**Appendix 1**

****

****

**NICCY Comments 20 February 2017**

**Please note NICCY is not commenting on all recommendations but highlighting some examples of concern. These comments accompany NICCY’s November 2016 paper.**

**Second Composite CSE Implementation Plan Progress Report**

**1st October 2015 to 30th June 2016**

**Second Composite Progress Report**

**This is the second composite CSE progress report. It documents the progress on all of the recommendations in the Marshall report for DOH, DOJ, DE and their respective bodies and agencies. For ease of reference the recommendations for other bodies are also shown. The progress report is ordered numerically, beginning with key recommendations 1 to 17, followed by supporting recommendations, 1 to 60. This Report charts progress during the period 1 October 2015 to 30 June 2016.**

| **Recommendation** | | **Lead** | **Progress** | **Rag [[1]](#footnote-1)** | **Phase[[2]](#footnote-2)** | **NICCY Comments** |
| --- | --- | --- | --- | --- | --- | --- |
| **K1** | In response to the reality of CSE identified in this report, the Department of Health, Social Services and Public Safety (DOH) should direct the Public Health Agency to undertake a public health campaign on CSE-related issues. This should complement the work undertaken by SBNI. | **SBNI** | Ownership of this recommendation has passed to the SBNI, which will separately publish an implementation plan for all Marshall recommendations to be delivered by the SBNI. |  | **1** | *Progress Reports should report on all recommendations regardless of department or agency. Two years on from the publication of the Inquiry Report it is not acceptable that updates on implementation are not provided or that the reporting process is not properly integrated.* |
| **K2** | The inquiry encourages the PSNI to pursue its commitment to strengthening relationships with communities and with young people as a priority in the context of the current climate of austerity. | **PSNI** | Complete – see previous report |  |  | *DoJ’s Second Progress Report cites detail not included here and it is unclear why this is not reflected in this report. The detail in the Second DoJ Report, while useful, does not demonstrate how relationships with young people, including those at risk of CSE have been strengthened. Recommendations should not be assessed as completed without evidence they have been delivered.* |
| **K3** | The DOH in conjunction with DOJ should develop guidance for parents and carers, including foster carers and residential workers, on how best to capture information and/or evidence when a child returns from a period of being missing or is otherwise considered to be at risk of CSE. | **HSCB** | Complete – see previous report |  | **1** |  |
| **K4** | SBNI’s developing plan for data collection should include a commitment to collation and analysis of the data in a way that will facilitate a strategic response to CSE. | **SBNI** |  |  |  | *NICCY notes the 2016 Jay Review of SBNI highlighted it did not have effective multi agency mechanisms for monitoring and reporting CSE.*  *It is of particular concern that no progress is reported on data collection as this is a key part of identifying need and consequently being able to plan and resource effective responses to CSE.* |
| **K5** | The DOH should explore the benefits of amending or adding to standards for inspection of children’s homes to ensure that they: a) promote a culture conducive to respect for the best interests of the child; and b) take account of the specific needs of separated and trafficked children and those affected by CSE. The DOH should issue a circular and associated guidance stating how these issues should be taken forward. | **DOH** | Completed - The current DOH standards for children’s homes were revised and reissued in 2014 just prior to the publication of the Marshall report. These standards have been revisited in line with this recommendation. The standards are based on a clear principle of the best interests of the child.  Issues relating to safeguarding and protecting children from abuse, whether this relates to trafficking or CSE, are implicit within the standards. Equally issues and an awareness of cultural sensitivities relating to particular ethnic groups are also implicit in the standards.  The HSCB will ensure that the detail and translation of these into practice and residential service delivery models are fully attended to in each facility’s statement of purpose and function.  Work is currently underway to review the current Statement of Purpose and Function of the specialist facility for separated children with the assistance and input of the Belfast HSC Trust Review/Training Team. This will afford an important opportunity to make explicit some of the particular issues pertaining to safeguarding, trafficking and cultural / ethnic issues.  It is proposed that the HSCB will lead on a review of regional specialist children’s services. Among other things, the review will consider the policy, legislative and standards frameworks underpinning that specialist provision and make recommendations for change as appropriate. This will include specialist provision for separated children. |  | **1** | *NICCY’s 2015 paper on action plans highlighted concerns that the standards were not being amended. The DoH plan stated guidance would be produced to accompany standards by December 2015. This is not referenced in this report and no evidence is provided to indicate that inspections routinely assess whether children’s homes respect best interests and meet the* ***specific*** *needs of separated children and those affected by CSE.*    *Other information provided illustrates ongoing or planned activity associated with the recommendation rather than evidence it has been implemented. No timeframes are given. Recommendations should not be completed without assurance of implementation.* |
| **K6** | The DOH, along with the HSC Board and HSC Trusts, should consider how “safe spaces” could be developed for children and young people at risk of, subject to, or recovering from CSE. This development should take account of models of best practice and the views of young people, and should respect international human rights standards. | **DOH** | See previous report for details of progress made April to September 2015.  Work to develop a range of “safe spaces” for children continues on a number of levels.   * Learning from best practice in NI and elsewhere, with a number of study visits and research into how other parts of the UK are developing services to help create a safer environment for all children subject to CSE. * Engagement with local communities, raising awareness about CSE and helping develop defence mechanisms against CSE for parents and communities. * Ongoing improvements in statutory services designed to support victims of sexual crime such as the Sexual Assault and Rape Centre (SARC). * Continuous review of the service provided by the newly established specialist home for unaccompanied and trafficked young people. * A series of consultations and engagements, led by VOYPIC, has commenced with children and young people within the looked after system and with those who have left the system. The purpose of this engagement is to help understand, from young people’s perspectives, what actions could be undertaken to make them feel safer both within the care system and in the wider community. * The HSCB and HSC Trusts are taking forward the learning from the SBNI Thematic Review to ensure that the residential child care sector and foster care services continue to provide a safe environment for the vulnerable looked after population. * Family support Hubs continue to develop across each of the five HSC Trusts to ensure the coordination of early help to children and families to prevent them becoming at risk of, or subject to, CSE.   Review of secure care – on 11 March 2016, the former Health Minister agreed to an HSCB-led review of secure care. The Terms of Reference for the review have been drafted. It is intended that the review will consider: management and governance arrangements; and the interface between the regional secure care facility and other regional facilities/services. |  | **3** | *The work outlined should address all three aspects of the recommendation: safe spaces for children who are  - at risk of CSE*   * *victims of CSE and need to be safe* * *recovering from CSE.*   *All three elements should be addressed in progress reports. NICCY is concerned that activity is focused on the latter two aspects and progress should be reported across all three areas.*  *The outcome of activities, including consultation with young people through VOYPIC, and how DoH will develop this into concrete provision and access to safe spaces is not clear.*  *Only information relevant to the intention of the recommendation should be included.* |
| **K7** | The Northern Ireland Assembly, through the Office of the First Minister and Deputy First Minister, should re-affirm its commitment to strategic, long-term and sustained funding of services for prevention and early intervention. | **TEO** |  |  |  |  |
| **K8** | The Department of Education should conduct a review of youth services that takes account of the views of young people and aims to ensure that such provision is attractive and appropriate. | **DE** | The Department completed a review of youth services as part of the development of its youth policy, *Priorities for Youth*. Implementation of the new youth policy is underway. Participation is a central and key theme of the policy and children and young people are actively involved in advising the EA on the implementation through the Regional Advisory Group and a number of working groups such as Small Grants Scheme, Local Advisory Groups and the development of a Network for Youth model. As part of the 16-17 Regional Youth Development Plan the EA will establish and implement an agreed model for a Network for Youth for strengthening participation in the Youth Service at local, sub-regional and regional level by March 2017. |  |  | *Detail on how children’s views on and experiences of youth work should be collected and reported on as part of work on this recommendation.* |
