A Review of Practice and Audit of the Management of Cases of Neglect

Report on the Findings of the Pilot Phase of the National Audit of Neglect

Internal Circulation within HSE at Discretion of National Office

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ABOUT THE AUTHOR

Lynne Peyton is a Child Care and Management Consultant with extensive experience of auditing and quality assuring children's services. She has been a Senior Manager in both the statutory and voluntary child care sectors and since establishing her Consultancy in 2001 has provided independent advice on a range of projects throughout Ireland. She was a core member of the Inspection of Child Protection Services in Northern Ireland which reported in 2006 and which was a catalyst for significant developments in child protection procedures and practice. Lynne has conducted independent reviews of child protection, family support and foster care practice on behalf of a range of agencies and has chaired and facilitated a number of serious case reviews. Her focus is on providing comprehensive advice to improve outcomes for individual children as well as on improving practice and enhancing governance arrangements at all levels in organisations. As a Lay Magistrate she is regularly involved in decision making in both private and public law proceedings in the Family Court.

PART 1

CONTEXT

1. INTRODUCTION AND SUMMARY OF FINDINGS

This report represents the findings of 3 pilot exercises to independently review practice and audit the management of cases of neglect in Ireland, in preparation for a National Audit of Neglect as recommended by the Roscommon Child Care Case Inquiry (October 2010).

Each of the 3 Local Health Offices (LHO) chosen for the pilots had a case which was subject to an Inquiry because the children had experienced chronic neglect. In 2 of these families a child had died and in Roscommon, several children suffered severe and sustained neglect over a period of years.

In total almost 100 cases involving more than 300 children were considered by the Reviewer and where appropriate recommendations were made to better safeguard the young people involved. The findings add to the knowledge base of characteristics of neglectful families demonstrating the significance of alcohol abuse and to a lesser extent drug misuse among neglecting parents. The circumstances of children was often a matter of concern to the entire range of involved disciplines including public health nurses, school teachers, psychologists, speech and language therapists, and to those who were providing a range of family support services.

Increased awareness due particularly to Children First training, has led to an increase in child neglect referrals to social work departments in recent years. However across the 3 Pilot areas there was evidence that the thresholds for allocation of cases to Social Workers was often too high and that generally children who had allegedly been physically or sexually abused were more likely to receive services than those who experienced neglect and emotional abuse. Consequently there was evidence that many neglected children were not receiving a service and in two areas there was a substantial waiting list.

There were many examples of good practice resulting in greatly improved standards of care although for some children their welfare and protection were only achieved through placement with foster carers including relative carers. However there were many families in which the circumstances for children did not improve despite the involvement of statutory services and even with the provision of very considerable supports including in home services, parenting programmes, sponsored playgroup places and centre based activities. The threshold for escalating neglect cases to the Child Protection Notification System (CPNS) differed considerably in the three areas and even when cases were included on the CPNS parental resistance to change and non compliance with child protection plans was not adequately challenged. Although neglect was the most common reason for inclusion of children on the CPNS across Ireland, these audits found that inclusion on the CPNS did not necessarily improve children's circumstances. This appeared to be due in part to a lack of understanding of the harsh reality of everyday life for children, the cumulative long-term consequences of neglect, a cultural commitment to keeping families together at all costs

and a perceived reticence by the Courts to grant Care Orders in neglect scenarios. This belief, based on Social Workers' experiences that courts were less likely to grant Care Orders on the basis of neglect, meant that many applications were delayed. When Care Order applications were instigated it often took up to a year and more than 10 court appearances to achieve a full order. This level of court activity placed enormous pressures on already stretched social work services and contributed to other cases being held on waiting lists for allocation.

The situation was compounded by the absence of timely paediatric developmental assessment and by delays in undertaking comprehensive assessments including an evaluation of parental capacity. In some areas it was also difficult to secure timely support for children with mental health issues from Child and Adolescent Mental Health Services. Staffing constraints in all disciplines, including extensive acting up arrangements throughout the organisation, contributed to challenges with the provision of services as well as with supervision, leadership and governance.

Although significant numbers of the sample cases were known to Gardai there was limited evidence of parents being prosecuted for neglecting or indeed assaulting their children until after successful Care Order proceedings.

The pilot audits are set in the context of available research, current legislation and local as well as national policies. The significant learning achieved throughout this interactive process included an increased awareness of the devastating impact of emotional and physical neglect on children. The audits took place during late 2010 and in 2011, at a time of massive organisational change for the HSE and acknowledged the anticipated establishment of a dedicated national agency to support children and families which will become operational in 2013. The likely challenges facing the new Children and Families Support Agency, in overcoming the considerable variation in demography, staffing, activity levels, management styles, policies and practice cannot be overestimated and these 3 areas amply demonstrate the governance agenda.

Identification of the strengths, challenges and frustrations within each discipline was collated through a process of interviews and focus groups. The findings are presented here in some detail so that they inform the national audit and support HSE managers' understanding of each discipline's contribution to the multi-agency and inter-disciplinary management and prevention of child neglect. Communication and coordination will be imperative in ensuring that there is effective joint working between the HSE and the Agency.

Involvement of senior management and Heads of Disciplines throughout the process was critical to its success and the report captures the nature of the commitments made by managers in each area to build on current practice and strengthen governance

arrangements. The Reviewer makes a number of additional recommendations and in particular highlights the need for inter-Departmental communication and dialogue with the judiciary about thresholds for statutory and legal intervention to protect neglected children.

2. BACKGROUND AND CONTEXT FOR THE NATIONAL AUDIT

The Roscommon Child Care Case Inquiry

A review of neglect practice in Roscommon was commissioned by the National Director of Integrated Services Directorate in the Health Services Executive (HSE) and the Regional Director of Operations (RDO) Dublin Mid Leinster, as part of the coordinated response to the findings and recommendations of the Report of the Inquiry Team into the Roscommon Child Care Case (published in October 2010).

The Roscommon Inquiry considered the historical involvement of the former Western Health Board with a family from 1996 until the children were admitted to care in 2004. The Inquiry Team's findings were considered to be of national significance.

The Inquiry Team found that:-
'Despite the good intentions of the staff involved there was a failure to identify the extent and severity of the neglect and abuse suffered by each of these children'

In the view of the Inquiry Team factors which contributed to this failure to respond appropriately included:-

- The absence of meaningful engagement with the children
- Over-valuing the use of family support work in situations where child protection should have been an ongoing concern
- Inadequate assessment of the family circumstances and risks to the children resulting in an inadequate response to the ongoing and long-term effect of chronic neglect
- Gaps in interdisciplinary working including the absence of GP involvement at critical points in the management of the case
- Inadequate record keeping by Social Workers, Public Health Nurses and Professional Managers
- Inadequate opportunities for training and professional development including changes in legislation and practice and integrating the learning from inquiries and serious case reviews
- Decision making at case conferences which failed to challenge lack of progress against previous recommendations and confront parental attempts to deflect attention away from the core issues
- An absence of appropriate governance arrangements by management within the former Western Health Board, to monitor delegated functions and within Roscommon Community Care Area to quality assure the child protection system and its outcomes
- The absence of a nationally agreed assessment tool

The Inquiry Report includes among its many recommendations, the need for the HSE to develop national arrangements for auditing practice in neglect cases against agreed standards.

Recommendation 5.2.2 of the Roscommon Child Care Case Inquiry Report was that the HSE should develop and implement a national policy of audit and review of neglect cases commencing with Roscommon. The Inquiry Team envisaged a process of peer audit whereby experienced senior practitioners from another HSE area would undertake practice audits within an agreed national audit of practice framework. In so doing they could identify cases where drift rather than active planning and management had occurred and recommend any appropriate changes. It was hoped that this would identify best practice models for dealing with neglect cases and develop national standards to guide practice in the management of neglect.

In order to ensure that the review of neglect cases in Roscommon Local Health Office (LHO) proceeded as a matter of urgency, the HSE commissioned an independent consultant to undertake an Audit of Practice and a Review of the Management in cases of Neglect in September 2010. It was envisaged that this would represent a pilot for the national audit process.

National Audit of Neglect - Pilot Phase

Two other serious case reviews were due to report their findings in 2011 and it was subsequently determined by the National Director of Integrated Services Directorate that the pilot should be extended to include the Local Health Offices concerned. A Steering Group was formed to support the pilot project. This was chaired by the National Specialist Quality Assurance in the Office of the Assistant Director of Children's Services and initially comprised the National Specialist HSE who was a member of the Roscommon Child Care Inquiry Team and senior child care managers from Roscommon, Waterford and Dublin South East LHOs, as well as the Independent Reviewer. The group also benefited initially from input from the National Lead for Child Protection. During the course of the pilot audits membership of the Steering Group changed and latterly comprised the Regional Directors of Children and Family Services.

Terms of Reference

The Terms of Reference for each of the pilot reviews were:-

- To undertake a review of a proportionate and representative sample of neglect cases reported/notified to Social Work Teams

- To engage with managers at all levels and within relevant disciplines
- To identify strengths and challenges and make recommendations for future practice at all levels in the organisation
- To design a template to facilitate a national review of practice in neglect cases reported to Social Workers and enhance peer audit

The project proposal included an examination of the following factors, all of which provide the contextual background for a review of practice:-

- the legislative and policy provisions
- relevant publications and papers including previous audits and inspections in relation to neglect
- operational arrangements for the delivery of services
- an analysis of statistical data in relation to referrals and workloads

Process

The initial pilot took place in Roscommon in September to December 2010 with the feedback workshop in February 2011; the Waterford pilot took place from February to April May 2011 with the feedback workshop in September 2011; and the Dublin South East pilot occurred from May to July 2011 with the feedback workshop in October 2011. A review of progress occurred in Roscommon in May 2011 and is scheduled for Waterford and Dublin South East LHOs for May 2012.

The methodology employed in each area was as set out in the project proposal. This was further developed following the Roscommon pilot and the core elements of the review process included;

- **Initial Workshops to engage relevant managers, including:-**

  - Senior Management and the professional Heads of Services for all disciplines involved with children
  - Principal Social Worker (PSW) and Social Work Team Leaders (SWTLs)

  The workshops focused on the rationale for reviewing practice in neglect cases, identifying and building on current strengths, identifying challenges and considering how the Review could be structured to improve the overall service to children experiencing neglect and in particular chronic neglect.

