialist multidisciplinary service comprising of personnel from a range of professional disciplines and backgrounds including medicine, psychology, social work and nursing. In addition to providing a comprehensive and multi-factorial approach to the origins of difficulties in sexual functioning and sexually abusive experiences (Bio-Psychosocial approach) the staff team provide a wide range of therapeutic expertise and experiences in these areas.
- 5.3** Mr Arthur McElhill attended the PPSA as a condition of his deferred sentence in September 1993. Following his second offence and on his discharge from prison in 1999 he was referred again to PPSA and was seen regularly by the psychologist up until his discharge from probation in August 2001. Ms Lorraine Mc Govern attended Erne House during 1998-2000 as a condition of the child protection care plan, but attended only two of the sessions convened by the nurse therapist in 2000.
- 5.4** The therapists were changed during the period 1998 and 2000 at the request of Mr Arthur McElhill and Ms Lorraine McGovern. The psychologist changed in 1998 and the social work therapist was replaced by the nurse therapist in October 1999. The latter change was shortly before the decision was taken to transfer the case in Social Services, from the short term F.I.T. to the long term team. There was evidence in the files examined that Social Services communicated well with Erne House during the period when the case was carried by the short term F.I.T. and during the period when the social work therapist was engaged in working with Ms Lorraine McGovern at Erne House. The records and minutes of meetings confirmed regular contact and attendance at core group meetings and case conferences to communicate on issues and to progress the care plan and

this continued up until early 2000. During 2000, following the transfer of the case, the level of social work input was weak, poorly managed and core group meetings were not held.

- 5.5** The psychology file records were weak and they did not contain an initial assessment, overall plan, objectives for each session, analysis of how the risk was being assessed and managed, or a summary of work regarding the interventions. There were no file records for the work undertaken by the nurse therapist during 1999 and 2000, although detailed records were maintained by the previous therapist, which set out clearly the work plan, work undertaken and work to be achieved. There were no records of the communications and issues arising from sessions across the therapists in relation to the individual work undertaken with partners;
- 5.6** The psychologist and nurse therapist were members of the core group but there was no evidence of any core group meetings during 2000 and reports for case conferences were not coordinated. The reports provided by the nurse therapist for the case conference in December 2000, which determined the removal of Caroline's name from the Register, arrived a day after the case conference. Neither the psychologist nor nurse therapist were present at the case conference and an oral report was provided by the social worker, which did not reflect the content of the reports. The report provided to the case conference by the psychologist was the report drafted in October 2000 for the MASRAM group and therefore had a different focus and was not up to date with the last therapy session of November 2000, prior to Mr Arthur McElhill moving to live with Ms Lorraine McGovern. The psychologist was unaware of the change in the living arrangements and unresolved issues were not identified or taken forward either by the psychologist or the social worker as the case was not visited by Social Services after December 2000;
- 5.7** The report provided by the nurse therapist for the December 2000 child protection case conference recommended the removal of Caroline's name from the Register. The rationale for the recommendation was unclear as this was based on limited contact with the family and limited experience and working knowledge in this area.
- 5.8** The Review Panel met with several disciplines who had attended the case conference in December 2000. They had not received the nurse therapist report, either at, or following the case conference and viewed this for the first time at the Review interview. They further advised that if the report had been available it would have influenced the decision regarding the agreement to remove Caroline's name from the Register at that point, as the work with Ms Lorraine McGovern was an important part of the child protection plan and this had not taken place;
- 5.9** Following the removal of Caroline's name from the Register, in December 2000, there was no further involvement by the nurse therapist with Ms Lorraine McGovern, as she failed to keep appointments. Social Services ceased contact with the family in December 2000 and did not inform Erne House of the case closure. While staff at Erne House were unaware that the case had been closed they did not make contact with Social Services between December 2000 and August 2001 (when Mr Arthur McElhill's

period of probation terminated) to inform Social Services of their continued work with Mr Arthur McElhill. Mr Arthur McElhill was categorised at that time as medium risk and his name was on the sex offender's list.