| **K9** | The DOJ should establish an inter-agency forum drawn from across the criminal justice sector and third sector stakeholders to examine how changes to the criminal justice system can achieve more successful prosecutions of the perpetrators of CSE. This must be informed by the experiences and needs of child victims. | **DOJ** | In March, the Department held a workshop involving a wide range of practitioners from the Criminal Justice and Health sectors as well as community and voluntary sector organisations that provide support to child victims. A report from the independently facilitated workshop will be prepared and will assist in further consideration of this recommendation. |  |  | *We note a single workshop event is not a forum. We also understand the workshop report has been completed and circulated. Detail on the timeframe for bringing forward concrete changes and how the impact of this on prosecutions will be monitored should be included.* |
| **K10** | The DOH should ensure that the forthcoming, planned review of SBNI should consider streamlining joint working arrangements to make them more realistic, efficient and effective. | **DOH** | The terms of reference for the review of the SBNI were:  “To undertake a comprehensive Review of the Safeguarding Board for Northern Ireland to:   * examine the extent to which the SBNI is meeting its statutory objective, that is, improving inter-agency co-operation and facilitating/contributing to the effectiveness of what is done by member bodies to safeguard children and young people in Northern Ireland and promote their welfare; and * make recommendations on the future arrangements for inter-agency co-operation to safeguard children and young people in Northern Ireland”   The Review Report and recommendations are currently being considered by the Minister. |  | **2** | *We understand that DoH is progressing elements of this through the development of Regulations but detail on how the Department will ensure more efficient joint working between SBNI and others should be provided.* |
| **K11** | The DOH should ensure that there are clear reporting pathways 24 hours a day, seven days a week, for reporting concerns about children and young people, including CSE, with appropriate feedback provided to the individual or agency making the report. | **HSCB** | Complete – see previous report |  | **1** |  |
| **K12 K13**  **S1**  **S9**  **S11**  **S19**  **S41**  **S57**  **S58**  **S59** |  | **SBNI** |  |  |  | *Progress Reports should report on all recommendations regardless of department or agency. Two years on from the publication of the Inquiry Report it is not acceptable that updates on implementation are not provided or that the reporting process is not properly integrated.* |
| **K14** | The DOJ should lead on a project to examine legislative issues highlighted in this report and bring forward proposals for change. These include: | **DOJ** | Departmental officials are engaging with relevant criminal justice organisations to assess these proposals for legislative change.  Work is continuing towards establishing possible provisions to bring forward for future consultation and presentation to the Northern Ireland assembly. |  |  | *It is very disappointing that the recommendation on strengthening the law to better protect children from CSE has not yet resulted in concrete legislative proposals and no definitive timescale in which these could be expected is provided. NICCY notes that similar recommendations have previously been made other bodies, including the UN Committee on the Rights of the Child.* |
| **K15** | The DOH should lead the development of a regional strategy to prevent, identify, disrupt and tackle CSE. It should involve DOJ and DE and should: a) be informed by the experiences and views of children, parents and carers; b) recognise parents and carers as partners in preventing and tackling CSE, unless there are strong indications that they are involved or complicit; c) recognise the support and training needs of frontline workers in all agencies in relation to CSE; d) reflect the particular role of schools in raising awareness and identifying concerns about CSE; e) acknowledge the role of heath workers in early intervention, prevention and in reporting CSE, which should be made more explicit in policies, guidance and training; f) recognise agencies operating in the vol (non-statutory) sector as equal and valued partners; g) equip communities with the information, support and confidence to identify and report concerns about CSE; h) link into and build upon, existing work in relation to child trafficking as well as strategies tackling known vulnerabilities for CSE, such as alcohol, drugs (including legal highs), sexual health and domestic violence; i) explore the potential contribution to this issue of strengthening a statutory duty to co-operate among stakeholder agencies; and j) establish a process for promoting and monitoring the implementation of the recommendations of this report. | **DOH** | A Cross Departmental Implementation Group, led by DoH, was established in May 2015. The group will lead on the development of a regional CSE strategy. A high level plan relating to the development of the strategy was agreed in June 2015 by DE, DOJ and DOH Ministers and is published on the websites of all three departments  [https://www.health-ni.gov.uk/sites/default/files/publications/DoH/cse-cross-departmental.pdf](https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/cse-cross-departmental.pdf)  DfE and DAERA subsequently joined the Cross-departmental Implementation Group, specifically because of their responsibilities in the areas of further education, careers service and training.  Mapping work has been undertaken which links Marshall recommendations to elements of a strategic framework identified by Professor Marshall. A further mapping exercise, which links areas for improvement identified by the Thematic Review undertaken by the SBNI, has also been conducted. [https://www.health-ni.gov.uk/sites/default/files/publications/DoH/getting-focused-staying-focused-1.pdf](https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/getting-focused-staying-focused-1.pdf)  The aim of both exercises was to potentially gaps in activity. |  | **3** | *The development of a regional strategy was a key recommendation of the Inquiry. The First Progress Report from DoH noted a draft strategy would be consulted on in June 2016, this has not happened and no clear commitment is given to a strategy in this report.*  *NICCY highlights that the 2016 HMIC report into PSNI effectiveness cited lack of an overarching CSE strategy as a factor in inconsistent responses to missing children.*  *It is unhelpful that the first embedded weblink simply highlights the June 2015 Cross-Departmental Plan which states the draft strategy will be consulted on in June 2016 while the second links to the published SBNI CSE Thematic Review document (which cross references Marshall recommendations within the report) but does not link to the further mapping exercise discussed.*  *NICCY believes that if the DoH have identified an alternative method to ensure a co-ordinated response to CSE than it must be explicit.* |
| **K16** | The HSC Board should adopt a strategic approach to the provision of support services for those who have been subject to CSE, to ensure equality of access. This should build on current, good practice examples. | **HSCB** | The HSCB through the Regional CAMHS Steering Group is bringing forward the development of an Integrated Care Pathway to promote greater understanding of and accessibility to support services for those who have suffered or been exposed to trauma, including CSE. This will include services within CAMHS, LAC Therapeutic Services, the Regional Trauma Centre and services provided by the Voluntary sector.  This process will ensure a strategic approach to the provision of services both statutory and non statutory across the region, providing consistency in quality and accessibility of services. This approach also has the potential to reduce duplication and multiple referrals to a range of service providers. An assessment of the accessibility and appropriateness of service provision will be made to identify gaps in service provision which can then inform commissioning decisions.  At a practical level there has been additional investment into the Barnardo’s Safe Choices service to ensure greater access. Additional investment has also been made into LAC Therapeutic Services and discussions are progressing to take a more strategic view in relation to providing alcohol and drugs supports which have been significant issues where young people have been subject to CSE.  The HSCB has a contract with Nexus to provide support to those adults or those entering into adulthood and have been subject to sexual abuse. |  | **3** | *This simply repeats information provided in the 2015 First Progress Report. It is of concern that there is no new update on how this work is being taken forward and that no information is provided on whether services are currently able to properly support victims of CSE.* |
