

**DHSSPS Logo**

**THE REVIEW OF HEALTH AND SOCIAL  
SERVICES  
IN THE CASE OF DAVID AND SAMUEL BRIGGS  
(THE LEWIS REVIEW)**

**REPORT OF THE IMPLEMENTATION TEAM**

**March 2004**



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## **PREFACE**

In September 2003, the Minister for Health, Social Services and Public Safety, Angela Smith, directed me to establish a team to ensure that the recommendations of the Review of Health and Social Services in the Case of David and Samuel Briggs (The Lewis Review) would be implemented fully and without delay.

No one who is acquainted with the facts of this case could fail to be moved by the tragic events that surrounded the early lives of these infant twins, adopted in Romania to start a new life in Northern Ireland. I shared in full the concerns of the Minister that the issues arising from both the Lewis Review and the preceding Social Case Management Review, convened by the Craigavon and Banbridge Community Health and Social Services Trust, should be addressed at the highest level.

To this end I brought together a Team representing key interests in children's services. I am grateful to the members of the Team - some of whom were personally responsible for implementing the majority of the recommendations of both Reviews - that in a very short time, I am able to report that significant progress has been made in taking the work forward.

This report to Minister sets out for each recommendation exactly what has been achieved and what is currently happening to ensure full implementation. A number of the recommendations have implications for all Health and Social Services Boards and Trusts in Northern Ireland. The Minister was particularly concerned to ensure that those aspects of the Case Management Review and the Lewis Review that have a regional significance should be implemented throughout the health and social services. The Team is still working to ensure that this happens and that all remaining matters will be fully completed by Autumn 2004.

I understand that my colleagues in the Northern Ireland Office, who are represented on the Implementation Team, also intend to produce a report outlining the changes that have been introduced as a result of an

independent, internal review into pathology practices and procedures commissioned by the State Pathologist's Department and the NIO.

Significant improvements and changes have therefore already been made to a wide range of policies, practice and procedures. I believe that these have provided additional support in intercountry adoption services and have helped to strengthen safeguards for all children and families some of whom may, for a variety of reasons, find themselves in vulnerable or difficult circumstances. It is of crucial importance that out of the sad and distressing events in two such young lives, we make sure that the lessons learned will greatly improve professional practice across all children's services for many years to come.

**PAUL MARTIN**

**Chief Inspector**

**Social Services Inspectorate**

## **1 INTRODUCTION**

- 1.1 The Minister for Health, Social Services and Public Safety, Angela Smith, published the Review of Health and Social Services in the case of David and Samuel Briggs (The Lewis Review) in September 2003.
- 1.2 The Review was commissioned in 2002 by the then Minister, Bairbre de Brún and was led by Mr Bob Lewis, a former Director of Social Services in England. It followed a Case Management Review, established by the Craigavon and Banbridge Community Health and Social Services Trust, into the tragic death of David Briggs and the non accidental injury of his brother Samuel, infant twins brought from Romania to be adopted in Northern Ireland. The Case Management Review was conducted under the Children (NI) Order 1995 guidance and regulations, 'Co-operating to Protect Children' (DHSS, 1996).
- 1.3 The Lewis Review was concerned with the provision of child and family health and social services by the Craigavon and Banbridge Community Health and Social Services Trust, the role of the Southern Health and Social Services Board in the commissioning of services, the responsibilities of the Department in intercountry adoption and other matters raised by the case of the Briggs children. The Review made some 39 recommendations which focused mainly on organisational, management and governance matters in addition to wider communication issues between the Trust, the Board and the Department.
- 1.4 In publishing the report, the Minister directed that a number of actions should be taken. These and the extent to which they have been achieved are set out below.

## Action

## Progress

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| a) Craigavon and Banbridge Community Health and Social Services Trust and the Southern Board to draw up implementation plans.  | The Southern Board established a working group with its four Trusts and this has taken forward the recommendations of the Case Management Review and the Lewis Review. The Board has confirmed that the recommendations relating to the Board and its Trusts have been fully actioned.                                 |
| b) The Social Services Inspectorate to inspect the Trust's Child Protection Services and Intercountry Adoption arrangements.   | The Social Service Inspectorate's regional inspection of Child Protection services is scheduled to commence in Spring 2004 and the Craigavon Banbridge Trust will be the first Trust to be inspected. Arrangements have been made for the inspection of intercountry adoption services to take place at the same time. |
| c) The recommendations of the Independent Review to be disseminated to all Boards, Trusts and voluntary adoption agencies in Northern Ireland.   | The Department has circulated the report widely to statutory and voluntary adoption and other relevant agencies.   |
| d) The Chief Inspector to set up an Implementation Team to ensure that all the recommendations contained in the Independent Review are fully implemented and those with wider relevance for all Boards and Trusts in | The Implementation Team was established in September 2003 and made its first report to Minister in January 2004.   |

## **Action**

Northern Ireland are taken forward on a regional basis.

- e) In view of the heavy reliance of the Lewis Review on the findings of the Case Management Review, Minister also requested that the Team should address the CMR recommendations within the scope of its report.

## **Progress**

The Team has considered the recommendations of both the Case Management Review and the Lewis Review and is working to ensure that those with regional implications are progressed without delay.



## 2. THE IMPLEMENTATION TEAM

- 2.1 The Implementation Team's terms of reference, as agreed by the Minister, are set out at Annex A. Its core membership comprises representatives from the Social Services Inspectorate, the Child Care Policy Directorate and the Nursing and Medical professional advisory groups within the Department of Health, Social Services and Public Safety. The Team includes Senior Managers from the Southern Health and Social Services Board, Craigavon and Banbridge Community Health and Social Services Trust and the Craigavon Area Hospital Group Trust as well as representatives from the Northern Ireland Office and the NSPCC. Its members are listed at Annex B.
- 2.2 Reports have been submitted to the Social Services Inspectorate by the Department, the Southern Board, its Trusts and the NIO relating to progress in implementing the recommendations of the Case Management Review and the Lewis Review. The Implementation Team has kept this information under review and will continue to ensure that any outstanding work is taken forward and that there are timescales for its completion. Full account will be taken of the significance of each recommendation for children's services across Northern Ireland.
- 2.3 This report to Minister charts the progress made in relation to the recommendations of each Review. Parts 3 and 4 contain the information provided to the Social Service Inspectorate, detailing what has been accomplished, what has still to be done and who is responsible for ensuring full completion. It is intended that the Implementation Team will meet again in Autumn 2004 to receive work that has been allocated to Departmental branches, NIO and other groupings to take forward. In the interim, the Social Services Inspectorate will be conducting an inspection of child protection services and intercountry adoption within the Craigavon and Banbridge Trust. This will provide an independent perspective on the standard of services and will assist the Board and Trust in monitoring the implementation process.

2.4 The Team will review and comment on this work and should be in a position to confirm full implementation by Autumn 2004.

