Criminal Justice Inspection Northern Ireland
a better justice system for all

The Regulation and Quality Improvement Authority

The Education and Training Inspectorate
Promoting Improvement

A PILOT JOINT INSPECTION OF

CHILD PROTECTION ARRANGEMENTS

IN THE SOUTHERN HEALTH AND SOCIAL CARE TRUST AREA

SUMMARY REPORT

JUNE 2023

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Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

CONTENTS

LIST OF ABBREVIATIONS

CAMHS	Child and Adolescent Mental Health Service
CJI	Criminal Justice Inspection Northern Ireland
CPSS	Child Protection Support Service (of the Education Authority)
CRU	Central Referral Unit (within Police Service)
CSE	Child Sexual Exploitation
DE	Department of Education
DoH	Department of Health
EA	Education Authority
EOTAS	Education Other Than at School
ETI	Education and Training Inspectorate
EWS	Education Welfare Service
GP	General Practitioner
HSC	Health and Social Care
ICPCC(s)	Initial Child Protection Case Conference(s)
ISA	Information Sharing Agreement
NPT(s)	Neighbourhood Policing Team(s) (within Police Service)
Police Service	Police Service of Northern Ireland
PPBS&P	Post-Primary Behaviour Support and Provisions (Education Authority service)
RQIA	Regulation and Quality Improvement Authority
SBNI	Safeguarding Board for Northern Ireland
The Trust	Southern Health and Social Care Trust

JOINT FOREWORD

Rosabeth Moss Kanter, renowned Harvard Professor and writer, is quoted as saying *"The most radical thing we can do is connect people to one another. That starts conversations towards a vision for change."*

That quote resonates when we agreed to work in partnership on this pilot inspection with one key focus - how could our Inspectorates work together to better understand and improve multi-agency arrangements for child protection in Northern Ireland?

The origins of this pilot were founded in CJI's 2020 *Child Sexual Exploitation in Northern Ireland* inspection and the report's strategic recommendation that a framework for independent joint child protection inspection in Northern Ireland was developed. We wanted our Inspectors to better understand the child's journey, how they were treated and how those working with them were supported to develop a truly multi-agency jointly planned response.

Joint inspections are carried out in other regions and we wanted to test how it could work in Northern Ireland. We also agreed that a pilot inspection could inform the development of a framework and our Inspectors have been liaising with the Child Protection Senior Officials Group throughout this pilot.

Getting this pilot inspection off the ground and completed has not been swift nor easy. As well as the obstacles of the COVID-19 pandemic and pressures on front line services, we were considerate of each Inspectorate's legislative powers, methodologies and capacity to deliver. We were also conscious of our ask from our Inspectors, who needed to connect with each other to form an effective joint Inspection Team and also connect with inspected organisations. This was vital to not only deliver a quality pilot inspection, but to use their professional development and insights to reflect on the lessons learned from it. This was a challenge when the Inspection Team was not co-located and had other ongoing inspection priorities in their own Inspectorates.

The invaluable support and training provided from His Majesty's Inspectorate of Constabulary and Fire and Rescue Services at the early stages of design and planning was greatly appreciated.

It was important that this summary report reflected strengths as well as areas for development and improvement. We know there are many dedicated professionals doing their best every day for children at risk and in need of protection and who are also committed to improvement.

We also believe it is important that other Health and Social Care Trusts, the Police Service of Northern Ireland Districts, and Education Authority education providers consider this report and how it applies to their service provision area and the partners they work with. The benefits of effective self-evaluation, both individually and collectively, are emphasised in this report.

As the methodology explains, when we agreed to focus on 'front door' in this pilot and initial response and assessment of risk, we knew engaging with children and their parents or care givers would be very difficult given the early stage of contact with services. Effective engagement with children and hearing their lived experience is a core consideration at the planning stage of any pilot like this and will be important to consider in any future plans for a joint inspection.

We have agreed that we want to build on the lessons from this pilot to not only inform an agreed framework that is adequately resourced; but also to sustain the connections, experience and learning the Inspection Team have established.