| **K17** | The HSC Board should ensure that accessible and appropriate support services are made available for adults who were abused as children. | **HSCB** | The HSCB is planning to establish a new regional Trauma Managed Care Network. This network will bring together all trauma services across the region into a single integrated system. An assessment of the accessibility and appropriateness of service provision will be made to identify gaps in service provision which can then inform commissioning decisions. |  | **3** | *It is again concerning that this is the same information provided in the 2015 First Progress Report. There is no indication of work undertaken to date or timeframe for completing the assessment of service provision for adults who were abused as children.*  *It is important to clearly state that the Trauma Managed Care Network will be accessible to, and provide specialist support for adults who were abused as children.* |
|  |  |  |  |  |  |  |
| **S2** | PSNI should take action to strengthen enforcement of licensing laws and especially those concerning the supply of alcohol to young people. Police and Community Safety Partnerships should lead localised approaches to address the issue. | **PSNI** | PCSPs have been reconstituted and a number of young people have been appointed as independent part of Local Government Reform, will be encouraged to continue to develop innovative mechanisms, informed by SBNI, to specifically reflect issues affecting children and young people. |  |  | *Detail on what action has been taken to strengthen the enforcement of licensing laws and the impact of this should be given.*  *It should be made clear if young people appointed to PCSPs include under 18s.* |
| **S3** | In order to improve understanding and vigilance, schools should be alert to the possibility that young people who do not return after holidays abroad may have been subject to forced marriage. Any concerns should be reported to the designated teacher for child protection within the school for further escalation if appropriate. | **Schools** | This issue is now included in the specialist training provided to Designated and Deputy Designated Teachers for Child Protection in schools.  DE is drafting updated information and advice to schools in a new Guide to Child Protection in Schools which will include reference to the 2012 DFP Statutory Guidance on the Forced Marriage (Civil Protection) Act 2007. |  |  | *It is positive this is now included in training for Designated and deputy Designated Teachers but there is no detail on how the impact of this on schools’ understanding, vigilance and reporting in regard to forced marriage will be tracked.* |
| **S4** | Schools should be encouraged to engage parents with regard to the preventative curriculum, including those with literacy difficulties or for whom English is not the first language. | **Schools** | DE wrote to all schools, EA and other Education partners on 24 June 2015 highlighting recommendations in Marshall report aimed directly at schools including the need for greater parental engagement in relation to the preventative curriculum.  All DE iMatter materials are available in a variety of languages.  The NSPCC has been commissioned to undertake a Preventative Education project for the Department. Preventative Education includes the issue of CSE.  This includes the development of resources for use by school leaders, designated teachers and external agencies around their role in preventative education, a whole school approach to safeguarding and working with external agencies in promoting preventative education.  A suite of resources will be developed for use by teachers with pupils and for parents to use with their children supported by the teacher. The resources will be used to identify the expressed training needs and the criteria for the delivery of a training and support package for teachers and other schools’ staff. |  |  | *No information is provided to demonstrate whether schools have engaged with parents and no detail is given on plans to capture this information.*  *No timeframe for the dissemination of NSPCC materials through schools to parents (including teachers supporting parents with materials) is given.*  *There is no specific reporting concerning parents with literacy difficulties or those for whom English is not their first language.* |
| **S5** | The Department of Education should give guidance to schools on how they can provide flexible support sessions about CSE that are accessible for parents of disabled children. | **DE** | Circular 2015/22 has been issued to schools alerting them to the revised guidance. The guidance specifically acknowledges the role that effective RSE provision can play with regard to child sexual exploitation.  The PHA is conducting a survey of post-primary schools during March of the training provided iro RSE. A report on the findings will follow in due course.  The revised RSE guidance highlights the need for careful planning and adaptation of resources and teaching activities for pupils with Special Educational Needs (SEN). For example, there is reference to some learners being vulnerable to abuse who may need explicit teaching and there is a version for MLD students.  The need for communication with parents/carers is also clearly highlighted in the revised guidance so that learning can be reinforced in the home environment |  |  | *While revised RSE guidance has been issued by CCEA, NICCY notes that this (as stated in DE’s Circular) does not address the content of RSE teaching and learning. To be assured that the guidance makes a positive difference to how schools are providing support about CSE for parents (including parents of children with disabilities) this should be reported on.*  *This is particularly important following the 2016 ETI report which highlighted teachers not being confident or being uncomfortable addressing the ‘sensitive’ aspects of RSE and the need for further teacher training.* |
| **S6** | The HSC Board should ensure that child protection issues are consistently and skilfully addressed in LAC and disability settings, where these are separate from specific child protection processes. | **HSCB** | See previous report for details of progress made April to September 2015.  Child protection issues relating to children with a disability  A comprehensive review of the child protection services available to disabled children has now been completed by Queen’s University Belfast, SBNI and Disability Network –  “Safeguarding Disabled Children and Young People: A Scoping Exercise of Statutory Child Protection Services for Disabled Children and Young People in Northern Ireland”.  A subgroup with representation from all 5 HSC Trusts is now working its way through the recommendations of this report to ensure this Marshall recommendation, as it relates to disabled children, is met.  Child protection issues relating to Looked after Children Protecting Looked After Children Guidance was first issued to staff in September 2010.  This had been developed to provide guidance on protecting and safeguarding children who are ‘Looked After’ within the context of minimising the number of meetings and discussions young people had to attend. The guidance was developed taking cognisance of:   * Co-operating to Safeguard Children * Review of Children’s Cases Regulations (Northern Ireland) 1996 * RCPC (SBNI) Regional Policy and Procedures on child protection * Missing Persons Guidance   This guidance has been reviewed by the HSCB. Discussions are ongoing between the Department and the HSCB about the outcome of the Review. |  | **1** | *NICCY requests more detail on why this recommendation has been coded red.*  *The Scoping Study referenced highlights a range of concerns in this area and makes a number of useful, practical recommendations. A timeframe for the subgroup’s work on taking these forward should be provided.* |
| **S7** | The Department of Education should ensure that all young people can access more information and support on healthy relationships, including LGBT young people. This could be included within the CCEA review of Relationships and Sexuality guidance materials | **DE** | Circular 2015/22 has been issued to schools alerting them to the publication of the revised guidance, one for Primary and one for Post Primary.  Links to relevant resources were included including those on sexual orientation, gender identity and homophobic bullying.  The EA, Education Committee and all HEIs were sent letters advising them of the revised guidance.  The Education Authority is considering how best to disseminate the key messages in Circular 2015/22 and the guidance itself across the youth sector. |  |  | *As already noted,**the publication of guidance does not in itself provide assurance that recommendations are being properly met and changing practice on the ground. In this instance, it does not ensure that all young people can access healthy relationship support and the Progress Report should outline how this is being monitored, particularly for LGBT young people.* |