#### Summary of progress in the implementation of the Case Management Review

2.5 The Craigavon and Banbridge Trust's Case Management Review into the death of David Briggs and the serious injury to his brother, Samuel contains 51 recommendations. These cover wide ranging issues relating to the following services: intercountry adoption; community paediatric health and public health; GP services, Health Visiting, child and family care services, hospital services; the Police Service of Northern Ireland (PSNI); and the State Pathologist's Department. Also included are general recommendations to all agencies covered by the review in relation to notification arrangements, liaison and communication, records, training and miscellaneous matters. The recommendations in the main are directed to the Board and Craigavon and Banbridge Trust, but include some to the Department, PSNI, the State Pathologist's Department and the Craigavon Area Hospital Trust.

2.6 The vast majority of the recommendations have been fully implemented and the remainder are in the process of implementation. The Implementation Team is currently working on wider regional matters arising from the recommendations and these are identified in Parts 3 and 4.

#### **Summary of progress in the implementation of the Lewis Review**

2.7 The 39 recommendations of the Lewis Review focus mainly on organisational, management and governance matters in addition to wider communication issues between the Trust, the Board and the Department. As with the Case Management Review, the Board and its Trusts have reported that all relevant recommendations have been fully implemented

or are in the process of being taken forward and will be fully implemented in the near future. Many of the recommendations, however, have a much wider dimension and need to be considered at a regional level. To facilitate this, the Implementation Team has agreed that the Chief Inspector, SSI should establish a group with representation from Boards' Directors of Social Services, Trust Directors of Social Work, legal advisors and other Departmental interests. This group will take forward recommendations relating to the clarification of the role of Boards and Trusts in relation to the delegation of statutory functions, including monitoring, quality control and quality assurance issues. The group will present its final report to the Implementation Team by Autumn 2004.

- 2.8 In 2001, the Department's Nursing and Midwifery Advisory Group convened a Regional Nursing Child Protection Group (RNCPG). This has representation from Boards, community and acute Trusts, midwifery, nurse education, primary care and the professional nursing organisations. The Group's remit is to raise awareness and promote best practice across all settings. The RNCPG is currently examining the recommendations from the Lewis Review and the Case Management Review that refer explicitly to nursing, midwifery and health visiting. These will be cross-referenced against any other recent reviews that are in the public domain to identify common messages. A regional action plan will be drawn up to address these and will include the CMR and Lewis Review recommendations. The action plan will ensure consistent implementation across all Boards and Trusts, where possible via existing structures e.g. Area Child Protection Committees and Trusts' Child Protection Panels.
- 2.9 Work is also underway to address other regional matters arising from the Reviews such as: Departmental policy on the circulation of documentation; the need for shortened versions of professional practice guidance; further intercountry adoption training initiatives and recommendations aimed at GP services. These are being taken forward by relevant Directorates within the Department within the timescales set out in Parts 3 and 4 of this report.



**3. REVIEW OF HEALTH AND SOCIAL SERVICES IN THE CASE OF DAVID AND SAMUEL BRIGGS**

**IMPLEMENTATION OF THE RECOMMENDATIONS OF THE CASE MANAGEMENT REVIEW**

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.1	The DHSSPS should give priority to introducing Inter Country regulations to Northern Ireland	DHSSPS	✓		The regulations are already in place	N/A	Completed
7.2	The Trusts in the Southern Area should make use of the draft Intercountry Policy and Procedures which are currently available. Any Social Worker and relevant Senior Social Worker (Team Leader), dealing with an intercountry adoption, should be trained in the implementation of these procedures.	SHSSB and its Trusts	✓		The SHSSB and its Trusts are working to the new DHSSPS procedures and training has been provided to all relevant staff in the implementation of Intercountry adoption procedures.	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.3	The 3 Health and Social Services Trusts in the Southern Area should consider providing an intercountry adoption service on a consortium basis by appointing a part time senior practitioner to operate across the Trusts.	SHSSB and its Trusts	✓		A senior social worker has been appointed. Additional funding has also been allocated by SHSSB for the appointment of 1 WTE Social Worker to undertake ICA work.	N/A	Completed
7.4	Given the SSI inspection findings the Trust should initiate a review of the provision and management of its intercountry adoption service as a matter of urgency.	CB Trust	✓		A review has been completed by the Trust	N/A	Completed
7.5	When prospective adopters have been accepted by the country of their choice, an inter-agency and multi-disciplinary plan 'adoption plan' should be drawn up by the Trust and reviewed on a regular basis	DHSSPS and all Trusts	✓		Equivalent implemented in full – IC guidance issued by the Department addresses this but establishes slightly different process for plan to be drawn up	N/A	Completed
7.6	A Consultant Community Paediatrician should undertake an assessment of the child, as soon after his arrival in Northern Ireland, as possible, and no later than four weeks from entry.	DHSSPS, and all Trusts	✓		Equivalent has been established in full – some designated paediatricians will be hospital based	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.7	The DHSSPS should review its role and responsibilities in relation to intercountry adoption, with a view to ensuring the maximum involvement of the Trusts at the 'matching and entry clearance stages.	DHSSPS	✓		Draft IC guidance and Hague Convention regulations make provision for this	N/A	Completed
7.8	In fulfilling its legal responsibilities the DHSSPS should liaise closely with the relevant Trust and confirm any action taken in writing.	DHSSPS	✓		This is the current policy of the Social Services Inspectorate and the Child Care Policy Directorate (CCPD) in relation to Intercountry adoption matters	N/A	Completed
7.9	The DHSSPS should give consideration to the issue of 'parental responsibility' given the legal authority which might need to be exercised, with regard to a child in the period before an adoption order is made in Northern Ireland.	DHSSPS	✓		This has been addressed in the Department's new Intercountry Adoption guidance	N/A	Completed
7.10	The Adoption Consortium of Trusts within the Southern Area should	Southern Area	✓		The British Association for Adoption and Fostering (BAAF)	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	undertake a revision of the guidance in relation to adoption assessment, taking account of the model developed by BAAF entitled "Making Good Social Assessments" (1999)	Adoption Consortium			format has been implemented		
7.11	Training in the revised guidance for adoption assessment should be made available to all staff undertaking assessments, and their Senior Social Workers (Team Leaders).	DHSSPS and CB Trust	✓ (Trust)	✓ (Regional)	In house training has been provided for staff. Training also already undertaken by DHSSPS will be supplemented by regional BAAF training in the professional assessment of prospective adopters	The Child Care Policy Directorate (DHSSPS) has commissioned BAAF to provide regional training on assessment following the issue of the Department's final IC guidance in Spring 2004	By Autumn 2004
7.12	Guidance to Adoption Panel Members should be revised to ensure that it is in accord with the revised adoption assessment guidance.	Southern Area Adoption Consortium	✓		Adoption Panel guidance has been revised and issued to Panel members	N/A	Completed
7.13	Every Adoption Panel Member should receive training in relation to this guidance.	Southern Area Adoption Consortium	✓		Training has already been provided and further training is to be offered in the next 2 months	N/A	Completed
7.14	A review of the notification of infectious disease and action taken within Trusts and the Southern HSS Board should be carried out to ensure: - - Clarification of the roles	SHSSB	✓		The Board has reviewed procedures in this area. Correspondence has been sent to hospitals and GPs to ensure better understanding and awareness of actions to be taken. Timescales for response have been agreed and relevant professionals	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	<p>and responsibilities of the medical, nursing, and clerical staff</p> <ul style="list-style-type: none"> <li>- Agreement of the timescales involved</li> <li>- The Public Health Department will continue to be the single contact point for notifiable infectious disease and will put in place mechanisms to ensure confirmation that appropriate action has been taken.</li> </ul>				<p>apprised.</p> <p>In relation to notifications to the Public Health Department, mechanisms have been put in place to ensure that appropriate action has taken place.</p>		
7.15	<p>There may be occasions, following a referral to the Paediatric Health Service, when it is not possible to carry out a full assessment. In this eventuality, it should be made explicit in the report provided and a full assessment carried out at the earliest opportunity</p>	SHSSB CB Trust	✓		<p>The Board has reviewed its referral and follow up procedures for Consultant Paediatric referrals.</p> <p>The Trust has reviewed the Paediatric referral process and has secured funding for an additional P/T Consultant Paediatrician and developed a multidisciplinary Child Health Centre.</p>	N/A	Completed
7.16	<p>Where there is evidence of developmental delay or failure to thrive then a written action plan should be developed by the General Practitioner in conjunction with the</p>	SHSSB CB Trust	✓ (Trust)	✓ (Regional)	<p>The Directorate of Primary Care has convened a Task Group, to develop local guidance on dealing with management of failure to thrive. The group will also make recommendations on</p>	<p>The Southern Board Multi-professional Task Group, chaired by a Consultant Paediatrician Including both General Practitioners and nursing representatives</p>	<p>(Board and Trust)</p> <p>Completed</p> <p>(Regional)</p>