We are grateful to the Inspection Team led by Dr Roisin Devlin, together with Muireann Bohill, CJI Inspectors, and all the Regulation and Quality Improvement Authority and Education and Training Inspectorate Inspectors whose collaboration, professionalism and child-centred focus made this pilot inspection possible.

We are also very grateful to all who supported this pilot joint inspection, particularly the Southern Health and Social Care Trust, the Police Service of Northern Ireland, the Education Authority and local education providers.

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

Criminal Justice Inspection Northern Ireland
a better justice system for all

Briege Donaghy
Chief Executive
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Chief Inspector
Education and Training Inspectorate

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The Education and Training Inspectorate
Promoting Improvement

SUMMARY REPORT

This report is the findings of the first pilot of a joint inspection of child protection arrangements for children aged 12 to 17 years, with onsite fieldwork conducted between 17-21 October 2022 by Inspectors from Criminal Justice Inspection Northern Ireland (CJI), the Education and Training Inspectorate (ETI), and the Regulation and Quality Improvement Authority (RQIA).

The joint inspection evaluated the effectiveness of multi-agency responses in protecting children at the 'front door'[1] through the identification of initial need and risk. It examined the multi-agency response of the Police Service of Northern Ireland ('the Police Service' or 'police'), social services and aspects of health care within the Southern Health and Social Care Trust,[2] and education[3] ('the agencies') to concerns about the risk of harm to children. The methodology is detailed in Appendix 1.

CONTEXT

There were complex existing strategic arrangements and structures within Northern Ireland for the multi-agency response to child protection. The overarching policy framework for safeguarding children was the Department of Health (DoH) *Co-operating to Safeguard Children and Young People,* which outlined *'...how communities, organisations and individuals must work both individually and in partnership to ensure children and young people are safeguarded as effectively as possible.'*[4] It set out the role of the Safeguarding Board for Northern Ireland (SBNI) in developing operational policies and procedures for child protection and safeguarding to be implemented by its member organisations. Individual agencies also had internal arrangements and guidance for instructing staff on how to protect and safeguard children.

1 The term 'front door' is used to describe the arrangements for assessing and responding to concerns reported about children. Northern Ireland does not have a central multi-agency 'front door' to services. The 'front door' and first point of contact for reporting concerns is the local Social Services Gateway Service (known as 'Gateway'). Within the Police Service, the Central Referral Unit (CRU) is the 'front door' for responding to concerns about offences of child abuse. Education providers refer concerns to the local Gateway Service or Police Service CRU as appropriate with help and support, if needed, from the Education Authority (EA) Child Protection Support Service (CPSS).

2 'The Trust' includes health and social care services. During this pilot, in addition to Gateway, the work of relevant Social Work teams and aspects of health care including the identification of concerns about risk of harm to children by the Emergency Department were considered.

3 Education here refers to post-primary and special schools, as well as Education Other Than At School (EOTAS) centres.

4 *DoH, Co-operating to Safeguard Children and Young People in Northern Ireland, August 2017*, page 5 available at https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland.

Multi-agency working in child protection was at a very early stage of development, and areas for improvement should be considered within these current challenges:

- the residual impacts of the COVID-19 pandemic on the delivery of services, for example, the pressures on the health and social care system and policing, and the increased need for mental health services;
- the significant pressures on current staffing, for example, social services in the Trust operating significantly below capacity; Designated Teachers in schools, and Police Officers, handling an increased complexity of need;
- the lack of a central 'hub' for multi-agency working to respond to concerns about risk of harm to children reported to the 'front door' in Northern Ireland.[5] In order for such a model to be introduced, significant change in policy and organisation of services would be required; and
- effective systems were not in place for multi-agency sharing of data and measuring impact or outcomes achieved for children and families.

KEY FINDINGS

There were benefits emerging from the examples of effective multi-agency responses, which highlighted the importance of a partnership approach. Effective multi-agency working involved more than co-operation by one agency in response to another's request for help. It included joint decision-making and a clear vision shared by partners for responding to concerns about a child. For example, when multi-agency working was effective:

- risk was identified early;
- professionals understood each other's roles and responsibilities and had realistic expectations;
- information-sharing was prompt and efficient;
- ongoing review and development enhanced streamlined approaches to multi-agency ways of working;
- confidence and trust developed between lead personnel enabling more effective decision-making;
- *Operation Encompass* demonstrated early successes in modelling effective multi-agency working to better protect children;[6]
- in most instances, where children were at high risk and in need of immediate protection, they received support to meet initial needs; and
- despite contextual pressures, highly committed leaders and staff teams work well to protect children.