- **Review of local policy and procedures and relevant documentation about activity**

A range of documents was examined in each area pertaining to local policies and to factors impacting upon the delivery of services such as staffing levels, workload activity and training.

- **Review of Cases**

  It was determined that a sample of 30 cases per LHO including the pilot cases would provide a representative cross section of neglect cases along the continuum of assessed risk. In total, files relating to 96 family cases and 5 relative and non relative carers were considered. In any circumstances where the Reviewer considered that action was needed to safeguard a child or young person this was communicated to the PSW and where appropriate to senior management. All cases of concern were followed up by the Reviewer.

- **Focus Groups**

  All disciplines working with children participated in focus groups and meetings were also held with external agencies such as An Garda Siochana, schools representatives, voluntary agencies and Guardians ad Litem.

- **Presentation of findings within workshops for General Managers and Heads of Services**

  At the conclusion of each pilot audit the Reviewer met with all of the local managers to present the findings and consider their implications for service delivery and future governance as well as the actions needed in the short term. These workshops were enhanced by the participation of Regional Leads for Child Care and the Chair of the National Steering Group.

- **Collation of findings agreements and recommendations in a report.**

  A report was provided for each of the pilot areas summarising the findings for each aspect of the Review and Audit. Following checks for factual accuracy the reports have been formally submitted to the General Managers for Roscommon and Waterford and to the ISA Manager with responsibility for Dublin South East. They have also been submitted to the National Specialist Quality Assurance in the Office of the National Director for Children and Family Services and to the appropriate Regional Director.

Composite Report

This report draws together the findings from the pilot audits, compares practice, identifies common themes, captures the learning and raises issues which need to be addressed at national, regional and local level. It also describes the methodology used in sufficient detail to enable other areas to review their multidisciplinary arrangements and audit the outcomes for children within individual cases. The standard audit template requires qualitative analysis of practice and results as well as a check of adherence to procedural requirements

As noted above the organisational context within the HSE was moving rapidly during 2011 and early 2012 and this created some challenges for the Reviewer in collating the findings across the three areas. Many of the recommendations from the first audit in Roscommon were already being put into operation and across the country management arrangements were changing in anticipation of the creation of the new Agency. It will be imperative that the impact of these positive structural and policy changes is appropriately monitored and that they result in quantifiable benefits for vulnerable children.

3 LEGISLATIVE AND POLICY PROVISIONS

The main legislative and policy provisions governing the protection of children in Ireland from abuse and neglect are summarised at Appendix 1.

They include:-

- United Nations Convention on the Rights of the Child (1989)
- Child Care Act (1991)
- Children First: National Guidelines for the Protection and Welfare of Children (1999; 2011)
- National Children's Strategy (2000)
- Agenda for Children's Services (2007)

Since its establishment in 2005 the HSE has actively sought to address the variation in policy and procedures across the country, through mechanisms such as the National Children and Families Steering Group. One of the most significant achievements of this group was the Social Work and Family Support Survey of 2008 which collated comprehensive information about children's services across all HSE Regions (see Appendix 3).

The survey identified many challenges with the adequacy of existing arrangements and led to a national review of child protection arrangements, undertaken by PA Consulting Group the recommendations of which are included in Appendix 2.

During 2010-11 a systematic approach was underway to develop and roll out national policies and procedures for all aspects of children's services incorporating standard business processes and a national computerised information system.

The following section summarises the review of local policy and procedures in each LHO at the time of the pilots and demonstrates the variations which exist.

Local Policy and Procedures

Policy and Procedures in Roscommon LHO

Children and Family Services in Roscommon are delivered in line with Children First (1999) and there are detailed and appropriate Standard Operating Procedures (SOPs) for the management of all aspects of the family support and child protection process.

These include:-

SOPs for referrals, preliminary inquiries, and for notification of child abuse including neglect to the multi disciplinary Child Protection Management Team (CPMT) and for requesting a case conference. There are also SOPs governing application for a Court Order, preparation of Court reports and arrangements for transferring cases in and out of the locality. Other detailed SOPs deal with family support referrals, assessing the need for family support and plans for meeting assessed need.

These SOPs were developed by the former Principal Social Worker in 2000 and updated by the current Principal Social Worker and Child Care Manager in 2005. Copies of all the SOPs are available to each team in their local office. Induction training for new staff includes familiarisation with SOPs.

Annual audits of adherence to SOPs have been conducted to ensure compliance and concerns about non-compliance due to shortages of Social Work staff were reported in 2005. Detailed policy and procedures were also available in relation to each component of the Family Support Service including criteria, referral procedures and arrangements for review.

Policy and Procedures in Waterford LHO

Children and Family Services in Waterford are delivered in line with Children First and there are detailed and appropriate policies and procedures for the management of all aspects of the family support and child protection process.

These include:-

- HSE South (East) Guidelines Incorporating Children First "Child Protection and Welfare Process". This represents comprehensive working guidelines on all aspects of child protection and welfare processes from reporting concerns through preliminary inquiries, assessment, notifications to CPNS, strategy meetings, Child Protection Conferences and report writing. The Guidelines include a range of standard forms for each aspect of the reporting, notification and child protection conference processes.

Managers and staff also have ready access to a Child Care Legislation Resource Pack, compiled for Waterford Social Work Department by the Central Child Care Training and Development Unit. This comprises all relevant child care legislation including adoption and includes case law for example the Barr Judgement. A copy is held by each SWTL and new

staff are required to familiarise themselves with the legislative provisions as part of their induction package.

Additional Policies include:-

- A comprehensive Sub-Delegation instrument for Child Care and Family Support Services issued by the LHM in May 2009 clarifying which manager has delegated authority for a range of statutory functions
- Several memoranda issued by the PSW clarifying or augmenting existing procedures including guidance on authority to obtain legal advice, make applications to Court, place children with relatives, admit children into voluntary care and manage foster care placements at risk of breakdown

More recently there is good evidence of the Social Work Department embracing national policies in a comprehensive way and a clear commitment by the Principal Social Worker to ensuring that all staff are apprised of national, regional and local policies governing all aspects of their work. These include:-

- Induction of Social Workers Policy, October 2010. The Waterford PSW has produced additional guidelines and allocation of responsibilities for ensuring all new Social Workers receive appropriate induction training which were introduced in January 2011.
- National Child and Family Services Staff Supervision Policy (2009). A local supervision policy was implemented in January 2011
- National Business Processes for initial screening and assessment including associated computerised forms (2010)

The National Policy for Child Protection Conferences 2010 has been made available to staff via the PSW although at the time of the Review it had not yet been implemented as the CCM was seeking further clarification with regard to its operation.

Additional local policies (January 2011) had been provided for the Dungarvan Social Work Office comprising guidance on managing referrals, allocating cases, transferring and closing cases and referring families to other services.

Policy and Procedures in Dublin South East LHO

The Reviewer was not provided with an overall Policy and Procedures Handbook to guide child protection and welfare practice within Dublin South East LHO.

A document entitled "East Coast Area Health Board - Protocol for Child Protection Conferences" (ECAHB 2003) appears to be the only substantive procedure. This provides detailed guidance on the local implementation of Children First. It distinguishes the Child Protection Conference (CPC) from other interagency meetings, and establishes its key functions as being "consideration of the outcome of the initial assessment, and of further or comprehensive assessment" and ensuring that "the outline of a formal interagency Child Protection Plan is agreed". It indicates that the CPC will normally take place after both the Initial Assessment and the Child Protection Notification to the CCM (CPN1) have been completed. It states that CPCs taking place before the completion of the Initial Assessment will be exceptional. It also requires that CPCs should take place on all notifications to the Child Protection Notification Management Team (CPNMT) unless the CPNMT decides and records otherwise.

The Policy further requires Child Protection Review Conferences to be convened by the CCM on all cases which remain open to CPNS no later than 6 months, to review the Child Protection Plan.

Team Information Folders include a range of human resources and practice policies, including care planning and review, aftercare and fostering as well as information on good practice on recording and assessment, local resources and directories for approved therapists. An Induction folder for students and new Social Workers provided similar information in a more coherent format. Without an introduction and a guide for its use, it was difficult to understand the status of the information included in the Induction Pack, some of which was out of date. There was no reference to the National Induction Policy (October 2010) which is considerably more comprehensive than the information contained in the Induction Folder.

There was strong evidence of awareness among SWTLs of the new standardised business processes and these were accessed online. SWTLs preferred to use Statute Ireland for referencing copies of relevant legislation online and there was no hard copy of the key legislative provision evident within the Department.

Detailed local guidance for the Duty and Intake functions included responding to screening referrals, recording referrals on the Social Work Information System and conducting initial assessments of risk, criteria for allocation of cases which specifically includes cases of ongoing neglect and the procedure for transfer of cases from Intake to Long-Term Teams.

The requirement to undertake a formal Initial Assessment as envisaged in the Children First Initial Assessment Guidelines is not explicit and while the forms were available and used by one or two workers this was not standard practice. Social Work Managers were not clear as to whether staff had been given a clear directive for its use.

The new standardised business processes for the Intake Record and for Initial Assessment (2010) have been introduced across the Dublin Mid-Leinster Region with effect from 1 September 2011 and have recently been made available to Social Workers with detailed instructions for use. Arrangements are in place within Dublin Mid-Leinster to review the operation of the procedures after the first month to ensure practice is consistent across all the LHOs. This important development will have major implications for improving the management of new child protection and welfare referrals in Dublin South East.

Other examples of local procedures include:-

- A procedure for Governance of Early Warning Meetings (undated) issued by the General Manager to provide a mechanism for ensuring that senior management are aware of any children about whom there were unresolved child protection issues and challenges in meeting statutory responsibilities.
- A procedure issued in May 2009 by the CCM on Referral Pathways for Child Welfare and Protection referrals to the Primary Care Social Workers. This sets out the role of the Primary Care Social Workers in receiving, screening and assessing referrals and establishes the threshold criteria and mechanisms for passing these on to the Duty Social Work Team.

Conclusions

The significant gaps which exist in local implementation of national policy, as well as widespread variation in local policies have undoubtedly contributed to the divergent practices across the regions. Full implementation and monitoring of adherence to new national policies and business processes will be essential.