## **Recommendations**

- 51. The Trust should review and audit the clinical practice and record keeping at Erne House and ensure that they comply with the Trust and the relevant professional codes of practice regarding:**
  - **opening, closing and transferring cases;**
  - **maintaining clear records on all therapeutic interventions, which clearly set the objectives and rationale for the overall work and each session, analysis of how the risk is being assessed and managed and summary for each session;**
  - **communicating across therapists in the unit on the work progressed with the offender and partner, taking into account client confidentiality and professional codes of practice;**
  - **ensuring that issues emerging from the therapeutic sessions are clearly communicated to the core group and case conference and other organisations to enable appropriate decisions to be taken regarding safeguarding issues emerging and;**
  - **communicating with Social Services and all other relevant disciplines on new information emerging regarding levels of risk and on case closure.**
  
- 52. The Trust should ensure that reports provided to case conferences are discussed and agreed with the therapists involved with the offender and partner and that these are provided in advance of the date for case conference. The Trust should also ensure that Erne House discuss with Social Services a framework for sharing information and providing reports which inform child protection issues.**

## **6. THE POLICE SERVICE OF NORTHERN IRELAND (PSNI)**

- 6.1** The PSNI were aware of the previous convictions of Mr Arthur McElhill by reason of their involvement in the original prosecutions and by their involvement in the MASRAM process. From 2004 onwards Mr McElhill was not subject to Multi-Agency Risk Management, given his Category 1 level of risk, and was instead managed under the PSNI's statutory responsibilities for public protection.
- 6.2** The Designated Risk Manager visited Mr McElhill regularly in line with the required MASRAM procedures. When he became aware on 19 September 2007 that the teenage child was staying at 4 Lammy Crescent he acted appropriately by immediately contacting the Trust's programme manager who was also the trust representative on MASRAM/ASORMC and informing him of the potential risk to the teenage child posed by her staying in the same house as Mr Arthur McElhill.

The Review Panel interviewed the police officers involved in the incidents of 11 September, 19 September and 14 October 2007 as well as the social workers directly or indirectly involved. It was clear to the Review Panel that there were misconceptions on the part of many involved from the police and Social Services as to the role of the other agency and what might reasonably be expected from that other agency. In addition, on the 11 September 2007, the facility to check the Sex Offenders database was not used by the police officers involved and had that database been checked the earlier removal of the teenage child from 4 Lammy Crescent might well have occurred. In the view of the Review Panel these incidents underline the need for better communication between the police and Trust social workers involved in child protection and a clearer understanding between the agencies as to their respective roles in child protection.

- 6.3** Caroline contacted the PSNI on the 14 October 2007 in a distressed manner about a row between her parents, which she had overheard during a telephone call from her friend's house where she was staying that evening. Police officers attended at 4 Lammy Crescent within 7 minutes of the call and talked with Ms Lorraine McGovern who described a disagreement which had concluded. Mr Arthur McElhill and the children were not seen as it was reported they had retired to bed. The police officers did not immediately take further action but on the 25 October 2007 referred the matter to the Trust's F.I.T. The PSNI procedures for domestic violence and child protection were not fully complied with in relation to speaking with all parties including the children.
- 6.4** It has been noted by the Review Panel that the PSNI has developed and tested the MARAC process which has increased the communication in the areas of domestic violence referrals (4.5.3).
- 6.5** The PSNI has recently established, within each police district, Public Protection Units, that not only comprise of Child Abuse Investigation Teams, but also other key areas relating to child protection, including Domestic Abuse, Missing and Vulnerable Persons, and Sex Offender Management. The NIO, in conjunction with other key agencies, are

currently developing a Public Protection Team that will manage the most high risk sexual offenders and violent offenders in Northern Ireland. The secondment of Social Service staff members as appropriate to these teams would allow for the ready and continual exchange of information in order to provide the most effective arrangements for managing the risk created by these serious offenders (para 4.5.2)

### **Recommendations**

- 53. The present PSNI policies in respect of child protection and domestic violence matters should be reinforced within the PSNI by appropriate means and in particular the PSNI should ensure that their sex offenders data base is routinely checked when their officers are called to family situations where there are child protection issues.**
- 54. The PSNI in collaboration with the Boards and Trusts should consider the secondment of a Social Services staff member, as appropriate, to each of the eight PSNI Public Protection Units operating across Northern Ireland.**

## **7. HEALTH VISITING**

### **Background**

- 7.1** The Health Visiting Service is a universal service which is designed to promote the health and well being of individuals, families and communities. Historically most contact with families relates to children under the age of five years unless there are circumstances which determine the need for additional service. The fact that the service is designed to address the wider determinants of health is reflected in the completion of a Family Health Needs Assessment profile.