5 It is important to note that whether multi-agency safeguarding hubs should operate in Northern Ireland, or how such an arrangement would work, is not within the scope of this pilot and is beyond the remit of the services that were examined within the Trust.

6 *Operation Encompass* is '...a partnership between the Police Service of Northern Ireland, Safeguarding Board Northern Ireland, the Education Authority and schools aimed at supporting children who witness domestic violence or abuse in the home' (online at https://www.psni.police.uk/safety-support/keeping-safe/protecting-yourself/domestic-abuse/operation-encompass).

GOING FORWARD: WAYS TO IMPROVE

An effective multi-agency response to concerns about risk of harm to children referred by services to the 'front door' was not fully embedded, with safeguarding actions often considered to be the responsibility of the Trust. Greater understanding of the effectiveness of multi-agency working to improve outcomes for children was required to avoid working in silos. This would also enable leaders to ensure effective scrutiny of the quality of practice. In order to promote more shared responsibility and partnership working, it would be important for all agencies to self-evaluate robustly and transparently the effectiveness of multi-agency work in response to concerns reported about children at the 'front door' (or 'Gateway' being the 'front door' operated by social services, and the Police Service Central Referral Unit (CRU)). This includes:

- embedding the views and lived experience of the child in referrals, assessments and associated plans and better reflecting the diversity of children's safeguarding needs;
- quality assuring referrals, assessment and responses to reported concerns about children including the recording procedures and practices in relation to safeguarding actions;
- ensuring that governance structures and performance information is available that enables greater levels of accountability and support leaders to effectively challenge partner organisations' approaches to joint working;
- joint learning and professional development across agencies that focuses on understanding respective roles, decision-making thresholds and expectations about continuity of services; and
- identifying ways to improve multi-agency approaches at a strategic level. These approaches should seek to avoid silo-working and improve capacity for effective and protective safeguarding taking account of co-located services.

MAIN FINDINGS

The main findings are presented according to the three 'Ps' of 'promote', 'prevent', and 'protect.'[i] The findings also describe strengths and areas for development in promoting children's fundamental right to be safe including embedding their views in decision-making; the prevention of harm through early identification of risk, timely support and intervention; and protection of children from the threat of harm through an effective mult-agency response.

PROMOTE

Strengths

A strong culture recognising the child's right to be safe was evident among professionals across the agencies inspected. Staff who met with Inspectors were highly committed to safeguarding children, with examples of going 'the extra mile' to ensure children were protected. In most instances, there was an understanding that safeguarding was everyone's responsibility.

The Child Protection Support Service (CPSS) of the Education Authority (EA) worked effectively with schools, the EA Post-Primary Behaviour Support and Provisions (PPBS&P), including Education Other Than at School (EOTAS) and the strategic leadership of the EA Youth Service, to provide training, advice, guidance and support which promoted a culture recognising the child's right to be safe. The role of the CPSS Link Officer was particularly effective in supporting schools and as a result education staff were well-trained, confident and equipped to respond in a timely manner to a wide range of complex safeguarding issues, including making referrals to Gateway.

There were positive examples of promoting the child's best interests and need for protection was met through co-location of services, enabling professionals to work together. These included Social Work professionals working within schools, in General Practitioners (GPs) clinics and within policing, for example, in the Police Service CRU, in its Public Protection Branch and in tackling Child Sexual Exploitation (CSE), and School Nursing services within schools provided a key role in promoting a child-centred health approach.

i See p19 for further details.

There were examples of effective practice in considering how to understand and be informed by the experiences of children and families. The Police Service and Health and Social Care (HSC) partners were finalising a refreshed *'Interface Protocol'* to support children reported missing, to include new ways of engaging with children when they returned home. This does not currently include the involvement of the EA.