4 WHAT IS NEGLECT - RESEARCH FINDINGS AND LEARNING FROM INQUIRIES

It was important to set the pilot Reviews within the context of national and international information about the nature and impact of neglect and a summary of available research as well as the learning from inquiries is included at Appendix 3. This section was distributed as a paper at an early stage of the process in each LHO to help increase awareness of the impact of neglect for children and encourage a better understanding of the rationale behind the Review and the need for improvements in practice.

Neglect is the most commonly reported form of child abuse in Ireland, the United Kingdom the United States of America and Australia. It accounts for 27% of admissions to care in Ireland as recorded in the Social work survey (HSE 2008).

Research demonstrates that child neglect is a complex and multifaceted phenomenon resulting in serious short and long term consequences for children, which are often as serious, or more so than other forms of abuse.

Neglect often occurs alongside other forms of abuse and it can be difficult to separate out neglect and emotional abuse. The effective management of the omission by parents of appropriate care appears to challenge professionals more than the commission of acts of physical and sexual abuse on their children. This can leads to drift where children remain in unsafe circumstances and is compounded by definitional challenges which require neglect to be chronic and persistent before it meets the threshold criteria of significant harm (Child First 1999 and 2011).

While research on neglect is relatively limited, more recent reviews focusing on the impact of neglect on the physical and mental health of children have highlighted the significant long-term difficulties neglected children are likely to experience in every aspect of their lives, including their social, intellectual, educational and emotional functioning.

Inquiries and serious case reviews in the UK and Ireland (Laming 2003; 2009; Western Health Board 1996) have demonstrated that serious neglect can result in the death of a child and have challenged professionals to ensure their assessments are child centred and to avoid 'drift' in case management.

Research within Ireland, commissioned by the North Western Health Board in 2001 (Howarth et al, 2001; 2004), identified the need for an agreed assessment framework, effective case planning, adequate resources, and appropriate governance by senior management. Similar themes emerged from the Inspection of Child Protection Services in Northern Ireland (DHSSPS 2006). In particular the inspection found that excessive family support failed to bring about improvements for children whose basic needs were not being

met. Deficiencies in practice were exacerbated by inadequate governance arrangements in relation to workforce planning, supervision, support and audit of statutory responsibilities.

As noted in Section 1 a similar range of concerns was identified by the Roscommon Child Care Case Inquiry which triggered the need to determine the extent to which other children were in similarly vulnerable circumstances throughout the country. Consequently each of these aspects of practice and governance were considered as part of the process.

Focus groups with over 200 professionals from a wide range of disciplines explored the extent of understanding which existed in relation to neglect, the nature and level of training provided and the extent to which different disciplines and agencies recognised their responsibilities to contribute to arrangements for safeguarding children from the consequences of parental neglect. These focus groups also considered opportunities for strengthening existing arrangements

PART 2

FINDINGS

5 ORGANISATIONAL ARRANGEMENTS FOR THE DELIVERY OF MULTI-DISCIPLINARY SERVICES FOR CHILDREN AND FAMILIES WITHIN PILOT LHOs

Organisational Arrangements

This section sets out the organisational arrangements for the delivery of the HSE's multi-disciplinary services for children and families within the pilot LHOs. It considers pertinent factors such as geography, demographics and the nature and range of services available for children and families. It also considers staffing establishments and identifies some of the challenges within Social Work and other disciplines such as Psychology, Public Health Nursing and CAMHS which impact on the management of neglect cases.

When the HSE assumed the responsibilities of the former health boards in 2005, 32 Local Health Offices were established reflecting the former Community Care Areas, each with a Local Health Manager responsible for the overall management and development for services in their area. The 32 LHOs were divided into 4 Administrative Regions, each managed by an Assistant National Director who reported to the National Director with responsibility for all non acute health and personal social services, known as Primary Community and Continuing Care (PCCC) services.

Roscommon LHO is part of the HSE West Region, comprising Counties Roscommon, Galway, Clare, Mayo, Sligo, Leitrim, Donegal, Limerick and North Tipperary. Roscommon was previously part of the Western Health Board which comprised Roscommon, Mayo and Galway and some services are still managed on a cooperative basis.

Waterford LHO is part of the HSE South Region, comprising Counties Wexford, Waterford, Carlow/Kilkenny, South Tipperary, North Lee, South Lee, West Cork, North Cork and Kerry and was previously part of the South Eastern Health Board which comprised Waterford, Wexford, Carlow/Kilkenny and South Tipperary.

Dublin South East LHO is part of the HSE Dublin Mid-Leinster Region, and was previously Community Care Area 2, part of the former East Coast Area Health Board. The Region comprises Dublin South East, Dublin South City, Dublin South West, Dublin West, Kildare West Wicklow, Laois Offaly, Longford West Meath, South Dublin (Dun Laoghaire) and Wicklow. The identity as Community Care Area 2 still persists and as was the case in each of the other pilot LHOs, some services are managed on a cooperative basis because of their nature.

At the time of the Review all Heads of Services in each area including the Principal Social Workers and Child Care Managers reported to General Managers who had varying levels of experience of managing community care services. Each GM had around 20 direct reports which made it difficult for them to be available to all of them in a meaningful way. Each LHO had experienced an inquiry into the management of a serious child neglect case in their area and all three had systems in place for early alerts in matters of concern, including risks to children.

In Roscommon the Inquiry Team's report had been published and the LHM chaired a regular multi-disciplinary meeting to progress the recommendations. In Waterford child care professional managers met regularly with the LHM/GM to ensure compliance with national targets, address gaps in resources and respond to challenges with service provision. In Dublin South East the LHM (subsequently the ISA Manager) chaired a Child Care Review Meeting at which the Acting PSW and Acting Child Care Manager could alert senior managers to cases of concern including difficulties in sourcing appropriate placements for young people, such as beds in high dependency units.

Lead Local Health Manager

In 2005 each of the regions appointed a Lead Local Health Manager for specific care groups and service areas. This Lead together with the Leads from the other three regions acted in a representative role nationally to bring focus to specific aspects of that care group, to assist the HSE in adopting a national approach to discharging its responsibilities. The Lead LHM for Children and Families for each Region, along with the four full time Regional Specialists comprised the National Steering Group for Children and Families which was chaired by an Assistant National Director. This group was advisory rather than executive in nature and undertook extensive work in identifying the challenges and issues for children's services across the country. When it became apparent that there were vastly different staffing levels, workforce arrangements, policies and practices, it attempted to bring about standard national processes and systems.

Each LHM was assisted by a Regional Child Care Specialist who contributed to national projects and developments. The Lead would collate and represent the views of his area to the National Steering Group and reflect agreed policies and approaches back to the LHMs in the region through the mechanism of the monthly management meetings. Responsibility to implement national directives and policies rested with each operational LHM. Since January 2012 the former Lead Role in Child Care has been replaced with a full time management position of Regional Director for Children and Families, representing the Region within the evolving national structures for Children and Families Services. The former National Specialist for Child Protection has been appointed to the Regional Director position in HSE West and the former LHM for Waterford was appointed in HSE South. The LHM for Dun

Laoghaire has retained the Regional Lead in the new structures and until early 2012 was also the Area Manager for a virtual ISA for Paediatrics including hospital paediatrics and child health. He was appointed Regional Director for Dublin Mid Leinster in January 2012.

Integrated Service Areas

During 2011 the HSE embarked on a new organisational structure based on Integrated Service Areas (ISAs), involving larger geographical areas combining 2-3 LHOs and including management of both acute and PCCC services. It is anticipated that the PA Consulting Group recommendations (Appendix 2) for strengthening management and governance within children's services will be accommodated within the new ISA structures. Each of the 17 ISAs will have a Children and Family Services Manager with overall responsibility for local implementation of the national strategy for children's services and for managing the budget.

Accountability arrangements will be strengthened to ensure direct line management arrangements from Children's Service Managers through Regional Directors to the National Director. In early 2013 children's services will become part of the Children and Families Support Agency headed by a Chief Operating Officer.

The implications for the 3 pilot LHOs, is that Roscommon has amalgamated with Galway, Waterford with Wexford and Dublin South East with Dublin South and Wicklow to form ISAs.

Demographics

Roscommon LHO has the second lowest population and child population in Ireland with a total population of 58,768 and a child population of 14,503 (HSE Social Work and Family Support Survey, 2008). While the population of Roscommon has grown from almost 52,000 in 1996 to nearly 59,000 in 2009, due mainly to inward migration, this growth rate is below the regional and national average. Managers and staff in the LHO report an influx of families from other parts of Ireland, some of whom have availed of social housing and rural resettlement schemes. There is also a growing population of non Nationals living in the county. This phenomenon is consistent with the situation across Ireland as a whole and creates challenges for staff in all disciplines in overcoming language barriers and understanding cultural norms.

Roscommon LHO has several centres of population including Athlone, Boyle, Carrick on Shannon, Castlerea, Ballaghadereen, Roscommon town and Strokestown. It is however predominantly rural and staff often have to travel considerable distances to work with families, liaise with colleagues and attend meetings. Social work teams for children and families are based in Roscommon town, Boyle Health Centre and in premises on the

outskirts of Castlerea. Psychology services are based in Abbey Street, Roscommon and the CAMHS Team is based in Roscommon Hospital.

Waterford LHO does not coincide exactly with the Waterford County boundaries and takes in part of South Kilkenny. A small part of West Waterford falls within the South Tipperary LHO. Waterford LHO has a total population of 120,017 and a child population of 30,249 (2008 HSE Social Work and Family Support Survey). The child population represents 25% of the total population which is slightly above the national average of 24.4%. The overall population of Waterford LHO has grown from an estimated 111,443 in 2006 while the child population has also increased from 29,289 in the same period. This appears to be due mainly to a growing population of non Nationals including families from Eastern Europe and from Africa, especially Nigeria. In 2008 the total estimated ethnic minority population was 12,242 which represents 10% of the total population.