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	Health Visitor, and should be reviewed on an ongoing basis. This action plan may include referral to a Consultant Paediatrician. In the case of intercountry adoption this would form part of the adoption plan.				<p>good practice and how this might be encouraged within the General Practitioner community.</p> <p><b>The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report</b></p>	<p>Learning to be shared with other Boards and Trusts</p> <p>RNCPG – regional aspects</p>	The RNCPG action plan will be in place by Autumn 2004
7.17	Guidance should be developed by the General Practitioner Unit, SHSSB, as to the essential elements required in the action plan, in conjunction with senior nursing staff in the SHSSB and Trusts.	SHSSB, GP Practitioner Unit	✓ (Board)	✓ (Regional)	<p>The Directorate of Primary Care continues to work with the SACPC, the Social Services Training Unit, and the Southern Adoption Panel to raise awareness and develop training on Child Protection issues for general practitioners throughout the Board's area. A number of initiatives have already been undertaken or are planned to enhance knowledge in child protection across all relevant health and social care professionals.</p> <p>The regional aspects in relation to GPs are being taken forward by DHSSPS</p>	<p>The Directorate of Primary Care in conjunction with the SACPC and Social Services Training Unit and the Southern Area Learning as Teams (SALT)</p> <p>Primary Care Directorate (DHSSPS)</p>	Ongoing – planned initiatives to be completed by Autumn 2004
7.18	There may be occasions when the Health Visitor is the first point of contact for a child who is	SHSSB CB Trust	✓ (Trust)	✓ (regional)	Health Visitors continue to follow Regional Guidelines as per the Child Health System (N.I.) 2002. A child with a	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this	(Board and Trust)  Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	developmentally delayed or is failing to thrive. In these circumstances, the Health Visitor should make a written referral to the General Practitioner.				suspected developmental delay is referred to a Community Paediatrician using the Child Health System (CHS) referral forms. A copy of this referral is also sent to the General Practitioner and Nurse Manager Health Visitors also discuss individual child development concerns with the General Practitioner and agree a way forward.	recommendation forward. See paragraph 2.7 of this report	(Regional)  The RNCPG action plan will be in place by Autumn 2004
7.19	An audit should be undertaken as a matter of urgency in relation to the use of Growth Centile Charts with a view to informing future training needs, equipment used, and the range of Centile Charts required.	SHSSB CB Trust	✓	✓ (regional)	An audit has been completed across the three Trusts which demonstrated that the majority of centile charts were completed as per CHS guidance. Beeches Nursing and Midwifery Training Centre have provided training in relation to growth centile charts.  Further audits have been completed on a six monthly basis which show that centile charts have been completed in all cases.	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Board and Trust)  Completed  (Regional)  The RNCPG action plan will be in place by Autumn 2004

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.20	In respect of home visits where the child is not seen, a further visit should be undertaken as soon as possible, and not later than five working days.	SHSSB CB Trust	✓ Board and Trust	✓ Regional	Updated guidance has been issued to all health Visitors in respect of home visits where the child has not been seen. A difficulty has arisen in other SHSSB Trusts with families who live in RoI but use convenient addresses in the North. The Regional Child Protection Nurses Meeting is addressing this issue in relation to nursing and health visiting concerns.	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Board and Trust) Completed (Regional) The RNCPG action plan will be in place by Autumn 2004
7.21	The Trust should undertake an annual audit of the implementation of its supervision policy for Health Visitors.	CB Trust	✓	✓ Regional	The Trust has reviewed its supervision policy for Health Visitors. Supervision is provided through bi-monthly supervision sessions with Team Leaders as well as monthly structured Peer Supervision. Supervision is more frequent for newly qualified and newly appointed nurses	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Trust) Completed (Regional) The RNCPG action plan will be in place by Autumn 2004
7.22	The Trust should undertake an annual audit of the implementation of its caseload profiling and identification of families requiring additional Health Visiting support policy and procedures.	CB Trust	✓		Family assessment and the appropriate response to family and childcare needs were aspects of Health Visitor practice audited in the Health Visitor (SHSSB) audit in 2001. This subject is audited by Health Visitor Team Leaders on a six monthly basis.  The Trust has raised the issue	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
					of recording with the Regional Users Advisory Group and a revised format has been agreed by the Regional Group and amended to include the Framework for Assessment Triangle.		
7.23	The Trust should ensure that the Child Health System is operational and accessible at all times.	CB Trust	✓		The Trust's CHS is operational between 9am and 5pm Monday – Friday in line with regional access.	N/A	Completed
7.24	The Trust should ensure that Health Visitors are aware that if recall appointments of four weeks or less are required, then these will have to be made by the Health Visitor	CB Trust	✓ (Trust)	✓ (regional)	Team leaders addressed this recommendation with all Health Visitors who are aware of this requirement. This timescale is part of the system requirement for the CHS and part of the Regional Guidance.	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Trust) Completed (Regional) The RNCPG action plan will be in place by Autumn 2004
7.25	The respective roles and responsibilities of the Child Protection Nurse Specialist and the Health Visiting Team Leader in relation to child protection issues should be clarified.	SHSSB CB Trust	✓ (Board and Trust)	✓ (regional)	These roles have been clarified. A revised supervision policy has been issued in Policies, Procedures and Guidance for Community Nurses and the Role of the Child Protection Nurse Specialist, January 01. This document was circulated for consultation with the Trust	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Board and Trust) Completed (Regional) The RNCPG action plan will be in