Police Service Call Handlers were using the *Philomena Protocol*[7] to access up-to-date information about individual children who had been reported missing frequently. Electronic problem-solving folders created by Neighbourhood Policing Teams (NPTs) provided important contextual information about children's lives to inform Police Officers' interactions. There were examples of positive collaboration between the police CRU and schools, and of police working jointly with the Trust, which gave a more holistic understanding of concerns about the child. For example, in one school, prompt and accurate information shared by the NPT, alongside the school's extensive knowledge of the child, resulted in a prompt referral to the Trust whose instant response ensured the child was safeguarded within hours.

Measuring outcomes in the effectiveness of multi-agency working in promoting children's right to be safe was at an early stage and needed further development to demonstrate more clearly the impact of the work. Nevertheless, there were examples across the agencies of measurements available, which included:

- official Enquiry Logs demonstrated detailed research undertaken by the CRU on both the child and alleged perpetrator;
- more sophisticated monitoring of disruption and investigative actions within the Police Service Public Protection Branch;
- Police Service plans with HSC partners within the DoH Strategic Planning and Performance Group to understand Support Hub outcomes through the lens of the child and family's journey; and
- EA CPSS reported the number of Designated Teachers in schools trained and the nature of referrals made to Gateway.

Areas for development

The multi-agency partners needed to improve how the views of children in assessment and planning was evidenced. Evidence needed to demonstrate how children's rights and needs had been embedded effectively in practice. For example, the views and lived experience of the child were not regularly recorded or evidenced within case assessments. The voice of the child and its influence in relation to decision-making or the connection of what the child reported to the protective actions agreed, was not always clear. The views of children should inform better: the location and frequency of multi-agency meetings; the arrangements for transport; the type of meeting held, the outcomes and conclusions of meetings including agreed actions to protect and safeguard the child.

7 The *Philomena Protocol* was a pilot scheme for children in care at risk of going missing. Carers filled out key information about the child to aide the police response if they went missing (Available at: https://www.psni.police.uk/safety-and-support/missing-persons/philomena-protocol).

Multi-agency working did not take sufficient cogniscance of the diversity of children's needs in relation to, for example, ethnic backgrounds and disability. In a small number of cases there was evidence of 'adultification' of older children where plans and actions risked placing too great an emphasis on older teenagers to manage risk with limited or no exploration of their ability to protect themselves or others.[8] Decisions about whether to conduct joint police and social work investigations in relation to sexual activity between children aged 15 years and older needed greater scrutiny and better oversight to ensure against making assumptions about the child's maturity and understanding rather than the full assessment of need and risk.

There were insufficient outcomes-based processes that could provide evidence of the positive impacts and trends of multi-agency working on the children's right to be safe. There were in fact examples of negative trends that required greater exploration and oversight, for instance, the increase in numbers of children missing from education, intervention services working with increased waiting lists including the Education Welfare Service (EWS), and a backlog at the 'front door' Gateway Team and the Police Service CRU. Multi-agency partners would benefit from an improved and shared understanding about: thresholds for making referrals to each other and decision-making, and expectations about how to deliver effective care and support that is needed to meet children's protection needs.

Multi-agency protocols needed greater representation from education. For example, a new draft *'Interface Protocol'* for children reported missing had been developed between HSC partners and the Police Service, with no input from education. These protocols would have benefitted from including the important role that education providers play in safeguarding children. Furthermore, the EA had identified with the Department of Education (DE) the need for clarifying the outworking of current legislation from which to address: children considered missing in education; children in entertainment and employment; and children withdrawn from education by parents/carers. In addition, multi-agency analysis of data needed to be shared more systematically and regularly across all EA Directorates.

PREVENT

Strengths

Evidence of timely identification of risk was found when the threat of harm was acute. This was apparent within a hospital Emergency Department visited, during the time spent with Police Officers and staff in the CRU, and in Police Service Call Handlers use of the *THRIVE* risk assessment tool.[9] There were examples of professionals identifying risk and making appropriate and timely referrals to the CRU.

8 Davis, J., *Adultification bias within child protection and safeguarding*, HM Inspectorate of Probation Academic Insights 2022/06, available at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf.