Waterford LHO has several centres of population including Waterford City, Dungarvan and Tramore. Services for children and families are located within the Community Care Centre, Cork Road, Waterford with a sub office in Dungarvan Hospital serving the West Waterford area. Foster Care Services are based in Johnston Industrial Park in Waterford City near the Community Care Centre. The CAMHS service is located within Waterford Regional Hospital and is adjacent to the Community Child Centre which offers an assessment facility for children who are alleged or suspected victims of child sexual abuse. This service covers the former South Eastern Health Board Area. Services for children with a disability are located in Waterford and Mitchell Street, Dungarvan. Public Health Nurses (PHNs), Physiotherapists and Speech and Language Therapists (SLTs) are located mainly within Primary Care Teams. Because of the geography of the LHO, staff often have to travel considerable distances to visit families.

The geographical area covered by Dublin South East is from Glencullen in the South to Sandymount/Irish Town and Ringsend in the North and from Leopardstown in the East to Ballanteer in the West. The area includes a densely populated urban/residential section stretching North from Dundrum and a rural more mountainous area stretching from Glencullen southwards. The LHO is divided in terms of social well being between greater affluence generally in the south and pockets of deprivation in the north. The LHO Headquarters is located in Clonskeagh Hospital near Ranelagh. The majority of community services are delivered through 10 primary care teams within 2 primary care networks one for the north section of the LHO and one for the south.

Dublin South East LHO has a total population of 110,487 and a child population of 20,400 (2008 HSE Social Work and Family Support Survey). The child population represents 18.5% of the total population which is considerably lower than the national average of 24.4%. While overall the age structure of Dublin South East appears broadly representative of the

national picture, there is a higher percentage of older people and of adults in the 25-34 age group than the national average and fewer children aged 0-14 than the national average.

In 2008 the total estimated ethnic minority population was 17,601 which represents 16.5% of the total population of Dublin South East. This is higher than average with the LHO ranking 12th in terms of the numbers of non nationals within its area. There are an estimated 18 different nationalities represented within the LHO.

All social work services for children and families, including the Duty and Intake Team are based within the Clonskeagh Hospital Site, near Ranelagh. Public Health Nurses (PHNs), Physiotherapists, Occupational Therapists and Speech and Language Therapists are located mainly within Primary Care Teams. The CAMHS service is provided by John of Gods Hospital through Lucena clinics located at Rathgar and Dun Laoghaire.

Service Provision

Services for children and families for whom neglect is an issue are provided by a range of disciplines within the HSE, mostly on a referral basis. The only disciplines which provide universal services for all children are Public Health Nursing and Community Medicine.

Public Health Nursing

Public Health Nurses provide domiciliary and clinic based services for all client groups. Public Health Nurses have access to all children through the notification of birth system. Mothers are visited within 48-72 hours of discharge and the assessment at that stage determines the visiting pattern thereafter. Core visits include the initial visit after birth and visits at 3 months, 7-12 months, 18-24 months and 3.25-3.5 years in line with the Programme of Action for Children Policy (HSE 2005). Well baby clinics are run in each area. PHNs attached to schools provide screening for junior infants and children in the 6th class within schools in their geographical area and respond to concerns raised by teachers including neglect.

PHNs work closely with Area Medical Officers in regard to immunisations and second tier developmental clinics. Any concerns noted by PHNs during screening are referred to appropriate professionals, including the Area Medical Officer and Speech and Language Therapists. Although most PHNs have not received any specific training on neglect, their professional training and guidance in the Programme of Action for Children assists them in determining when children should be referred to the Area Medical Officers.

There is a strong commitment within Public Health Nursing to ensuring that children are observed within their home environment and strenuous efforts are made in each area to follow up on the small cohort of children whose parents do not bring them for

developmental screening. Nurses will attempt to encourage attendance and follow up with home visits. Following a second non-attendance an official letter is sent inviting parents to bring the child on a specific date and generally if that is unsuccessful there would be a referral to the Social Worker.

In all 3 LHOs, PHNs and Registered General Nurses are supervised by the Assistant Directors of Public Health Nursing who are available for consultation as required. In Roscommon an Assistant Director post has been vacant since May 2009 and each of the Assistant Directors is supervising 25 staff. These numbers make national aspirations for monthly supervision unattainable. The entire management arrangements within Public Health Nursing in Dublin South East are characterised by acting up arrangements. The current Acting Director has been in post since January 2009 and all of the Assistant Directors are acting up to cover vacancies in the substantive posts. A number of business cases to stabilise the Department through substantive appointments have been unsuccessful.

The Director PHN is a member of the Child Protection Notification Management Team in Waterford and Dublin South East and this role is delegated to Assistant Directors in Roscommon. Assistant Directors attend Child Protection Conferences in each LHO.

Area Medical Officers

In the early 2000s the post of Director of Community Care (DCC) was abolished and many of the DCC roles transferred to General Managers and Child Care Managers. Up to that point DCCs chaired child protection conferences and provided medical leadership within the child protection process.

Nationally between 2003 and 2005 a Department of Public Health Medicine was established separate to a Department of Community Health Medicine. In each Local Health Office, Senior Medical Officer posts were established and a Principal Medical Officer was appointed within each former Health Board. The Principal Medical Officer is the medical lead for all Community Health Doctors in each region.

In Roscommon the initial team of a Senior Area Medical Officer and four Area Medical Officers (AMOs), has been reduced over the years to 3 AMOs. One of these posts was vacant from July 2010 for several months before a replacement was appointed. The Senior AMO post was lost in the moratorium of December 2007 and as a consequence there is no medical representation on the LHO's management team and no medical representation at CPNMT. Management supervision and support is provided by the Principal Medical Officer for Galway, Roscommon and Mayo who is based in Mayo.

In Waterford there are 3 SMOs in post who have experience in general practice and public health medicine. One of the SMOs has the lead administrative role and sits on the Senior Management Team. Additionally, there are a small number of sessional Community Medical Officers.

Within Dublin South East the Community Health Service is led by the Senior Area Medical Officer who has extensive paediatric experience. There are 5 (4 WTE) AMOs and with the current recruitment embargo vacancies are not being filled.

While the AMOs role varies somewhat from area to area they appeared to undertake a range of common functions including:-

- developmental checks for all children between approximately 7-12 months - PHNs will usually alert the AMOs/SMOs in advance in relation to any issues or concerns
- regular referral clinics to respond to PHN referrals in respect of concerns about weight and overall developmental issues
- referrals for children with specific developmental problems to Paediatricians. Children with global development delay and those who need any two services are referred to the Early Intervention Service
- medical examinations for children coming into care.

AMOs/SMOs are aware of their responsibilities under Children First and will attend relevant child protection conferences and/or provide reports to the Child Care Manager on request. Given the demands of the national community health targets and the non replacement of medical staff, the time available to support the management of child abuse and neglect is limited.

Specialist Services

Neglected children and their families may be referred to a number of specialist services all of which will have a role in promoting their welfare and ensuring their protection. Children First (1999) and subsequent guidance in the revised Children First (2011) indicates that while Social Workers have the lead role in child protection, all HSE employees have a responsibility in this regard.

Psychology Service

The aim of the Psychology Service is to provide comprehensive assessments and a range of therapeutic interventions to enhance functioning and psychological well-being and reduce psychological distress. Unlike PHN and Community Medicine it is almost impossible to find

common ground between the staffing levels, specialties and core functions of the Psychology Services which operate in the 3 LHOs, with the exception of a commitment to the Early Intervention Service for children under 5 with complex needs.

The Psychology Service in Roscommon is significantly under resourced compared to the other LHOs and at the time of the pilot comprised only 4 professional staff, the Head of Service who is a Principal Psychologist and three Psychologists who are assisted by an Administrator. As one Psychologist works exclusively in the Roscommon Early Intervention Team, this leaves only a Senior Psychologist in South Roscommon and a Staff Grade Psychologist in North Roscommon, which is equivalent to one psychologist per 30,000 population. There are no psychologists within CAMHS. This compares unfavourably with the rest of HSE West and two posts lost in the moratorium in December 2007, have not been replaced.

The department continues to process referrals for time limited assessments for children in care and focused short term pieces of work up to 6 sessions. Prioritisation includes early intervention, for example school-refusers; Children at risk to themselves or others; Children with severe debilitating conditions.

Lost posts and a reported 500 per cent rise in the number of children in care referrals, has resulted in serious restrictions with regard to the Roscommon Psychology Department's ability to respond to referrals and at the time of the Review there were long waiting lists of 180 children with a waiting time of 1-2 years on average. The following critical services from a child protection perspective could not be provided-

- Parenting capacity assessments
- Attachment assessments
- Investigation of abuse allegations
- Interventions with children who have been abused

In relation to the management of neglect, psychologists were concerned about the lack of capacity for parental capacity assessments, the number of Interim Care Orders made by courts rather than full Care Orders, the limited inputs from mental health professionals working with parents and the impact of the training embargo on professional development. Following the Roscommon Inquiry attempts to recruit through a national competition were reportedly unsuccessful and it is important that other initiatives are explored to ensure the service is fit for purpose.

In Waterford the Psychology Service is managed by a Principal Psychologist who since the recent loss of a second Principal post has assumed managerial responsibility for all the

psychologists in both adult and children's services. The current staffing at the time of the audit was around 16.5WTE psychologists working within various specialties including :-

- The Community Care Child Psychology Service (0.5 Principal Psychologist, 1.3 Senior Psychologists and 3.4 Staff Grade Psychologists) which has recently been reconfigured to align psychologists with primary care networks
- CAMHS -3 posts (1 Senior, 2 staff grade)
- Children's Disability Services (1 Senior and 2 staff grade posts) A further approved Disability Senior post is unfilled due to the recruitment pause
- Community Child Care Centre (1.8 posts). This is a specialist sub regional facility for investigating allegations of child sexual abuse.
- Adult Mental Health services (0.5 Principal, 1 Senior and 2 Staff grades)

Further work is needed to agree the criteria for each of the different strands and resolve interface issues such as which cases should be dealt with by Community Child Psychology and which should be referred to CAMHS.

The Head of Service works closely with the Child Care Manager and Principal Social Worker on a range of issues and she personally contributes to the Foster Care Approvals Committee and Residential Care Admission and Advisory Committees. The Head of Service is also undertaking baseline measures with children's emotional and behavioural problems when they come into residential care and developing arrangements for providing consultations with residential care staff.