For this reason health visitors are particularly well placed to identify and respond to the needs of vulnerable children and their families. They are recognised as key nursing professionals in child protection and have a critical role in the assessment of children at risk, and the implementation and achievement of child protection plans.

Mr Arthur McElhill, Ms Lorraine McGovern and the family became known to the Health Visiting Service in March 1997. From that time until their tragic deaths in November 2007 health visitors were in regular contact with Ms Lorraine McGovern and her children. An analysis of the child health records and interviews with health visiting staff highlighted four key areas to be addressed.

### **Professional Practice**

- 7.2** There is evidence of good professional practice including Family Health Needs Assessment and additional supportive visits by health visitors delivering service from May 2000. The level of health visiting input prior to 2000 was however poor and failed to identify or respond to the vulnerability and isolation of Ms Lorraine McGovern and Caroline on arrival in Northern Ireland. This is further emphasised by inadequate contact by the service at a time when Caroline's name was on the Register and health visiting contact formed a constituent part of the child protection plan.

A review of the records showed a significant period of sick leave for the family health visitor during this time which contributed to the lack of consistent or targeted visiting.

The more recent introduction of the named nurse for child protection in the Trust, together with the implementation of the 'Health for All Children' (Hall 4, December 2002) guidance provides the Trust with the necessary assurances that in the absence of the family health visitor the needs of vulnerable families in the future do not go unmet.

## **Mental Health**

- 7.3** Health visitors visiting Ms Lorraine McGovern following the births of Sean, Bellina and Clodagh screened for postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS). There were occasions when the health visitors should have discussed the screening results with the General Practitioner. These discussions did not take place. Such communication is necessary as the treatment of postnatal depression requires a multidisciplinary response.

The Review Panel does however recognise that since the introduction of Hall 4 the use of EPDS is no longer used routinely and commends the Trust on the development of a Care Pathway which provides a framework outlining the critical roles and relationships between professionals involved with maternal mental health.

## **Multidisciplinary Working**

- 7.4** Throughout the Review the issue of multidisciplinary working has emerged as a common theme and there was evidence to suggest poor communication between health visitors, social work staff and General Practitioner, particular examples include:

- no communication between health visitors and General Practitioner during episodes of depressive illness and prescribed anti-depressants;
- no referral from health visitors to Social Services for additional support during periods of stress, e.g. Homestart, as staff were of the impression that these services were poorly resourced in the Omagh area;
- the health visitor visiting the family in the period proceeding the fire was not made aware, as would be expected, of the recent referral to Social Services for reassessment or of the notification received from the PSNI in relation to domestic violence.

It is the Review Panel's view that the family health visitor should have been made aware of these referrals and should have been consulted in the completion of the UNOCINI Assessment.

## **MASRAM**

- 7.5** Safeguarding children depends upon effective information, collaboration and understanding among agencies and professionals. Whilst all health visiting staff were aware of Mr Arthur McElhill's convictions for sexual offences, none were aware that he was on the Sex Offenders Register or subject to MASRAM guidance. All those interviewed, including the child protection nurse advisor, reported a lack of training and knowledge of MASRAM related issues.

## **Recommendations**

- 55. The Trust should ensure that health visitors make appropriate referrals for additional support to families on the basis of need and not on a perception of the lack of availability of those services.**
- 56. The Board and Trust should ensure that awareness training on sexual offenders and MASRAM issues is an integral part of child protection training provided to health visiting and school nursing staff.**
- 57. The Trust should consider with the appropriate authority the benefit of advising the child protection nurse adviser of those registered sex offenders residing in the local area.**

## **8. GENERAL MEDICAL PRACTITIONER**

- 8.1** All seven family members were registered patients of a small rural practice, eighteen miles from Omagh. At interview, the General Practitioner said that they did not frequently attend, and that she rarely saw the children other than for minor ailments and scheduled childhood immunisations.
- 8.2** It is clear that the GP was not in possession of all the wider facts of the case, particularly the health visiting, social care, psychosexual and sex offender monitoring aspects. With knowledge of these matters, more tightly focused consultations and decision-making may have resulted e.g. lower thresholds for referral to specialist services; together with better communications with health visiting and other services.
- 8.3** The GP did not know that Mr McElhill was on the Sex Offender's Register, nor that he continued to be visited by MASRAM. She did not clearly understand the role and function of MASRAM and while she had received some training in child protection processes that training appeared to be modest in time and quality. She had access to a copy of the ACPC Regional Policy and Procedures 2004.
- 8.4** The quality of note recording on both the electronic and manual (no longer in use) clinical records was lacking in a number of instances. In a small self-contained practice this may not be a significant problem, however, for locum GPs working in the practice, and the GPs to whom the family may have transferred in the future, important clinical facts would have been missing from the record.