9 *THRIVE* is the Threat, Harm, Risk, Investigation, Vulnerability and Engagement definition of vulnerability, see https://www.college.police.uk/guidance/vulnerability-related-risks/introduction-vulnerability-related-risk.

One case demonstrated a particularly effective contribution from school, which helped progress the joint protocol assessment and actions being put in place to protect the child.[10] Schools had been proactive in making appropriate and prompt referrals to Gateway and in completion of initial referral forms (Understanding the Needs of Children in Northern Ireland or 'UNOCINI') with evidence in some instances of this promoting collaboration and effective interventions and responses for children.

There were positive examples of all organisations working hard both individually and collaboratively to identify risk and prevent harm. The Inspection Team acknowledged that the Trust had Family Support and Safeguarding preventative initiatives in place, for example, Family Support Hubs. There was evidence that a range of professionals across the organisations inspected were involved in assessments, decision-making and development of plans. Some case conferences were well attended by an appropriate range of professionals including representation from education, for example, designated staff and School Nursing services.

Operation Encompass was in the initial stages of roll out in the Trust area and demonstrated the key strengths of multi-agency work. It enabled the Police Service Support Hub in the Southern Area to work with education, health and social care partners to enhance the timeliness of information sharing in promoting the child's right to be safe, when impacted by domestic abuse. During the inspection, a school involved in *Operation Encompass* provided evidence of a well-coordinated multi-agency response to ensure that the children involved received the right help at the right time before the start of the school day.

Community policing was reported by most schools as an important source of support. Police Officers provided safeguarding advice and briefed schools on local safeguarding issues. In monitoring its work, the specialist investigation teams within the Police Service Public Protection Branch enabled a focus on risks to children through dissemination of information about locations and persons of concern. The Police Service Youth Diversion Officers provided key updates to partners on emerging risks to children, which enabled preventive actions to be put in place.

There were examples of continuous organisational learning to improve services within individual agencies, including:

- the engagement in a SBNI programme of professional development training in trauma-informed practice;
- ongoing professional development for EA CPSS staff, which included evidenced professional learning hours with the Northern Ireland Social Care Council;

10 The 'joint protocol' is used to decide if investigations of alleged or suspect child abuse will be joint (by Police Service and Social Workers) or single agency (Police Service alone, or Social Workers alone). *Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse - Northern Ireland*, online at https://www.proceduresonline.com/sbni/files/joint_invest_protocol.pdf.

- the EA Youth Service reviewed its Safeguarding Guidance, and the EA PPBS&P delivered training to schools in preventative safeguarding through trauma-informed approaches, awareness of adverse childhood experiences and restorative practice to maximise early interventions and provision of support; and
- the Police Service was driving a shift in culture towards prevention, which placed identifying and addressing vulnerability, including safeguarding, at its core. There was internal monitoring with NPT Officers to assess the degree to which such a culture shift was taking place.

Areas for development

Single and multi-agency assessments received by the Inspection Team revealed examples of assessment information that was limited, lacked a comprehensive, child-focus and evidence-based risk assessment. In some cases, assessment of all potential risks posed by accused persons was not evidenced. More consistent engagement by, and information from, family members and school staff in the completion of referral forms was required to fill gaps in information and provide wider context. All agencies involved in the identification and response to risk of harm to children required improved understanding of each other's roles and responsibilities, including the roles of the Designated Teacher, Child and Adolescent Mental Health Service (CAMHS), and the Police Service CRU. There was also a need for training about, and quality assurance of, the information Gateway and the CRU needed to progress a referral.[11]

Greater synergy within and across services was required. Delays were apparent when children transferred between Trust social work teams, for example, from Gateway to the Family Intervention Team. In some cases, different Police Officers who had been involved with the child, for example Youth Diversion Officers, had not always been identified by the Police Service to inform the police response. The extent of the contribution, and performance of, policing teams outside of the CRU in identifying initial need and risk to children was uncertain and needed better strategic and operational management.