The waiting list for community care psychological therapy is currently approximately 1 year and this is mitigated to some extent through drop in clinics and screening strategies. It is acknowledged that neglected children are the hardest to reach and are unlikely to be brought to drop in clinics. Psychologists recognised the need for parenting capacity assessments and were able to provide examples of how these are critical to decision making about care arrangements for children. Most of the psychologists are qualified to carry out assessments but waiting list pressures and experiences in Court have led to some resistance and tensions about taking on this work. Scope exists for working collaboratively with Community Child Care Leaders to support their assessments and there is also a need to set standards for quality assuring assessments by private providers.

In Dublin South East **t**he Psychology Service is managed by a Principal Psychologist and comprises of 12 Psychologists (11.3 WTE) who are attached to specific programmes of work as detailed below:-

- Primary Care (3 Basic Grade Psychologists)
- Child, Adolescent and Family Psychology (1 Senior Clinical Psychologist)

- National Service for Separated Children Seeking Asylum and Anti-Human Trafficking (1 Senior Clinical Psychologist)
- Disability Services including Early Intervention Service for Children 0-5 with complex needs (1 Senior Clinical Psychologist) and School Age Intervention Service (1 Basic Grade (0.5 WTE)
- Adult Mental Health (1 Senior and 2 Basic Grade Clinical Psychologists
- Old Age Psychiatry (1 Principal Clinical Specialist (0.8 WTE) and 1 Basic Grade Clinical Psychologist)

While the service in Dublin South East started from a low baseline it has developed in recent years to maximise the available resources. The service operates an open referral policy and prioritises referrals based on the assessment of risk with higher priority afforded to:-

- Clients of any age who are at risk of suicide or self harm
- those who are at risk of placement break down, including children in care.
- Children and families at risk, who require psychological assessment to inform case planning, particularly where there are statutory and /or legislative requirements.

The provision of family support is therefore a service priority for the Psychology Service in Dublin South East yet, as pointed out by the Head of Service, this group is not specifically identified within the National Service Plan for 2011, unless the children and family fall into one of the categories outlined above.

The Senior Psychologist in Child, Adolescent and Family Psychology provides an assessment and therapeutic service for children and young people experiencing a range of difficulties and interventions include individual assessments, group based responses, including parenting training, consultation with Social Workers and Family Support Services and participation in relevant professionals meetings. Two of the Primary Care based Psychologists also run the 'Triple P' Parenting Programme which has had good results and feedback.

Parental capacity assessments requested by the Social Work Department and from the Court are undertaken by Psychologists in the Child, Adolescent and Family Psychology Service and Primary Care Teams. The volume of requests for assessments is increasing and there are challenges in responding within the timescales required by the Court. Greater collaboration is needed between the Psychology Service, Social Work Department and Family Support Service in determining their respective roles in assessing parenting capacity; identifying how each professional can contribute to the assessment; and clarifying which specific aspects need to be undertaken by Psychologists. There are no formal arrangements in place to quality assure assessments commissioned from private providers in any of the LHOs.

Child and Adolescent Mental Health Service

While mental health services for young people are provided by HSE multi disciplinary teams in Roscommon and Waterford, they are contracted in from the voluntary sector in Dublin South East.

The Roscommon Department comprises a Consultant Psychiatrist, Registrar, Principal Social Worker, 2 Nurses (1 Clinical Nurse Manager and 1 Clinical Nurse Specialist), 1 Senior Speech and Language Therapist, 1 Senior Occupational Therapist and 1 Administrator. The Team has no Psychologist which is considered a major gap in the staffing complement.

The arrangements for supervision and accountability are complex. The Consultant Psychiatrist has weekly meetings by video conference with a Consultant in Galway. The Principal Social Worker has weekly meetings as part of the Child Guidance Team and participates in a peer review process every two weeks. He reports to the Consultant Psychiatrist whose Line Manager is in Galway.

It is difficult to determine the number of cases on their books in which neglect is a feature as the Department does not have a database which allows them to identify cases by category. CAMHS has recently agreed to take referrals directly from Social Workers and to assist with assessments. CAMHS professionals attend case conferences when workload permits and provided there is adequate notice. The Principal Social Worker, CAMHS has attended the CPMT biannual reviews which consider the challenges for the child protection system. Tribute was paid to programmes such as Family Welfare Conferencing, Marte Meo, and Boystown, which have clear models of working and have had good results with some neglecting families as well as to the work of Child Care Leaders.

Staffing for the CAMHS in Waterford comprises a Consultant Psychiatrist, 3 Psychologists, 1.6 Social Workers (0.6 Vacancy), 1 Acting Clinical Nurse Specialist, 1 Speech and Language Therapist and 2 Occupational Therapists. The national standard is 1 Consultant CAMHS Psychiatrist per 50,000 population and this would require a minimum of 2 Consultants in Waterford LHO. Although the need for a second team has been acknowledged and additional staff appointed towards this objective, plans to have a West Waterford Team have been frustrated by failure to appoint a second Consultant Psychiatrist.

Despite this there is no waiting list and the team saw 480 referrals last year of which 71% were accepted. Non attendances are low at 9% compared with adjacent areas with rates of over 20%. The team operates to a medical model, is based within Waterford Regional Hospital and operates under the title of Child Psychiatry Department. An outreach clinic is provided in St Joseph's Dungarvan. Referrals are accepted from GPs, Paediatricians and Adult Psychiatrists who will refer children seen in Accident and Emergency Departments. Social Worker referrals are not accepted directly. The team's role is evolving in terms of

outreach services to schools and community and more preventative approaches. The experienced Social Worker appointed last year is providing behaviour management groups for parents and is considering group work with children whose parents have mental health problems.

The priority is on seeing children quickly for assessment and cases are allocated at weekly departmental meetings. Given the resources, some children are screened out and referred back to other services such as psychology. Interfaces with the psychology service have improved since the appointment of a Principal Psychologist although there are still reported challenges in determining the respective roles of CAMHS and Community Psychology.

The Head of Department mirrored the frustrations expressed by other Heads of Service about the lack of communication and the absence of an appropriate forum to plan, review and integrate services for children across disciplines.

There is scope for facilitated discussions within the team and with their referral sources about the nature of the service (Child Psychiatry Department or Child and Adolescent Mental Health Service?) its mission, purpose, referral criteria and the direct services provided as well as opportunities for outreach and consultation. There would be real benefit in CAMHS providing training, consultation and support for Social Workers and Community Child Care Leaders engaged in direct work with children and adolescents who have experienced emotional and psychological trauma as a consequence of deprivation and neglect. As with other multi disciplinary teams, issues about supervision, authority and accountability need to be acknowledged and addressed in a transparent manner in keeping with agreed standards and protocols.

Amalgamation with Wexford, which already has 2 CAMHS teams as part of an integrated Service Area, will also bring fresh ideas and challenges as teams strive to achieve a common approach throughout the area.

CAMHS Services for children in Dublin South East are provided under a service level agreement with St John of God's Hospital which operates Lucena clinics in Rathgar and Dun Laoghaire. Several Heads of Services, as well as many practitioners, reported ongoing challenges with service provision including the fact that the CAMHS Service operates to a medical model and will not accept direct referrals from Social Workers. Feedback from parents is that the multi-disciplinary initial assessment with parents and children can involve identified several professionals, is not child friendly, can be stressful and often frustrates engagement. Other challenges include difficulties in securing appointments and frustration with the selection criteria applied by the Lucena Clinics, which reportedly leaves many children with emotional and mental health needs waiting over a year for an appointment.

Attempts to address these issues and secure a more responsive service which meets the needs of the young people in the area have been ongoing for some time and concerns have been escalated to regional level without any significant progress. Managers are aware of the risks involved when appropriate psychiatric and psychological assessments of vulnerable young people are not available to inform case planning and management. When feedback was provided to local and regional managers it was decided that it was inappropriate for the Reviewer to meet with the service provider and that the service level agreement should be reviewed by appropriate managers in Dublin Mid Leinster Region as a matter of urgency.

Speech and Language Therapy Service

The longer term benefits of early intervention with children by Speech and Language Therapists include better outcomes in school, lower drop outs rates and better chances of employment. This makes it important to ensure that particular efforts are made to engage with children in neglecting families whose parents do not comply with clinic attendance and/or follow up exercises. Speech and Language Therapy Managers reported that, within existing resources, there is no capacity to focus a dedicated provision on neglected children. The HSE priority to date has been on reducing waiting list and enhancing clinical standards of care. The staffing levels and the organisational arrangements for screening, prioritising and allocating services differs in each LHO.

In Roscommon the Speech and Language Department services the whole population with the exception of children with learning disabilities as therapy for that population is provided under a Service Level Agreement with the Brothers of Charity Voluntary Organisation.

The Roscommon Service is provided on a clinic basis for all client groups and children are seen with their parents in a clinical environment for one or two appointments to make an assessment and create a plan. If the parents either cannot or will not comply with the plan resulting other options are considered. There is an extensive waiting list and children in care are prioritised resulting in the waiting time being reduced by half. The Head of Service attends the CPMT and Speech and Language Therapists try to attend every child protection conference where they have an input. Therapists will often not know if children attending their clinics are known to Social Work or Family Support Services. Only about 10% of Speech & Language cases are estimated to have neglect as a feature and most of these are referred by PHNs. Children First Training is the only input Speech & Language therapists receive on child neglect.

The Speech and Language Therapy Service in Waterford comprises of 1 Manager and 21.5 WTE providing an integrated service for acute, PCCC and disability services across Waterford LHO. The Speech and Language Therapy Service is provided on a clinic or school basis with venues in Waterford Regional Hospital (WRH), St Joseph's Dungarvan and Tallow. Ninety

percent of all interventions are with children under the age of 10. There is a waiting list of approximately 500 clients at any time. The waiting time for assessment is 4 months and 60% of clients are admitted directly for intervention. Where long term regular intervention is indicated children are wait listed for therapy with waiting times in the region of 8-14 months depending on severity. Speech and Language Therapists are not routinely invited to attend child protection conferences and therapists will often not know if children attending their clinics are known to Social Work or Family Support Services unless notified by Social Work Services.