| **S8** | DOH in conjunction with DOJ should pursue an All-Ireland Information Sharing Agreements to achieve closer collaboration on CSE and related issues. | **DOH** | See previous report for details of progress made April to September 2015  An Inter-Jurisdictional protocol, *“Inter-Jurisdictional Protocol for Transfer of Children’s Social Care Cases between Northern Ireland and the Republic of Ireland”* was published in November 2011 to assist with the transfer of cases and the sharing of information cross border on families and children known to Social Services.    Work is also ongoing to review the cross border information sharing arrangements between the PSNI and An Garda Síochána.  This Marshall recommendation has also been discussed under established North/South child protection arrangements.  Co-operating to Safeguard Children and Young People has been agreed by the Northern Ireland Executive and was published on the DoH website on 25 March 2016. This revised policy references information sharing with other jurisdictions and states, at section 8.3 (Information Sharing):  *“The SBNI is responsible for ensuring effective information sharing arrangements which includes information sharing agreements with and between its member organisations and key bodies (for example the PPS) and with other jurisdictions”.*  The SBNI is currently reviewing the RCPC child protection procedures and has indicated that information sharing across jurisdictions will be covered in the new procedures.  DOH officials are also examining the current guidance and practice in relation to cross border information sharing to ensure compliance with obligations under the Hague Conference on International Law: Convention 34 (19th October 1996) on Jurisdiction, Applicable law, Recognition, Enforcement, and Co operation in respect of Parental Responsibility and Measures for the Protection of Children |  | **2** | *Reporting should identify whether initiatives are leading to closer collaboration on CSE in frontline practice.*  *It is unclear whether an All Ireland Information Sharing Agreement is being pursued and this should be clarified.*  *Assurances should be given that, following the UK referendum, the impact of Brexit on all-ireland arrangements in relation to safeguarding, and CSE specifically, are being assessed.* |
|  |  |  |  |  |  |  |
| **S10** | DOH should ensure that the forthcoming revision of the guidance, Co-operating to Safeguard Children should take account of the conclusions and recommendations of this Inquiry. | **DOH** | See previous report for details of progress made April to September 2015.  Completed - Co-operating to Safeguard Children and Young People has been agreed by the Northern Ireland Executive and was published on the DoH website on 25 March 2016.  The guidance has been revised taking account of the findings of the Marshall report. Notable revisions to the document which are directly related to the findings of the Marshall report are:   * Specific policy messages have been incorporated to reflect the need for professionals to be aware of potential indicators and vulnerability factors related to CSE; * A policy imperative for existing referral pathways to be strengthened to ensure reporting protocols allow for feedback and evidence that the referrals related to CSE have been / will be been acted upon; and   Greater emphasis on prevention and empowering children and young people (appropriate to their age) to keep themselves safe. |  | **2** | *NICCY notes that Co-operating to Safeguard (2016) introduced a variation to the definition of CSE developed through SBNI and the CSE Knowledge Transfer Partnership. We request an update on whether a single regional definition of CSE has been agreed.* |
| **S12** | Police and Community Safety Partnerships should seek to add value to the policing of communities by creating innovative mechanisms to hear and reflect issues of local concern. This should specifically reflect issues affecting children and young people. | **PSNI** | Awareness training for all PCSP members and managers has been scheduled for delivery as they begin the process of setting their strategic priorities for the next three years. |  |  | *While planning awareness raising is positive, the Progress Report does not indicate how PCSPs are developing mechanisms to respond to local concerns and address children’s issues. Information on planned engagement with children and how the impact of this will influence the work of PCSPs should be provided.* |
| **S13** | The HSC Board should monitor the arrangements for private fostering to ensure that awareness of CSE is raised and to ensure identification of cases that have not been notified to the HSC Trusts. | **HSCB** | Completed - Articles 108 and 112 of the Children Order provide the relevant legislative basis for private fostering arrangements. Regulations made under Articles 108(2), 112(1) and (2) of the Children Order are the Children (Private Arrangements for Fostering) Regulations (NI) 1996.  Work to raise awareness of private fostering and what is required of individuals who privately foster is ongoing, led by the Regional Adoption and Fostering Team (RAFT).  The DoH has also reissued the circular “Children Living With Carers in Private Fostering Arrangements, Including Children From Overseas” (CCPD 1/11).  To accompany the circular, a leaflet entitled *‘Private Fostering – Taking Care Seriously’* has been produced which sets out the rights and responsibilities of Parents and Carers.  A link to the website has also been circulated to key stakeholders including: GPs, Pharmacies, HSC Trusts and the Department of Education for dissemination to all schools.  Data on the number of private fostering notifications is collected by each HSCT and submitted to the HSCB under Delegated Statutory Functions (DSF) arrangements. |  | **1** |  |
| **S14** | DOH should ensure the involvement of young people in any future review of the Regional Guidance on Police Involvement in Residential Units/ safeguarding of Children Missing from Home and Foster Care. | **HSCB** | Complete – see previous report |  |  | *It is important that a clear commitment to periodic review of the Guidance and the involvement of children and young people in this is provided.*  *This is particularly needed because of concerns highlighted by the 2016 HMIC review of PSNI regarding missing children and CSE and NICCY is aware of on-going work between PSNI and HSCB regarding missing children.* |
| **S15** | The HSC Board should address as a priority the provision of joint training on Regional Guidance on Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care. | **HSCB** | Complete – see previous report |  | **2** | *As above. NICCY seeks clarification that the training is ongoing and is undertaken on a joint basis across agencies.* |
| **S16** | The HSC Board Strategic Action Plan – Children Missing from Home or Care should be revised and implemented as part of the strategic overview of CSE. | **HSCB** | Complete – see previous report |  | **1** | *The two rounds of Progress Reports have stated this recommendation is completed. NICCY is unclear that a strategic overview of CSE has been undertaken. Detail on this and how the Missing Children Action Plan has been altered as part of the overview and how its implementation is being monitored should be provided.* |
| **S17** | Police evidence about the circumstances in which a child was found after going missing or putting themselves at risk can be vital to protection arrangements. PSNI should review current processes to ensure that in all circumstances, information is recorded and transmitted appropriately, both internally and to partner agencies. | **PSNI** | Complete – see previous report |  |  | *A number of interrelated Health and Justice recommendations, including this one and S18 below are recorded as complete but the 2016 HMIC inspection found the police response to missing children not consistently good.* |
| **S18** | HSC Trusts should ensure that when a child returns after being missing, he or she is offered an interview with an independent person in line with regional guidance | **HSCB** | Complete – see previous report |  | **1** | *As above. The 2016 HMIC inspection highlighted there was no consistent process to provide police with information from return interviews.* |
| **S20** | DOH, in conjunction with the HSC Board, should review the notifications that residential care staff make following an incident, with the aim of producing a single form that will act as the response to all agencies who have to be notified. | **HSCB** | An interagency group, chaired by the HSCB, has been set up and is currently reviewing the notifications that residential care staff make following an incident, with the aim of producing a more streamlined approach to reporting, taking account of children’s privacy and appropriate levels of information sharing. |  | **2** |  |
| **S21** | The HSC Board in conjunction with HSC Trusts should ensure that adequate support is available for foster carers (including kinship carers) and foster children, including health support through LAC nurses. | **HSCB** | See previous report for details of progress made April to September 2015.  Completed - The HSCB, in partnership with Trusts, has reviewed provision and is satisfied that the range of services for children and foster carers available within each of the Trusts are both equitable and adequate with core regional components enhanced by local services, developed with local partners. |  | **2** | *The Progress Report should provide information relevant to the recommendation. While DoH provided over six pages of information much of this is general and does not identify how effective provision is in practice or highlight uptake levels for support options.*  *Information on how ‘adequate’ levels of support were defined and assessed as satisfactory should be provided. Detail on how carers and children have been involved in this review and assessment should be given.*  *It is important that reporting addresses both areas highlighted in the recommendation - support for foster carers (including kinship carers) and support for foster children.* |