There was insufficient evidence that multi-agency meetings were consistently attended by the right person with the right information at the right time. Multi-agency audit and quality assurance of actions arising, and follow-up required, from multi-agency meetings needed to be more robust. The Police Service needed to review its mechanism for receiving and allocating invitations to Initial Child Protection Case Conferences (ICPCCs). The Police Service's target for attendance at ICPCCs, was not met in all instances across the small number of cases Inspectors considered. Those supporting children within education reported that they were not consistently provided with sufficient notice of case conferences nor given enough time to read associated documentation resulting either in their absence from the meeting or that they were not fully informed on all of the significant information.

11 (see also in 'Protect').

Multi-agency governance arrangements needed to ensure better structures and processes to improve outcomes for children through the collective monitoring and evaluation of performance to inform continuous improvement. For example, the impact of regional and multi-agency strategic documents on everyday child protection and actual children's outcomes was unknown. Performance management data provided to Inspectors in relation to the Police Service CRU and the Trust was limited to monitoring demand. Strategic analysis of the quality of response was not clear. Safeguarding outcomes for children within education was not measured beyond process and satisfaction rates and the EA needed to develop further the evaluation and analysis of the impact of their work, sharing information more strategically across and within their organisation set within a stronger focus on safeguarding in their Business Plan.

Standards and tools for risk assessment, case planning and management presented as implemented by each agency individually and did not always promote effective practice. The wide range and sources of policy and guidance made the process of child protection complex and onerous for staff, particularly for those within the Trust. As a result key areas of assessment could have been improved to enhance child-centred decision-making. In this respect, the accessibility of legislation, regional and local guidance should be improved to support staff in the early identification of risk and preventative actions.

PROTECT

Strengths

There were examples of professionals working together across agencies through formal and informal networks. Schools were key in advocating for, and supporting, children. Where risks had been identified for children attending the same school, information sharing with the Police Service about safeguarding and interventions in place appeared to demonstrate a co-ordinated and proportionate response to the threat of harm.

The Police Service Information Technology Records Management System enabled links between associated persons and addresses, resulting in effective safeguarding in some cases. Within police files there was evidence of children and families being linked to support through NPTs and the Support Hub. Innovative practice was at times evident with agencies trying to pull together to protect children. In a multi-agency meeting arranged as part of this inspection, there was evidence schools, health services, Social Work and Police Officers worked collaboratively to provide protective safeguarding in a way that the child could engage and trust.

In most instances, staff working to protect children reported feeling well supported. Management and staff were broadly aware of the pressures within those parts of their services responding to child protection concerns. Inspectors found examples of supportive management arrangements within individual agencies. There were examples of proactive supervision by the Police Service in some of the cases assessed.

Within schools, the development of safeguarding teams and regular debrief sessions had helped support resilience among staff in responding to the complex pressures of safeguarding children, while also delivering teaching schedules. The EA CPSS helpline was reported by Designated Teachers as particularly helpful in supporting staff through the referral process.

Staff described supervision within social work teams as good. Nevertheless, there was potential to bring about improvements in professional supervision and support to protect the emotional health and well-being of staff in all roles. This included, for example, within relevant policing roles and Designated Teachers within schools due to the increase in complex safeguarding needs of children. There were examples of staff with expertise and skills who had a positive impact on the future direction of plans for children They intervened when progress had slowed, or risks had not been correctly identified. In cases considered, it was individual staff who often made the difference.

Where it had been available, opportunity for multi-disciplinary training was welcomed by professionals. When provided, it enhanced shared understanding of roles and enabled a common language to work effectively together to protect children. A recent multi-agency interface meeting between police and the Trust examined how to work collaboratively together in meeting the needs of children in care. In addition, the Police Service Public Protection Branch had developed a schedule of training related to CSE which included multi-agency interactive simulation sessions and dedicated training for partners within education.

Areas for development

A multi-agency training needs assessment for those working in partnership with the 'front door,' including the central role played by school staff, was not evident. There was overall a lack of planned and ongoing multi-disciplinary training for professionals with a role in child protection to learn and develop skills together. This was required to enhance understanding and clarity about roles, expectations, systems in place and processes to be followed to support effective multi-agency responses.