In Dublin South East the service comprises of a manager and 14 (WTE) Speech and Language Therapists (WTE) who up until 2011 spent over 95% of their time providing services for children. Referrals come primarily from PHNs and parents. While the ratio used to be approximately 50/50, in the past 2 years, up to 75% have been referred by PHNs who are referring children at a younger age. Referrals are in the region of 350 per year and all referrals come through the Service Manager who screens out unnecessary referrals through reassurance and advice. There is a half time post in preventative work and this therapist works closely with PHN groups and breastfeeding groups. There is also a group for young and vulnerable mothers, which encourages pre-verbal techniques. Speech and Language Therapists provide a number of parent groups, giving parents tools to work with their children. They also provide training for pre-school and primary school teachers, helping them identify and address specific language issues.

Following experimentation with a number of models for managing waiting lists, the service currently runs block assessments for a week at a time in local health centres three times a year. This means that the maximum waiting time for assessment is 4 months and this is in line with national targets. Parents' groups are timed to run after the block assessments. The waiting list for treatment is longer and it has not been possible to achieve the 4 months target for treatment.

In terms of ensuring that S&LTs will know when children are subject to concern about neglect or abuse the PHN referral may include this information or the S&LT Manager might pick it up when reading the referral. Often the manager will ring schools or PHNs for more information if they indicate that a Social Worker is involved. Therapists do prioritise children in care and will try to provide court directed assessments immediately. The Service Manager is a member of CPNMT and attends regularly.

The non-attendance rate for speech and language therapy in Dublin South East is minimal at around 1%. If children known to Social Workers do not attend the therapists will try and make contact with Social Workers/PHNs or schools to give them more opportunities. The low rate of non-attendance is attributed in part to the approach whereby parents are

engaged, listened to and invited to have a say in what they want from the service, as well as a contract with families, part of which specifies the need for attendance.

Physiotherapy Service

The relevance of Allied Health Professionals' involvement with children and adults in neglecting families became increasingly apparent as the pilot reviews progressed. Unfortunately specific information on these services was not collated in Roscommon although the Heads of Services contributed to the feedback workshop and to a subsequent review of progress against recommendations.

There are 4 Paediatric Physiotherapists in Waterford who handle all referrals for children under 18 years of age within the LHO. PHNs are the main referral source and often identify children at 1½ to 2 years when issues such as flat feet manifest. Referrals for children younger than 18 months are treated as urgent and assessed within two weeks. There is no waiting list for the Statutory Assessment of Need for children aged 0-5 whose disabilities meet the threshold for the Early Intervention Team. School services for children 5-12 are now being rolled out.

All of the Paediatric Physiotherapists have completed Children First Training but in the last 10 years have not brought any situations of abuse or neglect to the attention of the Head of Service. Paediatric Physiotherapists work within network areas alongside primary care physiotherapists who work within multi disciplinary network teams, responding to the full range of referrals.

A multi disciplinary working group on non attendance by children at specialist appointments in Waterford has encountered considerable complexity in devising a workable common approach. The group is making progress and there is now much greater awareness of the need to follow up with parents who do not take up services on behalf of their children, particularly those for whom there are other indicators of abuse or neglect.

In Dublin South East the majority of physiotherapy services are provided through the 10 Primary Care Teams with one therapist attached to each team. There is a part time Senior Paediatric Physiotherapist (14 hours per week) in the Early Intervention Service. The Head of Service for Physiotherapy has extensive community experience and there was evidence among staff of a good understanding of the impact of neglect on children, including the isolation and desolation experienced by neglected children and their sense of fear and uncertainty. Physiotherapists in Dublin South East run a range of services including co-working the "Ups and Downs of Parenting" Group with Psychologists to target mums with post natal depression. This group includes relaxation techniques and exercise. Therapists have also provided support for women with stress incontinence and pelvic girdle pain as

well as breast feeding support groups. This summer they provided a camp for children known to the service and their families.

The demographics of areas covered by each Primary Care Team vary considerably and while the physiotherapists in one area might only receive 5 referrals about children a year, children represent about 25 per cent of the caseload of the physiotherapists in Leopardstown due to the number of young families living in new housing in that area. The threshold for referral to the service is generally appropriate. Although physiotherapists see most children at clinics, they recognise the importance of seeing the home environment and provided examples of when home visits had been necessary and the insights this provided into the family circumstances and interactions. The non-attendance rates for paediatric appointments are low and if children are not brought to clinics the physiotherapist will whenever possible follow up with the PHN, General Practitioner and Primary Care Team or make a visit to the family home.

Although there has been no specific training on neglect all staff have completed Children First training and it is a requirement that this is completed within three to four months of taking up post. Physiotherapists have also had training on the HSE's policy on managing violence. There is a buddy system within the Department for both safeguarding and support, whereby staff have to make contact with their buddy at the end of each working day. Two of the Primary Care Teams identified children as an area of concern and organised a day's training on child abuse and neglect which was delivered by the Training Unit. A monthly staff meeting affords opportunity to raise issues of concern and staff can consult about individual cases with either the Senior Paediatric Physiotherapist who is very experienced and/or with the Head of Service. A regular journal club provides a mechanism for staying current with practice issues and for critical reflection. Each Physiotherapist has a personal development plan with targets, which is reviewed 6 monthly with the Service Manager.

Staff indicated that competent and articulate parents sometimes made demands on services which were unnecessary whereas children in neglected families were much less likely to present for treatment. The outcome physiotherapists sought was to provide a better service to neglected children by ensuring the service was more transparent, more equal and more responsive to the most needy children and families. Increased awareness of the extent and impact of neglect as well as confidence in their role in prevention was an important starting point for physiotherapists.

Current challenges include the fact that many staff have limited experience of working with children and families, and there are inherent risks to clients due to under staffing and staff changes as well as the absence of Senior Paediatric Physiotherapists. There was also an

acknowledgement that even within Primary Care Teams, multi-disciplinary sharing of information could be improved.

Occupational Therapy Service

Information was only obtained in respect of this service in Dublin South East where Occupational Therapists are located within the Primary Care Teams and work closely with parents and foster parents, usually within the home environment, to support them in the care of children with disabilities. In situations where the adult is the client Occupational Therapists recognised the need to give more thought to their role in terms of their responsibility for children within a household where the adult has the disability. Examples were given of adolescent children caring for a parent with a debilitating illness.

Occupational Therapists demonstrated a really good understanding of the elements of neglect, empathy with the experience of children living in a neglecting household and an awareness of the potential long-term consequences for children. Half of the Occupational Therapists in Dublin South East have completed Children First training and value the opportunity to co-work cases within the multi-disciplinary Primary Care Team. The challenges for Occupational Therapists in identifying and sharing information with regard to children experiencing neglect is that they do not know or have relationships with the Social Workers and Social Work Team Leaders. Their experience has tended to be that they get requests for information when Social Workers have concerns about a child but often do not get feedback. They recognised that training in specifically recognising neglect would be helpful and saw the need for more joined up thinking and working between adult health services and children's services.

Social Work Service

While legislation and policy places a statutory responsibility on the HSE to protect children from abuse and neglect and to promote their welfare, the lead responsibility for discharging these obligations falls to the Social Work Department. The following sections describe the organisational arrangements for the delivery of child welfare and protection services.

Staffing in Social Work Teams

The pilot audits identified major variations in terms of staffing and workload between the three LHOs. This is consistent with the findings of the Social Work Survey 2008, which for the first time collated information for the country as a whole, and demonstrated significant differences within and between regions.

Table 1 Social Work Staffing Levels per 1000 Children (2009)

	Roscommon	Waterford	Dublin South East
Population	58,768	120,017	110,487
Child Population	14503	30249	20440
Social workers per 1000children	1.10	0.86	0.95
Number of SWs	17	26.04	19.5

While this suggests that Roscommon was relatively well resourced in terms of population the information in section 6 below demonstrates that Roscommon had higher levels of activity in terms of rate of referrals, children notified to the CPNS, child protection conferences and children in care.

Extensive information about all aspects of the service has been collated in the Social Work Survey (2008) and has been taken into consideration in the allocation of new social work posts created as an outcome of the Ryan report. However at the time of the Review there was limited evidence of existing resources being reallocated within regions to attempt to address the apparent imbalances. This may be due in part to a lack of historical practice of reallocation of resources between LHOs. It may also reflect the view that the statistics collated for the Survey are not wholly reliable and that even the apparently better resourced LHOs are still short staffed in comparison with Northern Ireland and other countries in the UK. During the period of the review radical restructuring was taking place with the creation of a new Children and Families Support Agency to improve governance and ensure direct line accountability from the point of service delivery to the Chief Executive Officer. Under the change programme an extensive exercise is being undertaken regarding staffing levels and equitable resource allocation.

Arrangements for the delivery of social work services were also different in each of the 3 pilot LHOs and further changes were taking place during the course of the Review, in an attempt to achieve greater specialisation. The following sections report the situation as it existed while the Reviews were taking place.

Roscommon

In Roscommon in late 2010 there were three geographical teams, each providing the full range of children's social work services for a discrete geographical patch and led by a SWTL who reported to the PSW. The PSW was also responsible for a team of Child Care Leaders attached to social work teams and in the absence of a Fostering Team Leader, had direct line management responsibility for 2.5 WTE Fostering Social Workers. Despite the very significant growth in referrals to the Social Work Department and in the number of children

notified to the Child Protection Notification System (CPNS), there was no growth in the number of social work posts from 2005 until new workers were appointed in July - September 2010 as a consequence of the Ryan Report.

Table 2 Social Work Staffing Establishment Roscommon 2002-2010

Staff Grades	2002- 2005	2006- June 2010	July 2010 (post Ryan)
PSW	1	1	1
SWTL	3	3	3
SWs	9	9	15
Fostercare SWs	1.5	2.5	2.5
Adoption	0.5	0.5	0.5
Total	**15**	**16**	**22**

Approved staffing levels only tell part of the story and liaison with each of the SWTLs revealed the impact of staffing embargoes when posts were not replaced, and the negative consequences for service delivery when absences due to sickness and maternity leave were not covered. The detailed effect of staffing shortages is reported below to provide an insight into the contextual circumstances in which services for children including those at risk of neglect were provided.

The Castlerea Team

Since 2002 the staffing establishment for the Castlerea Team was 1 SWTL and 3 Social Workers and from the latter half of 2007 until 2010 the same SWTL and Social Workers were in post. There were however significant periods of sick leave during this time. The team was operating in overcrowded facilities within Castlerea Health Centre with no on site administrative support and without appropriate facilities for interviewing families, holding meetings and conferences, report writing and making confidential phone calls in relation to cases. They moved to more spacious alternative accommodation just outside the town of Castlerea in 2009 and an administrative assistant had recently been appointed.