### **Mental Health**

- 8.5** Mr Arthur McElhill was last seen by his GP in September 2007. The GP's assessment and diagnosis excluded suicidal thoughts, nor did Mr Arthur McElhill express any intention to harm other individuals. She prescribed anti-depressant medication and asked him to return in two weeks but, despite a reminder, he did not attend.

### **Recommendations**

- 58.** **The Board should ensure that GP practices (e.g. through the practice clinical governance lead) understand their responsibility to review the quality of clinical note taking (now an IT skill) for all healthcare professionals in the practice. The Board should enforce this requirement through the regulations relating to the General Medical Services contract.**
- 59.** **For single-handed practices, the Board should put in place a system whereby single-handed practices work collaboratively, for governance purposes, with other practices or with an external mentor/assessor, to ensure due diligence and adequate support for the practice clinical governance lead.**

- 60. The Trust should be required to ensure that each GP practice is assigned a liaison social worker and health visitor, who will meet, on at least a specified cycle, with the GP practice clinical team to review issues of concern.**
- 61. GP patient lists do not respect Trust or locality boundaries: where health visitor and social worker caseloads include the patients of practices located outside their geographical patch, the Trust should ensure that these staff feed back concerns to practices in a timely manner.**
- 62. The Board should explore with the appropriate authority the potential benefits of identifying to General Practitioners those patients who are registered sex offenders and subject to MASRAM guidance.**
- 63. The Board should use its contractual powers under the GMS Contract to ensure that every healthcare professional working in GP practices has a working knowledge of Regional Child Protection Policies and Procedures. The Trust should provide the same assurance for other primary care staff. All should be trained in the nature and purpose of MASRAM.**

## **9. RECOMMENDATIONS**

### **Professional Practice**

1. The Trust must ensure that child protection work undertaken with children and families is structured, therapeutically focused and informed by the continuing contribution, skill and expertise from all relevant professionals and agencies. This work should be evidenced through the written records.
2. The social work practice and the supervision and management of this work should be appropriately audited to ensure that it meets professional standards and statutory requirements.

### **Assessment/ Risk Assessment/ Care Planning**

3. Trusts and agencies should review their implementation of assessment, risk assessment and care planning procedures to ensure they comply with the DHSSPS standards set and that they have fully implemented and trained their staff in:
  - a risk assessment protocol, procedure and format for undertaking risk assessment on individual children and their families and that this is appropriately compiled and shared with all the relevant disciplines and agencies;
  - the single assessment framework “ Understanding the Needs of Children in Northern Ireland (UNOCINI)” and that appropriate assessments and risk assessments are in place;
  - the recommendations contained in the DHSSPS reports issued to the Trust in 2004 and 2006 on the inspection of child protection services and the DHSSPS Regional inspection report “ Our Children and Young People Our Shared Responsibility” 2007, in respect of assessment, risk assessment and care planning.
4. The Trust should ensure that where a child makes a complaint about domestic violence that this is followed through as a matter of priority, and arrangements are made for the child to be interviewed and a full assessment made in relation to the risks.
5. The DHSSPS should give priority to finalising and issuing the draft Child Protection Standards 2004 which have been revised. The standards issued should:
  - reflect the areas highlighted in this Review regarding sex offenders and the new PSNI Public Protection Arrangements which commence in Northern Ireland in October 2008. Appropriate implementation and training should be provided.

## **Implementation of Child Protection Procedures**

6. The Trust should ensure that senior management monitor and audit implementation by staff of the ACPC and DHSSPS policies and standards on child protection;
7. The Trust should review their current format for providing staff with information on child protection and children's services procedures and ensure that this is produced in a comprehensive manual which includes guidance on: UNOCINI procedures and risk assessment; prioritisation and coding cases; Management of Sexual Offenders/MASRAM information; responding to domestic violence referrals; clarification interviews; multi-disciplinary /Interagency working; management of cases when staff leave or are on sick leave; allocation of work to AYE and Agency staff; exit strategy interviews; updating of SOS CARE and data protection; maintenance of the Child Protection Register and de-registration; and Out of Hours procedural manual. Each member of staff should receive their own copy of this comprehensive manual in an appropriate format that can be updated.
8. The interagency draft Domestic Violence Protocol 2006 should be reviewed and finalised and clear guidance provided to all staff on managing domestic violence notifications, ensuring a high priority is placed on responding and managing child protection concerns arising.