| **S22** | The HSC Board, in conjunction with the HSC trusts, should assess the appropriateness of existing unregulated placements to ensure that the assessed needs of young people in these placements are being met. | **HSCB** | See previous report for details of progress made April to September 2015  Completed - The HSCB has conducted an assessment of existing placements to ensure the assessed needs of each individual child are being met. This included:   * An audit of all current unregulated placements. * A ongoing series of HSCB assurance meetings with HSC Trusts to discuss each placement. * A checklist of minimum standards which are required to be met before any child is placed in an unregulated placement. * A review of HSCB/Trust notification arrangements.   HSC Trusts subsequently reported on the measures they have put in place to assess the appropriateness or suitability of each placement and the support arrangements to the young people.  In May 2016, the HSCB issued correspondence to each Trust Director seeking assurances that when unregulated placements are in use all staff are informed of the requirement for timely notifications to the HSCB; where there is potential for CSE, that risk assessments have been completed and risk management plans are in place; and that appropriate wraparound support packages are in place. All Trust Directors subsequently provided these assurances to the HSCB. |  | **2** | *This also applies to S23 below. Detail of the assessment exercise and how this has involved providers, including those involved in joint commissioning, RQIA and young people should be given. Information on how the status of unregulated placements impacts on their remit, on standards they operate to and on the role of RQIA should be included as part of this.* |
| **S23** | DOH should consider bringing forward regulations to require supported accommodation for young people under 18 to be registered by RQIA. | **DOH** | See previous report for details of progress made April to September 2015.  This recommendation is ongoing involving DoH, HSCB, NIHE and RQIA.  The HSCB and NIHE are working on the development of a joint governance and quality assurance framework document which will state clearly the roles and responsibilities of all stakeholders involved in the governance of supported accommodation. Key stakeholders in the process are NIHE, HSCB, RQIA, Health and Social Care Trusts and the DOH  At present, it is considered the current governance arrangements are sufficiently robust, although some streamlining of visiting and inspection activity may be needed. However, should these arrangements between partner organisations change, further consideration will be given to making provision for the inspection of jointly commissioned establishments in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. |  | **3** | *This also applies to S22 above. Detail of the assessment exercise noted in S22 should be outlined and how this has involved providers, including those involved in joint commissioning, RQIA and young people. Information on how the status of unregulated placements impacts on remit, requirements, standards and the role of RQIA in should be included as part of this.* |
| **S24** | RQIA should consider re-introducing the involvement of young people as peer reviewers in inspections of children’s homes. | **RQIA** |  |  |  | *Progress Reports should report on all recommendations regardless of department or agency. Two years on from the publication of the Inquiry Report it is not acceptable that updates on implementation are not provided or that the reporting process is not properly integrated.* |
| **S25** | HSC Trusts should endeavour to provide stability by minimising the movement of both children and staff throughout residential and foster care settings. | **HSCB** | See previous report for details of progress made April to September 2015.  Completed - In addition to improvements outlined in the previous progress report, the following actions were agreed at the HSCB Children’s Services Improvement Board in May 2016 aimed at minimising the movement of children in residential care and foster care: |  | **2** | *While DoH provides 10 pages of general information outlining plans and positions that have been agreed to promote stability for children this does not demonstrate how concrete change in children’s placements has been achieved. Recommendations, such as this, should not be assessed as completed if detail of impact on the ground (including children’s views on placement stability) cannot be provided.*  *NICCY would note more broadly, that reporting against complex recommendations provides departments with an opportunity to highlight barriers and challenges to progressing recommendations.* |
| **S26** | The HSC Board should consider the development of region-wide guidance about care and control in residential units. This should involve input from both young people and residential care workers. | **HSCB** | See previous report for details of progress made April to September 2015.  Completed *The* *Management of Behaviour, Physical Intervention and Missing Children, Supplementary Guidance* was published in April 2016.    A workshop for frontline residential care managers and line managers was held in March 2016 to ensure that the guidance is fully understood and to agree a process of implementation.    The HSCB has confirmed guidance has been widely circulated and is now in use. |  | **1** |  |
| **S27** | HSC Trusts should take responsibility for ensuring that frontline staff in residential facilities are helped to feel confident that they will be supported by management if something goes wrong when they have done their best. They should also feel confident about speaking up if they feel young people are in danger and they cannot keep them safe. | **HSCB** | See previous report for details of progress made April to September 2015.  Completed  *The Management of Behaviour, Physical Intervention and Missing Children, Supplementary Guidance* was published in April 2016.  Implementation of the guidance should help staff feel more confident when dealing with the behaviours referred to in the Marshall Report.  CSE Operational Meetings and liaison groups within the residential setting promote a culture of shared responsibility and accountability, and provide frontline staff with additional guidance and support.   * The use of therapeutic approaches in residential care and their effectiveness was also raised in the Thematic Review and is part of the areas identified for improvement. |  | **2** | *Detail on how HSCB is assured that CSE Operational Meetings are effective and particularly that staff across settings and Trusts feel well supported by management should be outlined. This should be linked to whether staff and Trusts are now better able and supported to effectively protect children.* |
| **S28** | DOH should take the findings of this Inquiry into account in its review of the definition of vulnerable adult to ensure that it is capable of accommodating young people who are vulnerable to CSE. | **DOH** | Complete – see previous report |  |  |  |
| **S29** | The Department of Education should ensure that there is provision for parents, carers and other educational professionals to improve their knowledge and skills in relation to modern methods of communication and to keep up-to-date on developments in social media. | **DE** | The Executive has commissioned the SBNI to prepare an e-safety strategy on its behalf. The Department of Education is a member of the project board overseeing the development of the strategy which is due to be published in the 2016/17 business year. |  |  |  |
| **S30** | The Department of Education should work with other departments to ensure that there are appropriate safeguarding arrangements for children in all non-statutory education settings. | **DE** | The Department has issued guidance and received assurances regarding CSE training for staff in the following:   * Sure Start Settings * Pre-school settings * Other early years settings funded by the Early Years Fund * Youth Services * Education Otherwise Than At School   The revised RSE guidance has also been shared with independent schools.  The EA is currently developing new procedures and arrangements to help parents who home educate and to encourage them to seek support. These procedures are being informed by a consultation exercise that took place during 2014. In developing this the EA will consider appropriate safeguarding arrangements. |  |  | *As NICCY has previously noted in relation to Elective Home Education, plans for the EA to consider safeguarding in broader procedures do not indicate how they and others will ensure that robust safeguarding arrangements are in place for this group of children.* |
| **S31** | Schools should ensure that Relationships and Sexuality Education is delivered by people with the skills and confidence to do so. | **Schools** | Complete – see previous report |  |  | *Previous reports from DE highlight that CCEA has published revised guidance but this does not meet the recommendation or demonstrate how government is ensuring RSE is delivered by those with the skills and confidence to do so.*  *Progress Reports should show how the impact of recommendations will be tracked from DE through regional bodies to school management and, most importantly, to quality of provision in schools.*  *This is of particular concern given the 2016 ETI report which highlighted teacher’s not being confident or being uncomfortable addressing the ‘sensitive’ aspects of RSE and the need for training on this (as noted against S5).*  *Recommendations should not be assessed as completed without evidence of completion.*  *Again, NICCY notes the reporting process provides opportunities to identify real challenges and barriers that can be faced in implementing the recommendations.* |
| **S32** | The Department of Education should develop a central register of quality assured external agencies and/or programmes that schools could access to source appropriate specialist support to deliver the preventative curriculum. | **DE** | The Department is considering the development of a set of principles that programmes on preventative education should include which will assist schools in identifying appropriate additional support. | Ongoing | **3** | *NICCY understood that DE was actively revisiting this recommendation following its initial position that it could not be implemented. Work to progress the recommendation is welcome and further detail on this should be provided.* |