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
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					Health Visitors.  Copies have been given to all health visitors and their team leaders and are included in the Health Visiting procedures manual. A copy is also given and explained to all nurses at induction interview with the Child Protection Nurse Specialist.		place by Autumn 2004
7.26	The importance of the adherence to the Trust guidelines on the Role of the Child Protection Nurse Specialist should be emphasised to all nursing and midwifery staff and team leaders, within the Trust.	SHSSB CB Trust	✓ (Board and Trust)	✓ (Regional)	This has been emphasised to all nursing and midwifery staff and Team Leaders within the Trust. The Child Protection Nurse Specialist has attended team meetings for all nursing disciplines at which the role and responsibilities of the Child Protection Nurse Specialist, Team Leaders and individual nursing staff are outlined and reference made to Procedures Manuals which include this information.	The Regional Nursing Child Protection Group (RNCPG) will take the regional aspects of this recommendation forward. See paragraph 2.7 of this report	(Board and Trust)  Completed  (Regional)  The RNCPG action plan will be in place by Autumn 2004
7.27	All staff involved in child protection should ensure that they comply with the SACPC Policy and Procedures.	SHSSB CB Trust	✓ (Board and Trust)	✓ (regional)	All Trust staff working with children have attended training on child protection procedures. On-going training on practice and policy issues relating to child protection is provided as part of the SHSSB Training Unit's in-service uni- and multi- disciplinary training programmes. Each Trust completes an annual training needs analysis and a	SHSSB Training Unit in conjunction with the GP Practitioner Unit  The regional aspects of this in relation to nursing will be taken forward by the RNCPG (see paragraph 2.7 of this report) and in relation to GPs by the	(Board and Trust)  Completed but ongoing as new staff are appointed  (Regional)  The RNCPG action plan

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					<p>comprehensive uni-disciplinary and multi-disciplinary (ACPC) training programme is available. This always includes significant training on child protection.</p> <p>GPs are offered child protection training, but not all choose to attend. Whilst the SHSSB strongly encourages attendance it has no power to enforce compliance by GPs</p>	Department's Primary Care Directorate (PCD).	and PCD plans will be in place by Autumn 2004
7.28	The Trust should take forward the recommendation, referenced within this Report, which came from the Social Services Inspectorate 'Planning to Care' Report:	CB Trust	✓		The Trust has an annual review of legal services with the Directorate of Legal Services. Feedback from practitioners and team leaders informs this exercise. A formal monitoring pro-forma is now being introduced.	N/A	Completed
7.29	Case Conference minutes should be dated and signed by the Chairman, and Recipients of the minutes should ensure that these are date stamped	CB Trust	✓		Minutes are dated and signed. Recipients are asked to acknowledge receipt of the minutes by using a tear off slip system.	N/A	Completed
7.30	The Trust Child Protection Panel should monitor the invitation lists for Case Conferences and report findings to the ACPC. Any areas of	CB Trust	✓		Case Conference Chairpersons and Social Work Team Leaders have been reminded who must be invited to all Case Conferences. The Child Protection Panel has	N/A	Completed

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	concern should be addressed.				<p>raised awareness as to the recommendations of the Case Management Review in addition to specific training being provided.</p> <p>The Board has provided some additional funding to the Trust to facilitate Community Paediatric attendance at the Case Conferences</p>		
7.31	Reports to Case Conference from within the Trust should be prepared by each individual Team who is in contact or has had contact with the family in question.	CB Trust	✓		This has been reinforced in training.	N/A	Completed
7.32	There is a clear requirement for attendees at Case Conference to ensure that their input is adequately reflected in the Case Conference minutes. The use of the 'tear-off slip' mentioned in ACPC procedures should be introduced across the Board's area.	CB Trust	✓		All attendees / participants have an opportunity to respond within 7 days of receipt of Case Conference minutes by using a tear-off slip system.	N/A	Completed
7.33	The Trust should ensure that appropriate arrangements are in place where supervised contact is deemed	CB Trust	✓		The Trust has ensured this recommendation has been notified to appropriate personnel and has confirmed that foster carers are not	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
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	necessary in child protection cases. In these instances, foster-carers should not be required to supervise the contact.				requested to supervise contact in child protection cases.		
7.34	The Trust should take immediate action to discontinue the contact which Samuel has with Mr and Mrs Briggs.	CB Trust	✓		The care proceedings in respect of Samuel concluded in January 02. At this time Mr and Mrs Briggs were offered one last contact which they declined.		

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.35	The DHSSPS should review the Sussex Joint Agency Protocol for Unexplained Child Deaths, with a view to a similar protocol being implemented	DHSSPS, NIO		✓	<p>This will be taken forward in the context of a paper to be issued early in 2004 by the Home Office on its position in response to the recommendations of the Shipman Inquiry and the Report on Death Certification and Investigation in England, Wales and Northern Ireland (2003) (The Luce Report), Recommendation 57 of the Luce Report states:</p> <p>"In all Coroners' areas there should be standing protocols between the Coroner and various children's services and child protection agencies setting out how the children's agencies should be involved in death investigations and how the coroner and his staff should work with them. These should include the National Care Standards Commission and its successor bodies"</p> <p>The Northern Ireland Courts Service is about to issue at the end of this month a consultation paper on the redesign of Coroner's Services in Northern Ireland. One of the proposals contained in the paper is to establish a working</p>	Home Office to issue paper early 2004	Autumn 2004