## **Opening, Transferring and Closing Cases**

9. The Trust should ensure that the decisions taken on case closure and transfer are based on a full assessment of the progress of the case in collaboration with the other agencies involved and that those decisions are made in accordance with the procedures and standards set.
10. When the decision is taken to remove a child's name from the Register the Trust should ensure that the care plan agreed at the case conference is actioned and reviewed with the agencies before case closure.

## **Understanding the Needs of Children in Northern Ireland (UNOCINI)**

11. Staff should be provided with the appropriate guidance, training and support in undertaking UNOCINI referrals, assessments, risk assessment and care planning. This should include training and support on the procedures to be followed from: making the UNOCINI referral to receipt of the referral, allocation and initial assessment stage; and the gathering of full and appropriate information from professionals involved to inform the initial assessment, risk assessment and action needed to ensure children are appropriately safeguarded.
12. The Trust should ensure that all cases where there are child protection concerns, including those where there are sex offender's issues, should be immediately allocated and the children seen in line with the UNOCINI guidance on the initial assessment and Co- operating to Safeguard Children DHSSPS 2003.

### **Communication- Interagency/multi disciplinary working**

13. The Trust should take immediate action to improve the poor relationships with the PSNI in the Omagh sector. Consideration should be given to identifying one key individual in the sector with lead responsibility to liaise, build and maintain relationships with the PSNI.
14. The Trust should set up an Interagency Review of their relationships and communication systems with other agencies including PSNI in the Omagh sector and ensure that plans are put in place to increase and improve the communication networks both informal and formal. The secondment of Social Services staff as appropriate to Public Protection Teams and attachments should be considered.

### **Interface with Probation**

15. The Trust and Probation Service should ensure that they continue to liaise and communicate closely on the progress of the care plan, that they seek and provide up to date assessment of the family position and share appropriate information with the relevant disciplines and agencies about risk, before deciding on case closure.

### **Interface with Multi Agency Sex offender Risk Assessment and Management (MASRAM)**

16. The Board and Trust should review the current arrangements for providing information to, and reporting back from the ASORMC meetings.
17. The Trust should ensure that there is a “consistent approach to the recording of MASRAM cases on the relevant Trust system” for both current and closed cases.
18. Staff should be made aware of how to access information on sex and violent offenders and this information should be available to the Out of Hours service.
19. The Trust should as a matter of urgency ensure that they co-ordinate meetings and share information with the PSNI in relation to child protection concerns and sex offenders.
20. The DHSSPS and the ACPC should review the current child protection guidance and ensure that there is clarity on the action that needs to be taken in convening a risk management meeting where the identity of the offender is known to Social Services.
21. The Board and Trust should ensure that the training which MASRAM has made available on sexual offenders and MASRAM issues forms an integral part of the child protection training provided to Health and Social Services staff involved in child protection, General Medical Practitioners and other relevant services and agencies.

22. The DHSSPS, the Board and the Trust and MASRAM should review their current procedures and ensure that the guidance provided for staff emphasises the importance of assessing the potential risks posed by offenders to their own children.
23. The DHSSPS, in their pending review of the policy guidance CTSC should provide clarity on the issues contained in this report including: access to the Register, sex offenders Register and data protection. The review of the DHSSPS policy guidance should be conducted in collaboration with the ASORMC review of the MASRAM guidance to ensure that the safeguarding issues are fully clarified.

### **Joint protocols and clarification meetings**

24. All staff appointed to child protection teams including AYE and agency staff should be trained in clarification interviews and Joint Protocols. A review of the procedures and training provided on single agency clarification interviews is needed to ensure staff are clear about their responsibilities, are able to conduct these effectively and are appropriately supported in this area of work.

### **Gateway Teams and Case Allocation**

25. The Trust should ensure that the Gateway teams are equipped with the appropriate numbers of staff who have the appropriate level of skill and experience, in line with the expertise required to undertake this high risk work and the directions issued by the DHSSPS regarding AYE staff and trainees;
26. The Trust should assess the resources needed to adequately equip the Gateway teams on a long term basis and provide the business case to the Board and the DHSSPS.