| **S33** | The statutory personal development curriculum should specifically reference CSE, with a clear focus on progressively developing the confidence, self-esteem, resilience and personal coping strategies of all children and young people in schools | **DE** | This requires legislative change and the Department will return to this point as part of a wider review of the statutory curriculum in due course. |  | **1** | *A timeframe for this review should be provided.* |
| **S34** | School staff and wider education professionals should receive training on CSE with the aim of integrating it into general safeguarding training. | **DE** | This issue is now included in the specialist training provided to Designated and Deputy Designated Teachers for Child Protection in schools.  ITE providers have confirmed that CSE is already an integral part of their courses and partnership arrangements with a range of other agencies. However some providers have indicated that they will take the opportunity to review and, if necessary, enhance their provision in this area in light of this report. |  |  |  |
| **S35** | The Department of Education should ensure that schools receive additional, regularly updated training and resources to support them in educating pupils and parents on how to use social media and online resources responsibly, and how to keep their pupils safe. | **DE** | The Education Authority, via the C2k programme, is now providing teachers with detailed advice and guidance on eSafety within an e - Safety zone available via the C2k Exchange. Resources are also available within the C2k Virtual Learning Environment, Fronter, for staff and pupils. Teachers have access to an Internet Safety Room which has a range of resources and eSafety policies.  Teachers can also now access a Fronter resource called, ‘Better safe than Sorry’. This is an online room that a teacher can bring children into, with a range of readily available educational resources relevant to safety. |  |  |  |
| **S36** | The Department of Education should give further guidance to schools on CSE and in its review of Relationships and Sexuality Education guidance for schools; CCEA should consider specifically referencing CSE. | **DE** | Complete – see previous report |  |  | *As highlighted in S31, the findings of the 2016 ETI report on RSE demonstrate that further work, including training for teachers, is required to ensure the guidance is implemented in schools and enables schools to better protect children from CSE.* |
| **S37** | The Department of Education should explore the possibilities for peer education and mentoring as a way of informing and supporting young people about CSE | **DE** | DE has supported the dissemination of the Barnardo’s/SBNI DVD and Resource Pack ‘False Freedom’ to all post-primary schools, the EA and regional youth officers. This resource was produced by young people for young people.  The 2016 School Omnibus Survey includes questions on peer mentoring and its use within schools. |  |  | *It is important that activity marked against recommendations properly addresses these. While the examples given relate to the area of peer education, they do not indicate how peer mentoring practices have been developed or how resources such as False Freedom have been used within schools and other settings.* |
| **S38** | The Department of Education should provide schools with clear, consistent guidance on recording, storing and handling of child protection records including CSE. | **DE** | The Department is currently drafting a records management policy for schools which will address this particular aspect of records management. Work on the circular is well advanced and it is anticipated that it will be circulated to schools in September 2016. |  | **2** | *The report should reflect that guidance has been provided by DE. DE should identify if the guidance is adhered to and does improve child protection records management in schools.* |
| **S39** | Schools should ensure that all school governors have child protection awareness training which includes reference to CSE. The designated governor for child protection should have additional, enhanced training. | **Schools** | There are 3 strands to child protection training for governors:   * All Governors receive child protection awareness training (which includes CSE) as part of their Governor induction training. This is provided by Assistant Advisory Officers in the EA. * The Chair of the Board of Governors and the designated Governors receive targeted child protection training (which also includes CSE), provided by the EA CPSSS.   Safer recruitment and selection training is provided by EA HR staff. |  |  |  |
| **S40** | The Department of Education should ensure that youth workers, whether paid or voluntary, should receive training to help them to inform and support young people, who may be at risk of CSE, and to identify and report safeguarding issues appropriately | **DE** | An Interim Child Protection and Safeguarding Policy was approved by the EA in January 2016. The policy applies to all EA services including the youth service. | **This action falls to the EA.** |  | *The information provided should be relevant to the recommendation. DE and EA should demonstrate how they have ensured youth workers have had access to training on supporting young people at risk of CSE and identifying and reporting safeguarding concerns.* |
| **S42** | HSC Trusts should explore the potential for school nurses to play a wider role in safeguarding issues, including CSE. | **HSCB** | A review of school nursing services is ongoing. The outcome of this review will determine whether additional action is required to deliver this recommendation. |  | **2** |  |
| **S43** | PSNI and criminal justice partners in the Prosecution Service and Court Service should continue to develop their approach to responding to victims of CSE in a way that treats them fairly and sensitively and avoids blaming them for offending behaviour associated with their abuse. This involves attitude, not just policy or process. | **DOJ** | NICTS continues to work with NSPCC’s Young Witness Service and others to maximise the use of remote live links so that young witnesses can give their evidence away from the formal court environment. This reduces anxiety and helps with giving better evidence. In addition to facilitating these and other special measures the court will prioritise cases involving young or vulnerable witnesses (based on information provided by the parties) to ensure that their evidence is taken as early in the day as possible.  Court staff and court clerks have customer service standards requiring them to treat all court users with courtesy and sensitivity.  Where a child appears as a defendant the Youth Court Guidelines require that the child is treated appropriately and in line with on-going need to ensure that the rights of children are maintained as paramount and that youth courts are fully compliant with ECHR fair trial provisions.  The Public Prosecution has established a Serious Crime Unit (SCU) to deal with all sexual offences cases including Child Sexual Exploitation. This Unit is staffed by 10 experienced Senior Public Prosecutors and is headed by an Assistant Director. All Prosecutors in the SCU have received training on sexual offences including sexual offences against children as well as specific training on Child Sexual Exploitation.  A new E-Learning DVD package and resource pack is under development by police and social services. It is anticipated this will be available first half 2016 for roll-out. Likewise, a ‘missing’ children’s training package underpinned by the ‘Runaway and Missing from Home and Care Protocol has also been developed. |  |  | *Further detail on how these actions are improving the way the criminal justice system responds to victims of CSE should be given. It is of concern that no detail regarding the work of PSNI is provided.* |
| **S44** | The Department of Justice should continue to seek to develop and improve the experiences of young witnesses, taking into account research and learning from other countries. This should include consultation with stakeholder groups and with young witnesses. | **DOJ** | Interviews have been undertaken on the experiences of victims of Sexual Abuse/Violence. Initial analysis of this has been undertaken and an overview of key areas has been published. A more detailed report, along with a response paper and action plan will be published shortly.  The Department is working to identify individuals that could participate in the research into the experience of young victims of crime. |  |  | *A timeframe for this work should be provided.* |
| **S45** | PPS should ensure that prosecutors dealing with sexual offences against children continue to receive training at regular intervals on the dynamics of child abuse, including CSE. | **PPS** |  |  |  | *Progress Reports should report on all recommendations regardless of department or agency. Two years on from the publication of the Inquiry Report it is not acceptable that updates on implementation are not provided or that the reporting process is not properly integrated.* |
