



The Regulation and  
Quality Improvement  
Authority

press release

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## **Child protection standards must be met.**

**EMBARGOED UNTIL: 12.01am Wednesday 18 November 2009**

Today, the Regulation and Quality Improvement Authority (RQIA) published a series of reports as part of its ongoing independent review of child protection services in Northern Ireland.

The review began in September 2008, focusing on recommendations from the DHSSPS overview report '*Our children and young people - our shared responsibility*', published in December 2006. The review has also taken account of relevant child protection standards and recommendations from recent child protection reports into the tragic deaths of Madeleine and Lauren O'Neill, and Arthur McElhill, Lorraine McGovern and their five children.

This first phase of RQIA's review focused on the three key issues of corporate leadership and accountability; the views of service users; and, record keeping within child protection services. The review examined how trusts have responded to these recommendations to ensure effective delivery of their statutory child protection functions. A second phase of RQIA's review is currently underway and looks at interagency working and local management and leadership of frontline services, and will be completed next year.

Glenn Houston, RQIA Chief Executive said: **"It is important that all trusts have robust systems and procedures in place to protect children from harm, and to support social workers in their challenging and demanding roles. At corporate level, trusts indicated that clear lines of reporting, and policies and procedures were in place. However, RQIA's review of frontline services identified shortfalls in some aspects of child protection."**

**"During the course of the review RQIA identified a number of specific child protection issues where the expected standards were not being met. These were brought to the attention of trust management for immediate action."**

Glenn Houston continued: **"RQIA highlighted concerns about risk assessment and prompt allocation of child protection referrals in gateway teams, the quality of record keeping and, in some child protection teams, an overreliance on newly qualified social work staff."**

During the review RQIA worked in partnership with VOYPIC (Voice of young people in care) to seek service users' perspectives. Vivian Mc Convey, Director of VOYPIC said: **"VOYPIC was pleased to work alongside parents from across Northern Ireland to find out their views and experiences of both family support and child protection services. Parents highlighted several areas of good practice. They spoke positively about their experiences of using family centres and the support they received. They also highlighted the courteous and professional manner of duty social workers and receptionists, and were satisfied with response times when they contacted their social worker."**

RQIA's Chief Executive concluded: **"RQIA has made a series of recommendations for each trust, to ensure the effective delivery of the statutory child protection function. We would expect all trusts to make sure that individual recommendations are implemented. Trusts should consider building upon examples of best practice observed during the course of the review and continue to implement the changes which are part of the DHSSPS reform programme."**

**END**

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## **Editors' notes**

### **About RQIA**

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

### **About the Review**

The RQIA began its independent review of child protection throughout HSC Trusts and HSS Boards in Northern Ireland (NI) in 2008. As part of an ongoing programme of review of child protection over the coming years.

This review aims to:

- Evaluate the implementation of identified recommendations of the SSI Overview Report within HSC Trusts.
- Inform on the actions being taken by HSC Trusts to implement relevant RIT policy directives and to apply the relevant Reform Implementation Team (RIT) guidance documents (relevant to those recommendations of the SSI Overview Report under review).
- Evaluate the implementation of key recommendations (relevant to those recommendations of the SSI Overview Report under review) of the Report of the Independent Inquiry Panel into the deaths of Madeleine and Lauren O'Neill which relate to child protection (O'Neill Report), and Independent Review Report of Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their Children - June 2008 (Toner Report).
- Inform on the actions being taken by HSS Boards with regard to the transition arrangements in place to ensure continuity of child protection services.
- Highlight for review in the future and, as appropriate, any other relevant issues which may arise during the course of this review.

### **Our children and young people - our shared responsibility. Inspection of child protection services in Northern Ireland -SSI Overview Report, December 2006**

This overview report presented the main findings of a multidisciplinary, interagency inspection of child protection services in Northern Ireland. The inspection was led by the Social Services Inspectorate (SSI) of the DHSSPS and undertaken in five health and social care trusts and their commissioning health and social services boards. This report, its 77 recommendations and the associated draft standards provide a clear and coherent framework for the future provision of robust, high quality child protection services. They also provide the basis for self-audit by providers of services.

<http://www.dhsspsni.gov.uk/oss-child-protection-overview.pdf>

**O'Neill Report**

Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards - May 2007 - Madeleine and Lauren O'Neill. This report examined the circumstances contributing to the deaths of Madeleine and Lauren O'Neill on 12 July 2005, and made 36 recommendations across a number of areas.

<http://www.whssb.n-i.nhs.uk/Inews/Executive%20Summary%20-%20of%20the%20Report%20of%20the%20Independent%20Inquiry%20Panel%20-%20PDF%2098Kb.pdf>

**Toner Report**

The Review Panel, which was chaired by Henry Toner QC, examined the quality of the professional work of the various agencies involved with Arthur McElhill, Lorraine McGovern and their five children. A total of 63 recommendations have been made in the report, which highlighted a number of deficits in key areas.

<http://www.dhsspsni.gov.uk/independentreview2008.pdf>