### **Coding of cases**

27. The Trust should conduct a review of the current coding system in order to ensure that a determination is made on the basis of need and that the coding system itself promotes compliance with the time limits set out in chapter 5, Co-operating to Safeguard Children DHSSPS 2003 and in chapter 5, ACPC Regional Policy and Procedures 2004.
28. The Trust should ensure that staff making referrals to the Gateway Team provide detailed information at the referral stage and as new information emerges, to inform the judgements made.
29. The decisions taken by the Gateway team should be based on the collation of appropriate information from the UNOCINI form, previous case records and professionals/agencies involved in the case.

## **Unallocated Cases / Waiting Lists**

30. The Trust should explore alternative methods to immediately resolve the unallocated waiting list within children's services and ensure that all cases, where there are child protection concerns, receive a visit and initial assessment within the timescales set in the DHSSPS policy guidance and child protection standards. Attention should be given by the Trust to the priority needed regarding sex offenders and domestic violence notifications.
31. The Trust should examine the waiting list regarding the high number of domestic violence notifications and identify solutions to the prioritisation of these cases.
32. The Board should monitor the Trust's action plan and ensure that the action proposed and taken by the Trust eliminates the waiting list and the problem with the coding and prioritisation used and the DHSSPS advised accordingly.

## **“Job Sharing”**

33. The Trust should identify such critical management positions in child protection services which are “job shared” and review the effects of any such arrangements upon those services.

## **Child Protection Case Conferences and Core Group Meetings**

34. The Trust should review the procedures for Independent Chair and ensure that the standards operated for case conferences are in line with those set out in Cooperating to Safeguard Children DHSSPS 2003, the ACPC Regional Policy and Procedures 2004 and the Draft Child Protection Standards DHSSPS 2004. In particular attention should be immediately given to the:
  - completion of UNOCINI assessment and risk assessment;
  - completion of uni-disciplinary/agency reports and their issue in advance of the case conference;
  - team leader attendance and representation from the agencies at the core group and case conference meetings;
  - adherence to statutory functions and the agreed care plan; and
  - quality assuring and auditing the full case conference process.
35. The Trust should immediately resolve the backlog in the issue of case conference minutes and take all steps necessary to ensure that in the future minutes are provided within the timescales set out in line with Co-operating to Safeguard Children DHSSPS 2003.

## **Core Group Meetings**

36. The frequency of core group meetings and representation from the key agencies, as identified at the case conference, should be adhered to in order to progress and monitor the implementation of the care plan.

37. The Trust should monitor and audit the quality of the work progressed by core groups.

### **Out of Hours Social Work Service**

38. The Trust should ensure that Out of Hours social work staff are clear about their statutory responsibilities regarding child protection cases, children who are on the Register and who are on Care Orders.
39. The Trust should ensure that Out of Hours staff have access to records held on a 24 hour basis and the SOS CARE system in order that they can respond appropriately to situations that arise and particularly where children are on Care Orders or on the Register.
40. The DHSSPS should convene an Independent Review of the Out of Hours social work service in Northern Ireland in order to professionalise, modernise and upgrade this service. The Review should consider the need for a dedicated full time team located outside the coordinators own home to operate the after hours service and: provide clear job descriptions, guidance manual and mandatory training; appoint staff with the relevant training and expertise to separately cover the programmes of care in adult and children's services; and provide access to SOS CARE data base and records held on a 24 hour basis. Consideration should be given to the potential benefits of co-location with other after hours services e.g. GP services and PSNI.

### **Work Force**

41. The Trust should review their strategy and procedures regarding the recruitment and retention of staff and ensure that: appropriately qualified and trained staff are engaged in F.I.T. child protection and Gateway teams; staff are appropriately managed supported and trained in their work and exit interviews are conducted and the necessary changes implemented.

### **Codes of Practice**

42. The Trust should review their implementation of the Codes of Practice for Employers regarding managing the performance of staff; supervision and induction training; and providing organisational policies and procedures, including risk assessment.
43. The Trust should ensure that social workers comply with their Codes of Practice including the areas of risk assessment, meeting relevant standards of practice and maintaining clear and accurate records.
44. RQIA should ensure that they monitor the Trust's compliance with the Codes of Conduct for Employers, as part of their routine Governance Reviews.

## **Supervision**

45. The Trust should ensure full compliance with the DHSSPS supervision standards which includes: providing appropriate induction and ongoing training and support for staff involved in high risk child protection services; reading, agreeing and signing case files regarding the therapeutic interventions provided; and conducting audits of the supervision files to ensure such full compliance.