The Team Leader post was vacant from April 2010 until one of the Social Workers acted up in June 2010 and continued to do so at the time of the Review. An experienced Social Worker left in April 2010 and the remaining Social Worker went on maternity leave in August 2010. Effectively therefore the Team has changed completely since April 2010. One of the social work posts has been filled by the transfer of an experienced Social Worker from another part of the LHO. The other two appointments in August 2010 were both newly qualified Social Workers with limited experience. Two additional posts have recently been funded. During June 2010 due to a combination of staff leaving and sickness absence the

Acting Team Leader was single-handedly covering a service which should have been delivered by 4 workers. This was an inherently unsafe arrangement.

The Roscommon Team

The Roscommon Team Leader had been in post for several years and staffing in the Team was consistent from about mid 2007 to late 2009 with the same three Social Workers in post. When one experienced Social Worker left in August 2009, the post was vacant for two months, filled on a temporary basis for four weeks, and vacant for six weeks before being filled for a further six months. The second post became vacant in April 2010, was filled on a temporary basis for four weeks, vacant for six weeks, filled again on a temporary basis for four weeks and was vacant for 10 weeks. Both these posts had been filled by newly qualified Social Workers in July and August 2010.

The remaining experienced Social Worker had periods of sick leave during this timeframe, leaving the team dangerously understaffed. Two additional posts were funded and filled in summer of 2010 with recently qualified workers.

The Boyle Team

The Boyle Team Leader was also very experienced and had managed the team of 3 Social Workers for many years. Although staffing in Boyle had been fairly consistent over the past number of years one post was vacant due to a long term sick leave for 10 months in 2005 and no cover was provided. Another post was vacant for 4 months from December 2009 to April 2010 when a worker left and there was no cover provided for this vacancy or for substantial sick leave during recent years.

Immediately following the review, Roscommon teams were being reconfigured to achieve greater specialism including the creation of separate teams for Duty and Assessment and Children in Care.

Community Child Care Leaders Team

The Community Child Care Leaders Service comprised a Team Leader and four experienced Child Care Leaders, two of whom worked part-time. Their work involved direct therapeutic interventions including work with children who had been sexually abused, children experiencing separation and loss, children who have witnessed domestic violence and those whose parents demonstrated addiction to alcohol and drugs as well as support for children in foster care. One member of the team was trained in investigative interviewing and all had been trained in the family preservation approach inherent in the Boystown Model. This

intensive model can be beneficial in promoting change with neglecting families but staff reported it was difficult to provide the recommended time inputs while carrying a full caseload.

CCCLs had good insight into the challenges in managing neglect which included other organisations advocating on behalf of parents sometimes to the detriment of the child's wellbeing, combined with an over emphasis on protecting the family unit.

Waterford

In Waterford there were 5 Social Work Teams, including specialist teams for children in care and foster carers. Three other teams provided the duty, intake, assessment and welfare functions for children and families in the city and throughout the LHO.

It proved difficult to trace the historical development and establishment of the teams due to the chronic instability created by the numerous acting arrangements at Head of Department level prior to the appointment of the current PSW in April 2008. Table 3 below demonstrates the social work staffing levels since 2006.

Table 3 Social Work Staffing Establishment, Waterford (2006-2010)

Staff Grades	December 2006	December 2007	December 2008	December 2009	December 2010
PSW	1	1 (Acting)	1	1	1
SWTL	3	4 (2.5 acting) (1 vac)	5	5	5
SWs inc Foster Care	15.65	21.04	24.04	32.1	32.1
Foster Care (inc in above figures)	SWTL + 3.0	SWTL + 3.3	SWTL + 3.3	SWTL + 6.1	SWTL + 6.1
Adoption	0	0	0	0	0
Total	**19.65**	**26.04**	**30.04**	**38.1**	**38.1**

The Children in Care Team

The Children in Care Team was established in 2006 and consisted of a SWTL, 4 Social Workers and 4 Child Care Leaders. Two of the Child Care Leaders were specifically working

in aftercare. This Team's objectives were to address the unmet needs of children in care, including providing them with an allocated social worker, undertaking statutory reviews and developing care plans.

Between the years of 2007-2010, the team had 3 different Team Leaders and a number of changes in Social Workers. In 2010 the Children in Care Team was expanded considerably with the allocation of Ryan posts and consists of 9 Social Workers, 3 of whom are situated in the Dungarvan office, and 1WTE Child Care Leader. Two other Child Care Leaders previously on the Children in Care Team were transferred to the Duty Team and to the Welfare and Protection Team in acknowledgement of the number of children in care on the caseloads of those teams. This strict criteria results in the Dungarvan and Waterford Teams having to retain responsibility for children in care under Interim Orders or shorter term Care Orders and the consequences of this are described below.

The consequences of the additional social work resources meant that at the time of this Review all children in care had an allocated Social Worker, and an up-to-date care plan, which was subject to regular review. The criteria for transfer to the Children in Care Team is that the child must be subject to a full Care Order until he/she is 18 and children in long-term voluntary care whose care plan envisages them remaining in alternative care until age 18.

Waterford Duty and Assessment Team

In July 2007 when the current SWTL was appointed the team comprised 1 SWTL, 1 Senior Practitioner (25 hours), the job share Social Work post at Waterford Regional Hospital, 2 newly qualified Social Workers, 1 experienced Community Child Care Leader and 1 full-time and 1 part-time Family Support Worker.

Although the policy at that time precluded having a waiting list, in reality the situation was reportedly chaotic with many unallocated cases and no systems in place for managing, processing and prioritising referrals. Since then there have been many changes in staff and periods of sick leave which seriously compromised the team's capacity to respond appropriately to the growing volume of referrals. From December 2009 to March 2010 there was only 1 SWTL and a part-time Senior Practitioner, making it impossible to respond effectively to referrals and resulting in only the most urgent and high risk cases receiving a service. As noted in Roscommon this staffing situation was untenable and resulted in many vulnerable children not receiving a service.

In April 2011, the team was fully staffed with 1 SWTL, 5.3 Social Workers including the job share post at Waterford Regional Hospital which is filled by 2 experienced practitioners, 1.3 Community Child Care Leaders and 0.5 Family Support Worker. The referrals had increased

from 311 in 2006 to 868 in 2010 and despite a number of blitzes on the waiting list, the team reported an extensive waiting list in April 2011. This included cases which had been screened and needed an initial assessment as well as cases which following initial assessment were awaiting allocation.

Dungarvan Team

This generic team covers the West of Waterford County and combines the functions of both duty and assessment and welfare and protection. The staffing circumstances of this team have been described as "chaotic" for a number of years and it is difficult to summarise the numerous changes and challenges reported by the current SWTL since her appointment as a Social Worker in Dungarvan in 2002.

In 2002 there was reportedly 0.5 SWTL, 2 Social Workers, 1 Community Child Care Leader, 5 Family Support Workers and 0.5 Foster Care Social Workers. There were numerous changes in 2004 and additional demands placed on the team in 2005 due to the increasing referral rate, Practice Teacher responsibilities, participating in residential inspections and running groups and early intervention initiatives. From 2005 to 2010 the SWTL post was still only half time and the Team Leader worked as a Social Worker, carrying a case load for the rest of the time. This was clearly an untenable and unsafe situation not least as regards supervision. In January 2010 the establishment was 0.5 SWTL and 4 Social Workers. However due to a combination of illness, maternity leaves, parental leave, staff training and staff transfers the situation throughout 2010 was reportedly chaotic and this was exacerbated by the fact that administrative support, at less than a half time post, was almost negligible.

The impact of the inquiry into the death of a child known to the Dungarvan Team has been significant in terms of the amount of time dedicated to interviews, both internally and with the Inquiry Team, the compilation of files and reports and attendance at numerous meetings.

The situation at April 2011 was that the SWTL post had been resolved as full time and there were 5 Social Workers on the team of whom 4 were newly qualified and had protected case loads. The team also comprised 1 (0.83 WTE) Community Child Care Leader and 1.87 Family Support Workers. The team were carrying a number of Care Order applications and children subject to Interim Care Orders. This involves considerable time in preparing reports, accessing specialist opinions and facilitating access arrangements as well as Social Workers and the SWTL having to be physically in Court on a regular basis waiting for cases to be heard.

While the national priority to ensure children in care have an allocated Social Worker has been addressed, it has not been possible to respond effectively to many of the duty referrals. Although initial screening takes place the waiting lists for assessment and for allocation have grown.

Waterford Welfare and Protection Team

Prior to the appointment of the current SWTL in September 2009 there had been no Team Leader for 18 months except for a brief period when a Social Worker was acting up. Support was provided by the PSW who managed waiting lists and held some team meetings and by two Acting SWTLs who provided supervision for approximately six months to the extent possible given their other responsibilities. The first challenge for the new Team Leader was to establish leadership and supervisory arrangements. There were 2 waiting lists for allocation including children and families who had not been in receipt of social work services for more than a year. The waiting lists were screened, subjected to initial assessment and allocated where appropriate. All case loads were reviewed and some cases were closed or transferred to other areas or organisations. The team carry responsibility for a significant number of children in care and as required by the PSW, have now carried out all outstanding requirements to ensure they are complying with statutory requirements for these children. All but 3 of the cases which met the criteria for transfer to the Children in Care Team were being transferred at May 2011. The Community Child Care Leader who took a career break in 2010 had not been replaced and this created a significant gap in the team's capacity to carry out direct work with children. This worker planned to return in May 2011 and in acknowledgement of the high numbers of children in care carried by the Welfare and Protection Team a Community Child Care Leader had also transferred from the Children in Care Team. It was anticipated therefore that by May 2011 the team staffing would be 1 SWTL, 6 Social Workers, 1.8 Community Child Care Leaders and 1 WTE Family Support Worker.

The main challenges experienced by the Waterford Welfare and Protection Team were similar to those in Dungarvan and included the number of cases where applications for full Care Orders have not yet resulted in dates for hearing, leading to regular appearances in Court for extension of Interim Orders, supervision of access including provision of transport, the reducing numbers and availability of Family Support Workers and the very limited administration support.