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
					<p>group with relevant agencies to develop protocols in relation to child deaths.</p> <p>In the meantime, the Southern Area Child Protection Committee (SACPC) is in the process of implementing the Case Management Review recommendation within its own area and has met with Coroner, State Pathology and other agency representatives with a view to agreeing a Southern Board Protocol.</p> <p>The membership within the current SACPC Working Group is comprehensive and other ACPCs have accepted this as a regional group.</p> <p>The Department will wish to ensure that the work already in progress in the Southern Board will be used to inform any forthcoming regional initiatives.</p>	NICS to issue consultation paper	Paper to be issued by Spring 2004
7.36	The current process in relation to quality assuring forensic X-rays should be reviewed as a matter of urgency and should not continue in its present unsatisfactory form.	NIO State Pathology Services	✓		Procedures are now in place to ensure that full skeletal X-Rays are taken and reviewed by a Consultant Radiologist in advance of the autopsy. If this is not practicable, then this will be taken as soon as possible following the autopsy.	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.37	When a child protection referral is made by the Hospital Social Work Team to the Child and Family Care Team, the Hospital Social Work Manager and Senior Social Worker (Child and Family Care Team) should agree and record roles and responsibilities	CB Trust Craigavon Area Hospital Trust	✓		<p>The respective roles of staff have been clarified by the hospital and community Trusts' managers. The SACPC multidisciplinary Assessment of the Needs of Children and their Families (issued June '03) facilitates the process of referral and assessment.</p> <p>The Social Work Department and the Craigavon Area Hospital Trust have drawn up new documentation to be completed at ward level on the referral and discharge of patients.</p>	N/A	Completed
7.38	In the light of the findings and concerns outlined in this Report, the Police should re-examine the circumstances and possible cause of David's death.	PSNI	✓		Postmortem findings have been received and an independent review has been carried out which involved a re-examination of the cause of David's death. The findings are with the DPP	N/A	Completed
7.39	An independent expert should be asked to analyse the autopsy findings. This expert should be asked to comment specifically on the likelihood of NAI as the cause of death in this	NIO State Pathology Services	✓		An independent review was conducted in respect of the autopsy findings which established a cause of death. A report is currently with the DPP.	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	case, based on the analysis of the multiple fractures, subaponeurotic hemorrhages, sub pleural hemorrhages and thymic hemorrhages.						
7.40	Post mortem skeletal surveys should be read and reported on by a Paediatric Radiologist prior to the body being released for burial.	NIO State Pathology Services	✓		This has been implemented. The opinion of a Consultant Radiologist is now provided in writing in each case.	N/A	Completed
7.41	Only a qualified Paediatric Pathologist should conduct an autopsy in cases of unexplained neonatal, infant, and childhood deaths.	NIO State Pathology Services	✓		A procedure for joint autopsies between forensic and paediatric pathologists has been implemented by the SPD in respect of autopsies performed on infants and young children. It is accepted that paediatric pathologists may not always be available at the time when the autopsy is due to be performed. If this happens and the autopsy proceeds, the autopsy findings must be seen by a paediatric pathologist soon after and before the autopsy report is completed. The State Pathologist's Department has now implemented a protocol for the management and review of all infant and children cases.		
7.42	Where there are issues				The Southern Health and		

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			In full	Under-way			
	relating to children with whom the Trust has an involvement that are likely to attract public interest or media attention, they should be notified immediately to Trust Headquarters. The Trust should notify the Board and Department as appropriate.	SHSSB CB Trust	✓		Social Services Board and Trusts have revised their notification of Untoward Events policies in line with the CMR recommendations. The policy explicitly informs staff on the need to bring matters to the attention of the Trust Chief Executive and Directors at the earliest opportunity and the Trust Chief Executive has then responsibility to inform the Board and Department as soon as possible thereafter. The policy has been circulated to all staff and training has been provided in its implementation.	N/A	Completed
7.43	In relation to child protection issues, there should be adherence to the notification arrangements outlined in the SACPC Child Protection Procedures.	SHSSB CB Trust	✓		See above	N/A	Completed
7.44	Notifications between Trusts, Boards, and Government Departments should be at Director or Chief Executive level	DHSSPS SHSSB CB Trust		✓	See 4.45 – DHSSPS procedures still to be determined		
7.45	All agencies should review their communication and liaison arrangements where shortcomings have been identified in this	DHSSPS SHSSB CB Trust	✓ Board and Trust	✓ DHSSPS	A range of interdisciplinary and inter-directorate forums now exist within the Trust to ensure effective communication between disciplines on all aspects of child care practice	Intercountry adoption communication issues to be considered by DHSSPS with the Regional Adoption Policy and Procedures	Autumn 2004

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	Report and take immediate action to address these deficiencies.				<p>in addition to the regular meeting of the Child Protection Panel. The Trust has developed a multidisciplinary Childcare/Child Health Forum chaired by the Director of Social Services, which further facilitates good interdisciplinary communication.</p> <p>The Board has revised its procedure on untoward events to improve communication. It is currently reviewing commissioning and performance management arrangements to improve communication and information flows.</p> <p>The new DHSSPS guidance 'Safeguarding Children' establishes the communication arrangements between DHSSPS and Boards and Trusts in Child Protection matters. Some issues still require to be resolved on intercountry adoption communications and general communication on matters of policy</p>	<p>Group to agree lines of communication.</p> <p>More general communication relating to policy, procedural guidance and other documentation issued by the Department to Boards and Trusts to be considered by Child Care Policy Directorate.</p> <p>These are being taken forward by the Department's Child Care Policy Directorate</p>	

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
7.46	All agencies should review their record keeping where shortcomings have been identified in this Report and take immediate action to address these deficiencies.	DHSSPS SHSSB CB Trust	✓ Board and Trust	✓ DHSSPS	<p>The issue of recording has been raised in training and at the Child Protection Panel. There has been a review of record keeping within Trust.</p> <p>Training in record keeping is now an on-going part of the training programme of health and social work staff.</p> <p>As a result of the Briggs case there has been a regional review of health visiting records and a new record has been developed.</p> <p><b>The previously identified training initiative for GPs has highlighted the need for guidance on record keeping as well as other issues.</b></p>	The Child Care Policy Directorate will be taking forward the Department's actions in this area.	(Board and Trust) Completed CCD Autumn 2004
7.47	The Hospital Social Work Department should review the referral proformas used within the Department when they are notified of child care/child protection concerns. The appropriateness of using the 'Child Care Referral Form' in use with the Community Trust should be considered.	CB Trust	✓		The Child Care Referral Form is now used. Also see 4.37 - The Social Work Department and the Craigavon Area Hospital Trust have drawn up new documentation to be completed at ward level on the referral and discharge of patients.	N/A	Completed
7.48	The SACPC Multi-disciplinary Training		✓		This has been completed.		

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	Officer should review the training needs arising from this Review and in collaboration with relevant agencies develop an action plan to address these needs						
7.49	Child and Family Care Social Work staff should receive awareness training on all aspects of adoption work, including intercountry adoption.	CB Trust	✓		Specific adoption and intercountry adoption training has already taken place, including training by DHSSPS on legal and procedural issues. The Southern Area Training Department is reviewing the CMR /Lewis reports to identify any further outstanding issues and will provide relevant updated training on a regular basis –see also 4.11 above	N/A	Completed
7.50	Craigavon Area Hospital should be asked to identify a suitable representative to serve as a member of the Craigavon and Banbridge Child Protection Panel.	Craigavon Area Hospital Trust CB Trust	✓		The Hospital is now represented on the CB Child Protection Panel by a children's ward Nursing Officer and on the Southern Area Child Protection Committee by a Consultant Paediatrician	N/A	Completed
7.51	Craigavon and Banbridge Community HSS Trust should initiate the necessary action to obtain compensation for Samuel for the non-accidental injuries he has	CB Trust	✓		This has been done	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation status		Comment	How to be completed and by whom	Completion date
			In full	Under- way			
	sustained.						