Workforce issues across all services had resulted in backlogs. Services accessed through the 'front door' (particularly through Gateway) were operating with waiting lists and this needed better communication and explanation to those making referrals. While there was a system to triage and manage those at greatest risk, oversight and monitoring of these cases required better prioritisation with consideration of the potential for multi-agency partnerships to assist in providing an effective and authoritative response to the threat of harm. Working collaboratively was often not multi-agency, with partners making joint decisions with a shared vision for responding to concerns about a child, because the analysis of risk and responsibility for the co-ordination of intervention and support was primarily the responsibility of social services within the Trust.

When risk had been identified, limited capacity within the Trust social work teams was impacting on timely interventions being available to children and families to support those in need and children requiring protection and help in their recovery from harm. There was an example of a school that chose to fund the employment of a Social Worker to work directly with children and their families due to the number and complexity of safeguarding issues, which did not meet the Trust's threshold.

Each organisation involved in child protection had different processes for referral to their services. A better understanding of these referral processes between organisations to improve the timeliness of response to risk and threat of harm to children was needed. Inspectors saw instances where internal Police Service referrals to the CRU for an assessment on whether the Police Service and Social Workers should investigate jointly was initially missed and investigative actions by the Local Policing Team had already begun. There was an insufficient process for and lack of understanding across the education system about reporting of safeguarding concerns for those aged 18 and over attending school, including in relation to the role of Adult Gateway Teams within the Trusts.

A lack of consistent, formalised and ongoing information sharing between agencies was limiting the collection of information and analysis of children's needs. It was not always possible to assess if actions had been proportionate to risk due to limited recording of information shared across partners. Regional systems and protocols and Information Technology had not always assisted this. It was important that appropriate Information Sharing Agreements (ISAs) between agencies were in place. An ISA between police and social services existed, one between the Police and the Youth Justice Agency had been recently finalised, and one between police and the EA in respect of *Operation Encompass*. The Police Service advised the Inspection Team that the Police Disclosure Unit was in the process of completing a Safeguarding ISA with the EA. Within individual agencies actions to protect children were not consistently recorded or easily discoverable. An up-to-date joint record of actions was not available.

The quality of records across the agencies about referrals and decision-making would have benefited from review. Records for deciding whether to investigate jointly by the Police Service and Social Workers (Joint Protocol decisions) were of variable quality. There were positive examples with clear rationale for the decision to proceed as a joint or single agency investigation within Police Service records, but this level of detail was not evident within the Trust's records. In several cases, police entries noted *'safeguarding being progressed by social services'* and it was not known from the record what this had entailed. Strategy discussions were not being recorded on the Police Service system and records were not consistently made available to the Trust. Timely information about the outcomes of assessments had not always been provided to agencies by the Trust. These deficits risked important information not being available to share with those supporting and safeguarding children each day, particularly education providers but also police.

A flag on the police system to alert Police Officers if a child was on the Child Protection Register, while positive, was not accompanied by information about the nature of the risk or who posed a threat of harm to the child.

Escalation to senior managers where there were differences in opinion about assessment of risk and decision-making required robust supervision and monitoring to ensure an effective and proportionate response by agencies responding to concerns about risk of harm to children. Evidence available in relation to an assessment about whether the Police Service and Social Workers should jointly investigate suspected child abuse did not demonstrate a timely response or satisfactory resolution when a difference of opinion between agencies had occurred.

AGENCY SELF-EVALUATION

The single agency self-evaluation reports for the inspection supported the agencies to identify strengths in practice and areas for improvement. Rigorous self-evaluation was at an early stage and a more joined up reflective approach was needed to understand what worked well and could improve outcomes for children in the future. Going forward, it would be important for agencies to develop mechanisms for the completion of rigorous individual and collaborative evaluations that measure the effectiveness of their multi-agency working. Any future framework for joint inspection of child protection arrangements in Northern Ireland should also facilitate this as part of the inspection.

NEXT STEPS

The Inspectorates recommend that:

- the Trust, the Police Service and the EA (the agencies) develop a multi-agency action plan to address the identified areas for improvement; and
- the agencies should propose an appropriate multi-agency mechanism to monitor and evaluate the implementation of agreed actions.

Inspectorates acknowledge the lessons learned through this pilot and ways to improve a joint inspection. The Inspectorates will provide a 'lessons learned' report to the Child Protection Senior Officials Group to inform its considerations about the development of a broader framework for joint child protection inspection in Northern Ireland.