## **Training**

46. Interagency training should be urgently provided on: sexual offenders and MASRAM issues; clarification interviews and joint protocols; interagency working; completion of referrals to UNOCINI, initial assessment and risk assessment; conduct of core group meetings; preparing reports for case conferences; record management; data protection; and mandatory training for all Out Of Hours coordinators.
47. The Northern Ireland Social Care Council, in undertaking the Review in the degree in social work, should ensure that the curriculum for undergraduate and post qualifying requirements adequately addresses the training needed for social work staff on child protection, the interface with sex offenders and MASRAM process.

## **Data Protection**

48. Clear guidance should be provided for staff on data protection regarding: discussing and recording risk re sex offender issues at case conferences and the minutes of records held.
49. The Trust should ensure that data logged on SOS CARE includes appropriate information on MASRAM and names previously placed on the Register. Staff should be able to access SOS CARE information on a 24 hour basis.

## **Record Keeping**

50. The case records should be kept up to date and in order. They should contain: clear records on opening and closing the case; a chronology of events, the objectives set for the work plan; all case reports and case conference/ core group minutes; an analysis and summary of the interventions provided; and an outline of the future work programme. The maintenance of records should be audited to ensure that they comply with the standards set by the DHSSPS, and professional codes.

## **Mental Health services**

51. The Trust should review and audit the clinical practice and record keeping at Erne House and ensure that they comply with the Trust and the relevant professional codes of practice regarding:

- opening, closing and transferring cases;
  - maintaining clear records on all therapeutic interventions, which clearly set the objectives and rationale for the overall work and each session, analysis of how the risk is being assessed and managed and summary for each session;
  - communicating across therapists in the unit on the work progressed with the offender and partner, taking into account client confidentiality and professional codes of practice;
  - ensuring that issues emerging from the therapeutic sessions are clearly communicated to the core group and case conference and other organisations to enable appropriate decisions to be taken regarding safeguarding issues emerging and;
  - communicating with Social Services and all other relevant disciplines on new information emerging regarding levels of risk and on case closure.
52. The Trust should ensure that reports provided to case conferences are discussed and agreed with the therapists involved with the offender and partner and that these are provided in advance of the date for case conference. The Trust should also ensure that Erne House discusses with Social Services a framework for sharing information and providing reports which inform child protection issues.

### **The Police Service for Northern Ireland (PSNI)**

53. The present PSNI policies in respect of child protection and domestic violence matters should be reinforced within the PSNI by appropriate means and in particular the PSNI should ensure that their sex offenders data base is routinely checked when their officers are called to family situations where there are child protection issues.
54. The PSNI in collaboration with the Boards and Trusts should consider the secondment of a Social Services staff member, as appropriate, to each of the eight PSNI Public Protection Units operating across Northern Ireland.

### **Health Visiting**

55. The Trust should ensure that health visitors make appropriate referrals for additional support to families on the basis of need and not on a perception of the lack of availability of those services.
56. The Board and Trust should ensure that awareness training on sexual offenders and MASRAM issues is an integral part of child protection training provided to health visiting and school nursing staff.
57. The Trust should consider with the appropriate authority the benefit of advising the child protection nurse adviser of those registered sex offenders residing in the local area.

## **General Medical Practitioner**

58. The Board should ensure that GP practices (e.g. through the practice clinical governance lead) understand their responsibility to review the quality of clinical note taking (now an IT skill) for all healthcare professionals in the practice. The Board should enforce this requirement through the regulations relating to the General Medical Services contract.
59. For single-handed practices, the Board should put in place a system whereby single-handed practices work collaboratively, for governance purposes, with other practices or with an external mentor/assessor, to ensure due diligence and adequate support for the practice clinical governance lead.
60. The Trust should be required to ensure that each GP practice is assigned a liaison social worker and health visitor, who will meet, on at least a specified cycle, with the GP practice clinical team to review issues of concern.
61. GP patient lists do not respect Trust or locality boundaries: where health visitor and social worker caseloads include the patients of practices located outside their geographical patch, the Trust should ensure that these staff feed back concerns to practices in a timely manner.
62. The Board should explore with the appropriate authority the potential benefits of identifying to General Practitioners those patients who are registered sex offenders and subject to MASRAM guidance.
63. The Board should use its contractual powers under the GMS Contract to ensure that every healthcare professional working in GP practices has a working knowledge of Regional Child Protection Policies and Procedures. The Trust should provide the same assurance for other primary care staff. All should be trained in the nature and purpose of MASRAM.