#### 4. REVIEW OF HEALTH AND SOCIAL SERVICES IN THE CASE OF DAVID AND SAMUEL BRIGGS

##### IMPLEMENTATION OF THE RECOMMENDATIONS OF THE LEWIS REVIEW

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
6.1.1	The Department should reclarify the roles of the Board and the Trust, in terms of commissioning, managing and delivering the service.	DHSSPS		✓	New guidance to be issued - to include DHSSPS functions	Group comprising representation from Board Directors of Social Services, Trust Directors of Social Work, legal advisors and other Departmental interests to be led by Chief Inspector, SSI to take this forward (See paragraph 2.6 of this report).	To report to the Implementation group by Autumn 2004
6.1.2	The Board should establish processes to enable it to monitor the standard and quality of services delivered in addition to the financial/quantitative data it collects.	SHSSB		✓ (Board)  ✓ (Regional)	This is a regional matter which needs to be considered across all delegated statutory functions – should be informed by the standards developed by HPSSRIA.  The SHSSB is however undertaking a review of its commissioning and performance management arrangements with	The regional aspects will be considered by the CI's group (see 6.1.1 and paragraph 2.6 of this report) with reference to the work already ongoing in the SHSSB	CI group to complete by Autumn 2004

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
					particular reference to the discharge of statutory functions. This will identify systems and mechanisms which currently monitor the standard and quality of services as well as improvements which should be made to improve the extent of qualitative monitoring		
6.1.3	Trust staff should have help in making easy reference to practice guidance (ie easily read shortened versions of existing guidance and use of technology to facilitate this).	CB Trust		<p>✓ (Trust)</p> <p>✓ (Regional)</p>	The Trust is reviewing is current procedures This was also a recommendation of SSI 'Adopting Best Care' report and Climbié Inquiry. Intercountry adoption procedural summary available and domestic adoption checklist should be available shortly through work of regional group and Strategy Worker who has recently been appointed. Child protection procedures checklists should also be developed	<p>Audit of existing procedures Required. Regional group led by Child Care Policy Directorate to identify key areas that require handy reference guidance.</p> <p>Use of existing consortia / partnerships to develop summary practice guidance e.g. Southern Area Adoption Consortium, ACPC; the Regional Adoption Policy and Procedures Group</p>	Audi to be completed by Autumn 2004
	The Trust should ensure that the intercountry adoption service adheres	CB Trust	✓		The Trust is working to DHSSPS May 2003 IC	Monitoring arrangements should tie in with 6.1.2	By Autumn 2004

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	to statutory requirements and Departmental guidance and should establish arrangements to monitor the standard of service provision.				<p>guidance. Monitoring mechanisms for standards of provision to be formally developed</p> <p>SSW Adoption specialist quality assures all ICA work by the 3 Community Trusts in the Southern area.</p> <p>Southern Area Adoption Panel Annual Report now includes a separate section on ICA</p>	above being taken forward by the CI's group	
6.1.5	The Department should review the resources it requires to effectively fulfill its responsibilities in relation to Inter-country adoption.	DHSSPS	✓		Administrative case worker and an additional DP adoption services post already established.	N/A	Completed
6.2.1	The Department should review the way issues that arise in inter-country adoption applications are communicated to Trusts to ensure that relevant managers in the Trust are aware of deficits in information or professional concerns relating to applications.	DHSSPS in consultation with Boards and Trusts		✓	The arrangements for communicating with Trusts in respect of ICA applications vary considerably – some are communicated through the contracted voluntary agency.	DHSSPS Child Care Policy Directorate CCPD needs to consult further about this issue with Trusts and agree a standardised reporting arrangement which will be included in final IC guidance	Spring 2004
6.2.2	We urge the Board to review how it monitors	SHSSB		✓	This is a regional matter	As 6.1.1 above:	CI group to

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			In full	Under-way			
	contracts from both a quantitative and qualitative perspective and how it ensures that all delegated statutory functions are effectively implemented.				<p>which needs to be considered across all delegated statutory functions in children's services – should be informed by the standards developed by HPSSRIA</p> <p>(Ref 6.1.2) SHSSB has commenced a review of contracting and performance management arrangements with particular reference to the discharge of statutory functions for adults and children in all programmes of care. This should inform a regional approach</p>	Group comprising representation from Board Directors of Social Services, Trust Directors of Social Work, legal advisors and other Departmental interests to be led by Chief Inspector, SSI to take this forward (See paragraph 2.6 of this report).	report to the Implementation Team by Autumn 2004
6.2.3	The Trust to review its guidance to staff in respect of multi-professional working.	Trust	✓		The Trust has complied with this. The SSI regional inspection of services for disabled children in hospital will require all Boards and Trusts to establish, review guidance in multidisciplinary working.	N/A	Completed
6.2.4	The Trust Directors to review the reporting strategies currently in	CB Trust Craigavon	✓		A range of interdisciplinary and inter-directorate forums now	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	place to ensure that in future all issues which require joint action are presented in a multi-professional format.	Area Hospital Trust			<p>exist within the Craigavon / Banbridge Trust to ensure effective communication between disciplines on all aspects of child care practice in addition to the regular meeting of the Child Protection Panel.</p> <p>The Trust has developed a multidisciplinary Childcare/Child Health Forum chaired by the Director of Social Services, which further facilitates good interdisciplinary communication.</p> <p>The issue of communication relating to referrals has been addressed in the new Child Protection Nursing Policy. Triplicate information/referral forms have been devised and have been introduced.</p> <p>Craigavon Area Hospital has advised that it has taken necessary action. The hospital social work department has also introduced new referral and discharge forms.</p>		

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
6.2.5	The Department should direct Trusts with responsibility to establish and implement a Care Plan when any children are adopted overseas or brought to Northern Ireland for the purpose of adoption.	DHSSPS	✓		Arrangements for pre-adoption and post placement/post adoption support are set out in the May 2003 IC guidance Trusts are currently working to this – some further requirements are contained in Hague Convention regulations.	N/A	Completed
6.2.6	The Board and the Trust should they receive on a regular basis reports from operational managers reviewing standards of practice.	SHSSB and CB Trust	✓		<p>A range of mechanisms are in place in the Southern area including</p> <ul style="list-style-type: none"> <li>- Statutory Child Care Monitoring Meeting</li> <li>- Child Care Managers Meeting</li> <li>- Residential Child Care Forum</li> <li>- Family Placement Committee</li> <li>- Adoption Consortium</li> </ul> <p>The SHSSB review of Commissioning and Performance Management will indicate methods of improving reporting (6.1.2 / 6.2.2)</p> <p>Craigavon &amp; Banbridge Trust audits community nursing 6 monthly and</p>	N/A	Completed