APPENDIX 1: SUMMARY OF METHODOLOGY

The commitment from inspected agencies to facilitate the arrangements necessary to enable the pilot to take place was notable and significant.

The fieldwork was completed using a combination of methods tailored to the nature of the inspection and Inspectorates respective functions. CJI and RQIA completed in-depth case assessments and dip sampling of records within the Police Service (in relation to missing reports, police custody and the CRU covering the Southern Trust Area), and Health and Social Services (in relation to the Gateway Service, Family Intervention Team and an Emergency Department within the Southern Trust).

In-depth case assessments were selected from all children aged 12 to 17 years of age within the Trust referred to the Police Service CRU in the six months prior to the inspection where a joint protocol decision had been taken. Further criteria were used to select five children including whether an Initial Child Protection Conference had taken place in the 12 months pre-inspection, whether the child had been placed on the Child Protection Register, and the range of multi-agency involvement (including education and health services).

Agencies completed a single agency self-audit of the five cases prior to the week of the inspection. The Youth Justice Agency was involved to a small extent in relation to two of the children. It completed a short self-assessment reflecting on multi-agency interaction, which helped inform the inspection in advance of the inspection week. There was a multi-agency reflective meeting in relation to two of the children's cases during the onsite week.

All Inspectorates were provided with governance and performance management information from the respective inspected organisations. Due to it not being involved in self-auditing cases, the Education Authority undertook a self-audit of its overall approach and role in relation to child protection. The Inspectorates held a planning day prior to going onsite to facilitate joint analysis of assessments and information received.

Each Inspectorate undertook a timetable of fieldwork which included focus groups, observational visits and interviews with professionals within policing, health and social services and schools and educational organisations (for children aged 12 to 17 years).

To help understand the range of experiences across education, ETI provided a survey to Designated Teachers within the relevant educational establishments in the Southern Trust Area and, based on information about the level of enquiries to the EA CPSS, undertook a number of visits to schools and other educational organisations.

Children and families were not spoken to as part of the pilot. This was due to the recency of concerns and ongoing investigations and the duty of Inspectorates to do no harm. Based on learning from this initial pilot, the development of a framework for any future 'front door' inspection should include exploration of supportive and meaningful ways for children and families who have past experience of 'front door' services to be involved in the development of the framework and in informing the inspection.

ENDNOTES

i The main findings have been categorised using the three 'Ps' to Promote, Prevent and Protect:

Children and Young People live in safety and stability (fourth outcome from the Northern Ireland Executive Children and Young Persons Strategy 2020 – 2030)

Evaluation criteria were aligned with three core principles: promote, prevent, and protect. Based on Department of Health Co-operating to Safeguard Children and Young People, the Northern Ireland Executive Strategy for Children and Young People 2020-2030; and the United Nations Committee on the Rights of the Child General Comment No. 13, these were defined as follows:

Promote	Prevent	Protect
There is a culture which recognises the child's fundamental right to be safe and **promote their best interests**. On an individual and strategic level, a child centred approach is promoted, which is based on obtaining the **views of the child** and an understanding of their rights and needs. Family-focused approaches where appropriate are adopted in the child's best interests. Recognition of the child's stage of development and age is promoted in strategies and actions to help children. Success is measured in relation to outcomes for children rather than processes.	Harm is **prevented through early identification** of risks and appropriate, timely interventions. There is multi-agency working to understand and tackle the occurrence of harm to children. Prevention includes co-operation to raise awareness about harm and to improve children's wellbeing. Leadership and governance ensures **continuous organisational learning and improvement** for effective prevention. On an individual level, risks to children are identified early and children who require assistance receive **early and sustained help, support and intervention.**	There is a full range of **integrated services for protective and authoritative safeguarding**, through to helping children in their recovery from harm. Professionals are **trained, supported and equipped** with the skills to protect children identified at risk of harm. There are clearly defined processes of **reporting risk of harm, which are well understood.** There is effective, co-ordinated and **proportionate multi-agency response** to the threat or occurrence of harm to children.

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First published in Northern Ireland in June 2023 by

Criminal Justice Inspection Northern Ireland
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