**Independent Review Panel**

**Panel Membership**

- |                                       |   |  |
|---------------------------------------|---|--|
| Mr Henry Toner QC                     | - | Chairman, Independent Review Panel   |
| Mrs Maire McMahon                     | - | Coordinator, Independent Review and a former Assistant Chief Inspector in the Social Services Inspectorate, DHSSPS |
| Mrs Maura Devlin                      | - | Assistant Director of Children's Services, South Eastern Health and Social Care Trust                              |
| Dr Sloan Harper                       | - | Director of Primary Care, Northern Health and Social Services Board  |
| Assistant Chief Constable Drew Harris | - | Head of Criminal Justice Department, PSNI  |

**Administrative Support**

- |                  |   |                         |
|------------------|---|-------------------------|
| Mrs Tracy Hodgen | - | Executive Administrator |
|------------------|---|-------------------------|

**List of Those Interviewed by the Independent Review Panel**

**Western Health and Social Care Trust**

- Director Social Services
- Director of Adult Mental Health and Disability
- Assistant Director Family Support
- Designated Child Protection Doctor
- Programme Manager (Family & Child Care Programme)
- Head of Service Gateway Intervention Services
- Independent Chair

**Social Services**

- Programme Manager (Family Intervention Service)
- 2 Senior Social Workers
- 3 Social Workers
- 2 Back up Social Workers
- 2 Out of Hours Coordinators

**Health Visiting Services**

- Child Protection Nurse Advisor
- Community Nurse Manager
- 3 Health Visitors

**Erne House**

- Psychologist
- Nurse Therapist

**Riverside Family Centre**

- Team Leader
- Family Support Worker
- Social Worker

**PSNI**

- PSNI Officer (Domestic Violence Officer)
- PSNI Officer (MASRAM Officer)
- 4 PSNI Officers

## **Education**

- Principal (Sacred Heart College)
- Form Teacher (Sacred Heart College)
- Principal (St Connors Primary School)
- Senior Education Welfare Officer

## **Probation Board**

- Senior Probation Officer
- Probation Officer

## **NICCY**

- Children's Commissioner

## **NSPCC**

- Chief Executive
- Director

## **General Practice**

- General Medical Practitioner

## **Others**

- A member of the public

**GLOSSARY OF TERMS / ABBREVIATIONS**

ACPC	Area Child Protection Committee (of a Health and Social Services Board)
ASORMC	Area Sex Offender Risk Management Committee
AYE	Assessed Year in Employment
Board	Western Health and Social Services Board
Caroline	Caroline McElhill
Case Conference	The Child Protection Case Conference is constituted as a multi-disciplinary, multi-agency meeting convened to assess relevant information with a view to determining plans to safeguard children.
Core Group	The core group is a multi agency, multi professional forum with a key role in developing and delivering the comprehensive child protection plan.
DHSSPS	Department of Health, Social Services and Public Safety; the Department
EPDS	Edinburgh Post Natal Depression Scale
Erne House	A mental health at the Tyrone and Fermanagh hospital site which provides a range of therapeutic services including psychosexual services.
FIT	Family Intervention Team
GP	General Medical Practitioner
Hall 4	Health for All Children (Hall 4) by Hall and Elliman, published in December 2002,
Home Start	Organisation who provide support to parents
HSS	Health and Social Services Boards
Joint Protocol	Protocol for joint investigation by police officers and social workers of Alleged and suspected cases of child abuse

MARAC	Multi Agency Risk Assessment Conference
MASRAM	Multi Agency Sex Offender Risk Assessment and Management
Multidisciplinary	Professional officers, (e.g. doctors, nurses, social workers, allied health professionals), working as a team providing care and treatment to patients.
NIO	Northern Ireland Office
PBNI	Probation Board for Northern Ireland
PPSA	Programme for Prevention of Sexual Abuse
PPU's	Public Protection Units
PSNI	Police Service of Northern Ireland
Review Panel	Independent Review Panel
RPA	Review of Public Administration
Register	Child Protection Register
SOSCARE	Social Services Client Administration and Retrieval Environment
UNOCINI	Understanding the Needs of Children in Northern Ireland
The Trust	Western Health and Social Care Trust
The Board	Western Health and Social Services Board