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			In full	Under-way			
					reports issues to the Trust Board		
6.2.7	The Department in its forthcoming inspection of child protection services should include the Craigavon and Banbridge Community HSS Trust.	DHSSPS		✓	The Trust will be included in this inspection which is due to take place in early 2004	Multidisciplinary inspection team led by SSI	Spring/ Summer 2004
6.3.1	The Trust should review its written guidance for staff to ensure it is more 'staff friendly' and therefore more likely to be implemented and have check lists for action by staff.	CB Trust		✓	As for 6.1.3 The Trust is reviewing its current procedures. This was also a recommendation of SSI 'Adopting Best Care' report and the Climbé Inquiry. Intercountry adoption procedural summary available and domestic Adoption checklist should be available shortly through work of regional group and Strategy Worker who has recently been appointed. Child protection procedures checklists should also be developed	As for 6.1.3 Audit of existing procedures Regional group led by CCD to identify key areas which require handy reference guidance.  Use of existing consortia / partnerships to develop summary practice guidance e.g. Southern Area Adoption Consortium, ACPC	Audit to be completed by Autumn 2004
6.3.2	The Trust should establish a policy on interdisciplinary working at a community level in	CB Trust		✓	The Trust has a tradition of multi-disciplinary management and working arrangements in most	CB Trust to review existing arrangements and develop	By Summer 2004

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			In full	Under-way			
	family and child health and social services.				Programmes of Care. It has a number of forums to facilitate multi-disciplinary working. It will review the effectiveness of existing arrangements and will issue new guidelines as required	new guidelines	
6.3.3	The Trust should establish systems to ensure that there is a multidisciplinary approach when implementing the Trust's policies and that this is evidenced in the practice of operational staff.	CB Trust		✓	New guidance on multidisciplinary working to be issued	CB Trust as above	By Summer 2004
6.3.4	The Board and the Trust should review their formal communication strategies to ensure that the Board is kept aware of specific practice issues.	SHSSB and its Trusts	✓		The Southern Health and Social Services Board and Trusts have revised their notification of Untoward Events policies in line with the CMR recommendations. The policy explicitly informs staff on the need to bring matters to the attention of the Trust Chief Executive and Directors at the earliest opportunity and the Trust Chief Executives have a responsibility to inform the Board and Department as soon as <b>possible thereafter</b> . The	N/A	Completed

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			In full	Under-way			
					policy has been circulated to all staff and training provided.		
6.3.5	The Department should review the way it issues written guidance in respect to their circulation and designated purpose.	DHSSPS		✓	Need to review existing policy on the issue of policy guidance and other Departmental documentation and if necessary, reissue	<p>Intercountry adoption communication issues to be considered by DHSSPS with the Regional Adoption Policy and Procedures Group to agree lines of communication.</p> <p>The Department's Child Care Policy Directorate is currently reviewing and evaluating its communication protocols in respect of advice and guidance issued, as part of this review the directorate will ensure that all policy advice, guidance and legislation is available to the HPSS through a range of different media</p>	To be completed by Autumn 2004
6.3.6	The Trust should introduce quality assurance processes which as part of the process would keep line managers informed of any major issues of concern held by operational staff.	CB Trust	✓		Systems of supervision are now in place in all SHSSB Trusts providing a mechanism for communication by practitioners also see 6.2.6 above.	N/A	Completed

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			In full	Under-way			
6.3.7	The Department should establish a protocol which sets out agreed arrangements for the circulation of all Departmental documents and formal communications with Boards and Trusts.	DHSSPS		✓	As for 6.3.5 Need to consider existing policy and if required review and reissue	As for 6.3. 5 Child Care Policy Directorate to follow up	By Autumn 2004
6.4.1	In its commissioning arrangements with the Trust, the SHSSB should ensure that these are able to take account of emerging pressures on the Trust in respect of service delivery, and to ensure that delays and deficits in service provision do not occur.	SHSSB		✓	This is currently under consideration as part of the review of commissioning and performance management being undertaken by SHSSB  SHSSB Programme Commissioning Groups are in place for each programme of care. They meet regularly with Trusts to review pressures, deficits and priorities, however in the context of resource limitations it is difficult to ensure that delays and deficits do not occur.	SHSSB	Ongoing responsibility
6.4.2	The Trust should review its workforce planning policies, especially in respect of health visitor staffing and ensure that	SHSSB and CB Trust	✓		The Trust is currently reviewing its workforce planning for health visiting The three Community Trust	CB Trust	Spring 2004

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	the SHSSB are aware of new demands in the delivery of services.				Directors of Social Services and HR meet at least quarterly with Board Director of Social Services regarding workforce issues in child care social work.		
6.4.3	The Trust should review its supervision policy, ensuring that policies mean that health and social care personnel have access to supervision applied across all services, and that appropriate records are maintained. A formal process for first line managers to report to more senior staff in the Trust on the general issues raised in supervision sessions should be introduced.	CB Trust	✓		<p>The Trust has reviewed its supervision policy for Health Visitors. Supervision is provided through bi-monthly supervision sessions with Team Leaders as well as monthly structured Peer Supervision. Supervision is more frequent for newly qualified and newly appointed nurses.</p> <p>Within health visiting and social services there are arrangements for first line managers to raise issues of concern with senior managers.</p> <p>Community Nursing has a system for auditing supervision records</p>	N/A	Completed
6.4.4	The SHSSB and the Trust should ensure that the staff development	SHSSB and the SHSSB	✓		SHSSB Training Unit has provided multi-disciplinary	N/A	Completed

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			In full	Under-way			
	and training needs of staff involved in intercountry adoption work are addressed.	Training Unit			training for staff involved in ICA. On-going refresher training and training for new staff is also programmed		
6.4.5	The Department should ensure that its forthcoming new guidance on intercountry adoption is underpinned by a comprehensive training programme in all Boards and Trusts.	DHSSPS		✓	SSI and CCPD have delivered multidisciplinary training on the May 2003 guidance in all Boards' areas. BAAF has also been commissioned to follow up issue of final guidance with training for all professionals in IC work	BAAF to deliver remaining training	Summer 2004
6.5.1	The Board should review its contracting policies, and how quality standards can be introduced to enable it to satisfy itself that policy is reflected in practice.	SHSSB		✓	The Board has established a review of its commissioning and performance management arrangements.  DHSSPS to undertake regional aspects of this,	As for 6.1.1 Group comprising representation from Board Directors of Social Services, Trust Directors of Social Work, legal advisors and other Departmental interests to be led by Chief Inspector, SSI to take this forward. (See paragraph 2.6 of this report).	CI group to report to the Implementation Team by Autumn 2004
6.5.2	The Department should review commissioning policies across all Boards and Trusts, and issue general guidance on how best issues of need (workload pressures),	DHSSPS		✓	As for 6.1.1 to be included in new guidance.	As above	CI group to report to the Implementation Team by Autumn 2004