| **S46** | Awareness-raising about the dynamics of child abuse and CSE in particular should be available for all legal personnel and should be mandatory for all legal professionals dealing with child abuse cases. This should be made the responsibility of the PPS for its own legal staff, the Northern Ireland Bar for its staff and the Judicial Studies Board for Judges. | **PPS**  **DOJ**  **NI Bar** | The Public Prosecution has established a Serious Crime Unit (SCU) to deal with all sexual offences cases including cases involving Child Sexual Exploitation. This Unit became operational on 4 January 2016 and is staffed by 10 experienced Senior Public Prosecutors and is headed by an Assistant Director who reports directly to the Senior Assistant Director. All Prosecutors in the SCU have received training on sexual offences including sexual offences against children as well as specific training on Child Sexual Exploitation which was provided by Barnardo’s which included potential indicators of CSE and the particular needs of children who have been subjected to or are experiencing CSE  **Judicial Studies Board**  The Judicial Studies Board has issued a notice to all members of the Judiciary informing them of the recommendation to raise awareness of the issue. JSB representatives plan to attend and continue to distribute further insight and learning points from CSE related events.  **Northern Ireland Bar**  The Bar of Northern Ireland is delivering a programme of specialist training in the next legal term targeting publicly funded barristers to include child abuse and CSE as well as vulnerable witnesses, violence against women and court users with communications needs. |  |  | *It is helpful that information has now been provided on this recommendation although the impact of training on management of cases, the experiences of victims and witnesses and prosecution outcomes should be monitored.* |
| **S47** | While we acknowledge the work already undertaken by the Department of Justice in order to avoid delay, robust case management is necessary. The DOJ should ensure that both statutory case management and statutory time limits are introduced in Northern Ireland. Both have already been the subject of clear recommendations by the Criminal Justice Inspection in Northern Ireland. | **DOJ** | The Justice (Northern Ireland) Act 2015 received Royal assent on 24 July 2015 and the Department will make regulations which will impose duties on the court, prosecution and defence. The arrangements for consultation on Statutory Case management regulations are on target.  The regulations will also confer functions in the magistrate’s courts and the Crown Court, and will define the court’s key case management responsibilities.  The Minister remains committed to STLs and the Department is engaging with the Justice Committee on a range of proposals and will shortly consult with key stakeholders on improving processing times for cases within the Youth Court. |  |  | *NICCY notes that no evidence of how improvements to case management have addressed delay have been provided. In relation to STLs it is concerning that no significant progress has been made on this and no timescale for achieving this is given.* |
| **S48** | PSNI should conduct a review of resources and operational delivery in respect of digital evidence examination to ensure that any evidence of CSE is provided to investigators in a timely manner, and to avoid delay in the courts. | **PSNI** | A review is currently being progressed regarding resource demand modelling which may identify resource deficiencies. Work has also been progressing to automate digital evidence examination services utilising various projects, one of which will improve imaging and dissemination of material for investigators to view and another which is intended to automate the examination of potential CSE material. Both of these projects are currently under development. |  |  |  |
| **S49** | HSC Trusts should consider how best to address the appropriate availability of social workers for Achieving Best Evidence interviews. | **HSCB** | Complete – see previous report |  | **2** |  |
| **S50** | PSNI, in its review and development of the Public Protection Units, should move to develop perpetrator profiling and a greater focus on perpetrators. | **PSNI** | Complete – see previous report |  |  |  |
| **S51** | The HSC Board in conjunction with SBNI should ensure that the availability of Recovery Orders in terms of section 69 of the Children (Northern Ireland) Order 1995 is highlighted in guidance and training. | **HSCB** | Complete – see previous report |  | **1** |  |
| **S52** | DOH should ensure that the revision of Circular HSS CC 3/96 (Revised), Sharing to Safeguard: Information Sharing about Individuals who may pose a Risk to Children, is accompanied by clear guidance to workers that will give them the confidence to act appropriately. | **DOH** | Circular HSS CC 3/96 will be replaced by Guidance on Information Sharing for Child Protection Purposes. The guidance has been drafted and will issue for public consultation in Autumn 2016.  The draft guidance takes account of developments since the publication of the original circular, including the introduction of PPANI arrangements relating to violent and sex offenders; information sharing; arrangements between the PSNI and schools; and arrangements for child protection disclosures to members of the public.  Section 48 of the Justice Act (NI) 2015, once commenced, will amend the Criminal Justice (NI) Order 2008, requiring that the PPANI guidance is extended to include guidance on disclosing conviction information on those being managed through PPANI to members of the public. |  | **2** | *DoH’s First Progress Report stated the Circular was being revised and guidance would be consulted in autumn 2015 and published March 2016. The latest Progress Report instead states the Circular will be replaced with guidance which will be consulted on in autumn 2016. NICCY is not aware of any consultation to date.*  *The information sharing addressed by the Circular, as highlighted by the Independent Inquiry, can pre-empt children’s exposure to danger and the current situation leaves frontline staff in a difficult position and should be addressed urgently.*  *The recommendation covers three areas – issuing the revised Circular; providing guidance; and ensuring staff have confidence to act appropriately to safeguard. Implementation should address all three areas.*  *It is unclear why this is coded green.* |
| **S53** | The DOH should consider further actions to protect children against offenders who will not have been brought to the attention of the statutory authorities in Northern Ireland for historical and cultural reasons. | **DOH** | Completed – The essence of this recommendation is to encourage victims to come forward to the authorities so that historical crimes against them can be investigated and to ensure that, when they do come forward, victims have access to services and support.  This requires raising public awareness that inspires confidence in victims to come forward and to offer them assurances that their complaints will be treated seriously and sensitively. HSC Trust Gateway Services and the PSNI Public Protection Units (PPUs) deal with any abuse allegation, current or historic. Recent publicity relating to the Historical Institutional Abuse Inquiry has raised awareness of the need to report and investigate historical abuse allegations.  This issue formed part of a recent workshop in June 2016 involving representatives of the PSNI and HSC Trusts. Both agencies confirmed that they have appropriate procedures in place to ensure that any individual who makes an allegation of historical sexual abuse will receive a professional and sensitive response and that their claims will be investigated thoroughly. Every effort will be made to bring alleged perpetrators before the courts and appropriate steps will be taken to protect others from such offenders. |  | **3** | *Information provided should evidence that the PSNI and HSCT procedures noted as satisfactory have resulted in improved safeguarding for children who may be at risk from those not brought to the attention of the authorities. NICCY notes that concerns about low confidence in reporting safeguarding concerns to authorities in some areas is not simply an historic issue. Statutory agencies should make sure that this continues to be addressed.* |
| **S54** | The DOH, supported by DOJ, should ensure that existing out of hours services across the health, social care and police sectors, are co-ordinated and strengthened. They should enable frontline staff from all sectors, as well as communities and concerned individuals, to access relevant information and skilled advice about safeguarding matters relating to children, including CSE. | **HSCB** | See previous report for details of progress made April to September 2015.  Completed – A framework of regular meetings, both strategic and operational, between social services staff and Police staff to improve coordination of services out of hours has been established and is working effectively.  Restructuring of front line services by both Social Services and Police across the region now ensures that both agencies have dedicated and experienced personnel available outside office hours to deal with all safeguarding matters relating to children, including CSE.  The Belfast HSC Trust manages all out of hours social work services across Northern Ireland, with a single point of entry for all out of hours child protection/safeguarding referrals.  The PSNI has developed a Central Referral Unit (CRU) as a single point of entry for all child protection referrals to police.  Trust geographical boundaries and PSNI PPU boundaries are co-terminous which facilitates the flow of information between both organisations and assists in the development of close working relationships at local level.  Both agencies have been involved in the revision of the protocol agreed by both agencies when investigating allegations of child abuse. The revised protocol was issued in April 2016 *“Protocol for joint investigation by social workers and police officers of alleged and suspected cases of child abuse – Northern Ireland” 2016.