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			In full	Under-way			
	quality and effective management can best be objectively monitored as part of the commissioning/contracting process.						
6.6.1	The Trust should review its corporate management arrangements with the objective of creating more integrated management styles to ensure that the potential for joint working exists in all community based services.	CB Trust		✓	<p>As for 6.3.3. New guidance on multidisciplinary working and organisational structures to be issued</p> <p>Multi-disciplinary management and deployment arrangements should be required of all Trusts</p> <p>Craigavon &amp; Banbridge Trust has established a Child Protection Practice Co-ordination Group where senior managers come together to ensure communication and consistency across disciplines. The Trust is also reviewing its corporate management structures.</p>	Trust implementation group in consultation with SHSSB	Autumn 2004
6.6.2	The Trust should consult with the Board and the Department to ensure current and future practice reflects the best	CB Trust	✓		Ongoing consultation with DHSSPS on individual cases and with Board on use of regional IC worker	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
	guidance available in respect of intercountry adoption						
6.6.3	The Board should review its policies in respect of 'serious incident' reporting and also to have a written policy in respect of a professional audit of practice and record keeping when such an incident is identified.	SHSSB	✓		SHSSB policy on serious incident reporting has been reviewed and reissued.  Policy in respect of audit of practice and record keeping when an incident is identified will be undertaken as an element of 6.1.2 / 6.2.2	SHSSB	Completed
6.7.1	The Trust in conjunction with the Board and Department should review its policies in respect of the provision of home study reports and the support and supervision of adopted young children recently brought into the country.	DHSSPS SHSSB CB Trust	✓		This has been addressed by the May 2003 IC guidance which the Trust is currently implementing	N/A	Completed
6.7.2	The ACPC should issue clear guidance on the procedure to be followed by all agencies following the reporting of a 'serious incident'. This should include the making secure of all records relating to children/families involved in the case.	SHSSB ACPC	✓		Co-operating to Safeguard Children addresses this recommendation	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
			In full	Under-way			
6.7.3	The Trust's Management should reviews how it reports both actual incidents and ongoing action plans to the Trust Board to ensure a multi-professional co-ordinated approach.	CB Trust	✓		The Trust's Service Directors report to the Trust Board in a manner which ensures that action plans are presented in a multi-disciplinary framework	N/A	Completed
6.7.4	We recommend the Department reviews its support to the members of staff co-coordinating intercountry adoptions, both from an organisational perspective and also the professional support (medical, nursing and social work) available	DHSSPS	✓		The Child Care Policy Directorate has appointed additional staff to support adoption services.	N/A	Completed
6.8.1	Multi-disciplinary working and training should be required when dealing with intercountry adoption.	SHSSB and CB Trust	✓	✓	This has been addressed in Department's May 2003 IC guidance and is currently being implemented by the Trust. Also addressed in DHSSPS training on implementation of guidance	N/A	Completed
6.8.2	The Board and Trust should ensure that the recommendation of the Case Management Review in relation to the	HSSB and CB Trust	✓	✓	This has been addressed in Departmental IC May 2003 guidance and is currently being implemented by the Trust	N/A	Completed

Lewis Review Ref.	Recommendation	Responsible body	Implementation Status		Comment	How to be completed and by whom	Completion date
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	need for a care plan for children adopted from overseas is implemented. The plan should be agreed by all parties, including the family, and should be regularly reviewed.						
6.8.3	The role of the Board in approving the entry of children adopted abroad should be clarified and as a minimum they should be informed of decisions and any problems which might arise during the process	DHSSPS		✓	The Board has no role in approving entry clearance – this is the responsibility of DHSSPS. Issue of problems arising in individual applications needs further consultation – see 6.2.1	Regional Adoption Policy and procedures Group to address this	Spring 2004
6.8.4	The Board should review and re-issue its guidance on 'serious incidents'	SHSSB	✓		SHSSB policy and procedures on serious incidents has been revised and reissued (see also 6.6.3)	N/A	Completed
6.8.5	The Trust should, in conjunction with the Department, review referral systems so that young children arriving from abroad are automatically referred to the health visitor and the family's GP, so that the Care Plan can be initiated immediately.	DHSSPS and CB Trust	✓		This is provided for in the ay 2003 IC guidance which all Trusts are implementing	N/A	Completed

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6.8.6	Given the clearer role for the Area Child Protection Committees set out in new Departmental guidance, we recommend that the ACPC should require all agencies involved in major child protection events (serious incidents) to prepare an Action Plan, and report periodically on its implementation.	DHSSPS – ACPCs	✓		This is addressed in the DHSSPS guidance 'Co-operating to Safeguard Children' (DHSSPS, 2003).	N/A	Completed

## **5 CONCLUSION**

- 5.1 Work to achieve full implementation of the Case Management Review and the Lewis Review will continue until Autumn 2004. An update on progress or access to final papers produced by the Implementation Team can be obtained by contacting:

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**Terms of Reference of the Implementation Team**

'The Team will consider the recommendations of the 'Lewis' report and the Case Management Review and will:

- report on the extent to which recommendations addressed to specific agencies and Departments have been implemented;
- identify those recommendations which have regional policy, procedural or professional practice implications;
- agree how recommendations which have not yet been implemented, including those with a regional focus, should be taken forward;
- where necessary establish arrangements and timescales for work to be completed on behalf of the team;
- identify any barriers to implementation and propose alternative actions;  
and
- ensure that learning and information are shared and disseminated to all relevant agencies.

**MEMBERS OF THE LEWIS REVIEW IMPLEMENTATION TEAM**

Mr Paul Martin	Chief Inspector, Social Services Inspectorate, DHSSPS
Mr Colm Donaghy	Chief Executive, Southern Health and Social Services Board
Mr John Templeton	Chief Executive, Craigavon Area Hospital Group Trust
Mr Brian Dornan	Director of Social Services, Southern Health and Social Services Board
Mr Denis Preston	Chief Executive, Craigavon and Banbridge Community Health and Social Services Trust
Mr Ian Elliott	Divisional Director, NSPCC Northern Ireland
Dr Carolyn Mason	Nursing Officer, Nursing and Midwifery Advisory Group, DHSSPS
Dr Miriam McCarthy	Senior Medical Officer, Medical and Allied Branch, DHSSPS
Mr Fergal Bradley	Head of Child Care Policy Directorate, DHSSPS
Mr Brian Ingram	Head of State Pathology Branch, NIO
Ms Roisin Morris	Intercountry Adoption, Child Care Policy Directorate, DHSSPS
Dr Hilary Harrison	Inspector, Social Services Inspectorate, DHSSPS