*  Both agencies have been involved in extensive communication with key stakeholders and the general public to ensure that communities and concerned individuals are aware of these after-hours services and are reassured that they can access appropriate advice from both PSNI and Social Services about safeguarding matters relating to children, including CSE, 24 hours a day, seven days a week.  Awareness raising information (such as posters, leaflets and call cards) have been distributed to other statutory services, voluntary and community groups to raise awareness of CSE, and where to report concern /access support.  The NSPCC has engaged widely to raise awareness of CSE and encourage individuals and their families to report CSE. They have a dedicated helpline and trained counsellors 24/7 to deal with anyone wishing to make a referral – NI Sexual Exploitation Helpline 08003891701. |  | **1** | *As noted in S17 and 18, a number of interrelated Health and Justice recommendations including this one are recorded as complete but findings from the 2016 HMIC inspection found the police response to missing children not consistently good and highlighted concerns about CSE risk assessments, sharing of information from return interviews and the need for specialist training. While there has been structural change, it is not clear that this has resulted in improvements in safeguarding outcomes for children.*  *The HMIC report raises serious questions about what evidence supports DoH’s view that this recommendation is complete and action taken “now ensures both agencies [social services and police] have dedicated experienced personnel available at the front door to deal with all safeguarding matters including CSE”.*  *We also note the DoH CSE Implementation Plan highlighted work on this recommendation would include extending regional CAMHS out of hours services and are concerned this has not been referenced in DoH’s First or Second Progress Reports.* |
| **S55** | The DOH supported by DOJ should ensure that information received by out of hours services regarding CSE should be communicated to the multi-agency safeguarding hub or equivalent model referred to in S60. | **HSCB**  **PSNI** | **See supporting recommendation 60**  Completed - As per supporting recommendation 54 above, restructuring of frontline services by both Social Services and Police across the region now ensures that both agencies have dedicated and experienced personnel available outside office hours to deal with all safeguarding matters relating to children, including CSE.  The Belfast HSC Trust manages all out of hours social work services across Northern Ireland with a single point of entry for all out of hours child protection/safeguarding referrals.  The PSNI has developed a Central Referral Unit (CRU) as a single point of entry for all child protection referrals to police and five PPUs for investigating such matters.  Each HSC Trust has a clear next day single point of contact for reporting safeguarding/child protection information received by the out of hours Social Work Service.  Each HSC Trust has appointed a full time Senior Practitioner social worker to liaise closely with the PSNI in the PPUs to ensure all child protection information is communicated in a comprehensive and timely manner. All Trusts have agreed in principle to co locate this worker in the respective PSNI PPUs to further enhance interagency communication. For further details on interagency safeguarding arrangements see supporting recommendation 60 below. |  | **3** |  |
| **S56** | All agencies, especially HSC trusts and PSNI must ensure that appropriate feedback is given to any person making a report regarding CSE. | **SBNI** | Ownership of this recommendation has passed to the SBNI, which will separately publish an implementation plan for all Marshall recommendations to be delivered by the SBNI.  **Supporting 56 as it relates to HSCTs**  All Trusts now have feedback mechanisms to those making day time referrals to HSC Trust Gateway Teams about children and young people including those expressing concerns about CSE.    The Regional Emergency Social Work Service is a central point for all new referrals outside office hours. All out of hours referrals are passed to the relevant HSC Trust through a single point of contact the next working day.  RQIA planned Review of Recommendations from the RQIA Child Protection Review (2011) in 2016/17 will include reporting pathways and feedback mechanisms as they relate to concerns about children and young people.  As a result of PSNI moving to 5 coterminous PPUs and a Central Referral Unit from 1 April 2015, operational protocols, including feedback mechanisms, are being updated/developed. |  | **1** | *Progress Reports should report on all recommendations regardless of department or agency. Two years on from the publication of the Inquiry Report it is not acceptable that updates on implementation are not provided or that the reporting process is not properly integrated.* |
| **S60** | The DOH should consider development of a model for a multi-agency safeguarding hub (MASH) in Northern Ireland which should take into account learning from the good practice in recent projects such as Operation Owl, the co-located project at Willowfield, and the Regional CSE Group | **DOH** | **Linked to supporting 55**  See previous report for details of progress made April to September 2015.  Completed - DoH gave consideration to this recommendation within the Northern Ireland context and practice of identifying and investigating child abuse including CSE.  Research into how the various models of MASH operate in England identified three key areas that any front door child protection services must address.   * The early sharing of information across agencies, (Health, Social Care and Police) which is then used to assess the level of risk and identify immediate actions within an early strategy discussion. * The signposting of non child protection referrals to an early help service. * Agreement as to the how child protection referrals to Police and Social Services are going to be managed.   Health, Social Services and Police in Northern Ireland have engaged extensively during the period since the publication of the Marshall Report to ensure the front door system operating here in Northern Ireland meets these core principles. A number of actions have resulted in confidence that the NI model addresses the issues outlined by Professor Marshall and creates an information sharing front door model, similar to a MASH in other parts of the UK.   * Restructuring of front line services by both Social Services and Police across the region now ensures that both agencies have dedicated, experienced personnel available at the front door to deal with all safeguarding matters relating to children, including CSE. * The restructuring has resulted in co terminous geographical boundaries between the 5 PSNI PPUs and the 5 HSC Trust Gateway Teams which facilitates the flow of information between both organisations. * The PSNI and Social Services have worked together to revise and agree the joint protocol for investigating allegations of child abuse. The revised *Protocol for joint investigation by social workers and police officers of alleged and suspected cases of child abuse – Northern Ireland* was issued in April 2016. * The PSNI has developed a CRU as a single point of entry for all child protection referrals to police and five PPUs for investigating such matters. * The HSC Trusts have strengthened their Gateway Teams and developed clear pathways to early help for those referrals which do not meet the criteria for child protection. * Each HSC Trust has appointed a full time Senior Practitioner social worker to liaise closely with the PSNI in the PPUs to ensure all child protection information is communicated in a comprehensive and timely manner. All Trusts have agreed in principle to co locate this worker in the respective PSNI PPUs to further enhance interagency communication. * All HSC Trusts now have feedback mechanisms to those making new referrals to HSC Trust 24 hours a day, seven days a week about children and young people, including those expressing concerns about CSE. * All five HSC Trusts have developed Family Support Hubs to create a clear pathway to early help for children and families who are referred to Police or Social Services but do not meet the threshold for a child protection investigation.  1. A clear protocol has been developed to ensure appropriate step up and step down pathways for families requiring early help and support; and clear pathways to family support and intervention teams for families who do not meet the threshold for child protection but require additional help and support from Social Services. |  | **3** | *As highlighted in S54, findings from the 2016 HMIC inspection raise significant concerns that changes made to date have not led to a consistently robust response to CSE. The commentary provided in the Progress Report does not demonstrate how DoH and others are making sure there are tangible and sustained improvements in how children are being protected across Northern Ireland.*  *In the absence of such evidence, the effectiveness of multiagency working, and the best structures to support this, should be kept under review.* |

1. Blue – Completed

   Green – Ongoing

   Grey - Withdrawn or ownership transferred

   Red - Commitments not achieved or not expected to be achieved or delivery of the targeted outcome(s) will not be achieved [↑](#footnote-ref-1)
2. Phase 1 – ends 30 November 2015

   Phase 2 – ends 30 November 2016

   Phase 3 – ends 30 November 2017 [↑](#footnote-ref-2)