Foster Care Team

The Ennis Tegg Report (2006) reported on a review of services in Waterford and demonstrated that the Waterford Foster Care Team was significantly under resourced when comparing the ratio of Social Workers to Foster Carers across the South Eastern area, with 1

Social Worker to 43 Carers in Waterford as compared to, for example Wexford with 1 Social Worker to 27 Carers. The national recommendation is 1:32 for general carers and 1:20 for relative carers.

For several years it had been the practice in Waterford for Link Workers to attempt to support Foster Carers in the absence of an allocated Social Worker for each child in care, often responding to day-to-day crises. This seriously limited their recruitment capability. The team was expanded considerably in 2009, and the current establishment is 1 SWTL, 6.3 Social Workers and 1 Community Child Care Leader. The main challenge for the team at the time of Review was the recruitment, assessment, training and support of Foster Carers to create new places for children received into care and to sustain high quality ongoing placements.

Community Child Care Leaders

In April 2011 there were 7 Community Child Care Leaders (CCCLs), all of whom were qualified and had experience in residential care. They worked directly with children and young people on a sessional basis, forming relationships and developing trust. CCCLs were assigned to each of the Social Work teams, had developed specialism appropriate to the work of their teams and benefited from regular supervision by SWTLs. CCCLs' involvement in assessments at both initial and core level kept the focus on the child's needs and the parents' ability to meet those needs. Their role included assessments of attachments and relationships when there were concerns regarding sexual abuse and physical abuse. Some CCCLs worked closely with the Community Child Centre and with Community Psychologists and often undertook programmes of follow up work on protective behaviour (e.g. Stay Safe) and self esteem as recommended by the Community Child Centre. Three CCCLs were trained to provide the Triple P Parenting programme which has had demonstrated outcomes in improving parenting skills.

Dublin South East

In Dublin South East at the time of the review in May 2011 the Service comprised of five teams including a Duty and Intake Team, 2 Long-Term Teams, an After Care and Primary Care Team and a Foster Care Team. The Department also included a team of Community Child Care Workers. Line Management for the Family Support Service which was located within the Social Work office building was transferred from the Acting Child Care Manager to the Principal Social Worker during the course of the Review.

There was limited information available about staffing levels within the Social Work Department prior to 2008 due to the fact that most of the senior professional and general managers were relatively new with the exception of the General Manager who has been in

post since 2006. As can be seen from Table 4 below, there had been only limited growth in the number of social work posts until new workers were appointed in July-September 2010 as a consequence of the Ryan Report. While the Department gained a number of new posts it has also lost some skilled and experienced Social Workers over the past two years, with the result that at least 6 newly qualified Social Workers had protected caseloads. There have also been significant gaps between staff leaving and posts being filled, as well as posts uncovered due to sickness and maternity leave which has had an impact on service provision.

Table 4 Social Work Staffing Establishment in Dublin South East LHO (2008-2011)

Staff Grades	December 2008	December 2009	December 2010	December 2011
PSW	1	1 A/PSW	1 A/PSW	1A/PSW
SWTL	3	3.5 (1A/SWTL)	4.5 (1A/SWTL)	4.5 SWTL (1A/SWTL Vacant)
SWs inc Foster Care	16.59	16.59*	23.59	24.59 (2.59 Vacant)
SSW Practitioner Aftercare	1	1	1SSWP (Vacant) 1SW	1SSWP (Vacant) 1SW
Foster Care (inc in above figures)	7.09	6.09	7.09	6.09 (0.59 Vacant)
Adoption	0	0	0	0
Total	**21.59**	**22.09***	**31.09**	**32.09**

*The figure for social work staffing provided by the LHO for 2009 (Table 4) is higher than that reported in the Social Work Survey for the same year (19.5).

Duty and Intake Team

At the time of the review the Duty and Intake Team, comprised an Acting SWTL, 2 Duty Social Workers and 3.5 Intake Social Workers. Both Duty Workers had considerable experience and the Intake Workers included an experienced Social Worker, Senior Social Work Practitioner and 2 newly qualified Social Workers with protected caseloads.

Within the Duty and Intake Team there are 2 distinct functions as set out in local procedures. Two full time Duty Social Workers screen all referrals and those which do not meet the threshold for the Social Work Department are advised of alternative options and

details are kept in a ledger for statistical purposes. Referrals considered to be appropriate are checked against the Social Work Information System to see if the family is known, and are subject to consultation with the referrer and initial investigations including network checks with the PHN and GP. Homes visits are conducted to apprise parents of the referral, assess their response, see the child and obtain consent where appropriate to liaise with other involved agencies such as schools and playgroups. Services such as Adult Mental Health, Addiction Services and CAMHS all require consent before releasing information. Most referrals get a same day initial screening response and all are responded to within the same week. The SWTL meets with Duty Social Workers each week to review cases open to the Duty Team and prioritise cases for further work. The SWTL maintains a database of cases and within this there appear to be two waiting lists, one for assessment and one for allocation as well as an overview of allocated cases.

The 4 Intake Social Workers (3.5 WTE) are allocated cases that need further assessment and cases where procedurally other non statutory services will only become involved if the case is allocated to a Social Worker at the time of Review. The team operated in the context of two major challenges, namely the extent of court work and difficulties in moving cases to the long term teams. All of the Intake Workers were carrying full caseloads and because of the demands of court, for example children coming into care under Section 12 or children deemed to be at immediate risk of harm at the point of initial assessment, the team was "blocked". Consequently there has been a pattern whereby cases were "held on duty" rather than allocated and have not been progressed appropriately. A major frustration for the Duty and Intake Team was the amount of time spent in Court which during May 2011 was estimated to be about 50% of the team's overall time. The non-availability of the Team Leader due to court attendance was clearly impacting on the management of the duty system.

Long Term Teams

In May/June 2011 there were 2 Long Term Teams each with a SWTL and either 4 or 5 Social Workers and an Access Worker. These teams supported children and families who following initial assessment required ongoing intervention and further assessment. Many of the cases identified by these SWTLs were characterised by chronic neglect and it was clear that over time extensive supports had been provided. The caseloads of the long term teams included a significant number of children in care, some of whom were placed some distance outside Dublin. This created considerable demands in relation to facilitating and, when appropriate, supervising access. Access Workers facilitate contact between parents and children, often under quite stressful circumstances when children have been removed from their parents' care and need help with managing that separation. When supervising access it is important to create an appropriate balance between safeguarding the child from any adverse comments or behaviour and supporting appropriate activities and interchanges between

parents and children. Access Workers have an important role to play in professionals meetings and review meetings.

Foster Care Team

The Foster Care Team comprised 1 SWTL and 7 (6.09 WTE) Social Workers, many of whom have had substantial experience in both working with Foster Carers and in other areas of social work practice. The team has benefited from additional staff in the last two years which has made it possible for all relative and non-relative carers to have an identified Link Worker. There were a small number of outstanding relative assessments which needed to be completed and presented to the Regional Foster Care Committee.

The main challenge for the team was the recruitment, assessment and training of new Foster Carers to create places for the increasing numbers of children being received into care. They were disappointed that a considerable number of potential carers who had been assessed, have not proceeded. The Team recognise the need for a coordinated and ongoing recruitment strategy which is supported and funded at regional level in order to sustain the required level of carers.

The Foster Care Team works closely with the Long Term Teams to sustain placements and to address issues as they arise. In addition the Fostering Team works with the Duty Team to identify placements for children coming into care in emergency situations. The team provides ongoing training and support for foster families in Dublin South East.

After Care & Primary Care Team

This Team was headed by a part-time (0.5 WTE) SWTL who supervised 1.5 After Care Workers and 3 Primary Care Social Workers. Arrangements for supervision of the Primary Care Social Workers were subject of protracted negotiations with the General Manager. In the absence of national guidance it had not been possible to agree safe and appropriate governance arrangements locally for Social Workers in Primary Care Teams and positions falling vacant will apparently not be filled until protocols are in place. There were approximately 31 young people receiving an after care service and a further 5 young people who will be 18 years before the end of December 2011 would also need an aftercare service. Cases selected for review by this team demonstrated the commitment and expertise of the After Care Workers and the good longer term outcomes being achieved by some young people removed from chronically neglectful homes. With hindsight SWTLs were of the opinion that many young people should have been removed from neglecting families at an earlier stage.

Community Child Care Workers Team

There were 4 Community Child Care Workers (CCCWs), all of whom were qualified and had experience in residential care. They worked directly with children and young people on a sessional basis, forming relationships and developing trust. CCCWs were benefiting from regular supervision by the SWTL for the After Care and Primary Care Team. In the past there have been a number of supervision arrangements for CCCWs dependent upon capacity at SWTL level.

CCCWs' involvement in assessments at both initial and core level keeps the focus on the child's needs and the parents' ability to meet those needs. Their role can include assessments of attachments and parent-child relationships. All CCCWs are trained in the Incredible Years Program and Triple P Program and deliver these programmes on a rotational basis. CCCWs also run two Social Skills groups, one for children between 6 years and 8 years and the other for children between 8 and 10 years.

Community Child Care Workers can often be the main professional contact with a child and can have the most consistent and therapeutic relationship, yet sometimes are not routinely invited to reviews. Referrals come mainly from the Social Work Department although some Public Health Nurses and other disciplines within Primary Care Teams also make direct referrals. Some of the challenges reported by CCCWs and the Access Workers include not having a dedicated facility in which to meet children and having to carry materials and set up sessions within a range of facilities. Clinical rooms are unsuitable. New improved facilities have been identified for the social work service in a primary care centre due to open in late 2012 and improved access facilities will also be made available in this centre.

Family Support Services

There were marked differences in the nature, location, range and extent of family support services in the three pilot LHOs.

Roscommon

While services in Roscommon had evolved in a piecemeal fashion, all of the services were delivered and evaluated against models of practice in which staff were trained and supervised. Some detail is provided below of the services provided and while these need to be rationalised, many of them are capable of being replicated in other areas and any national review of family support services should consider adopting some of the models that have a proven record of success.

In line with national policy to support families to provide adequate care for children, Roscommon LHO provided a range of Family Support Services, most of which were coordinated by the Children Act Services Manager and accessed via a referral process. The overriding aim of the Roscommon Family Support Policy was to target families considered to be at level 2 and 3 of the Hardiker Model (Hardiker et al, 2002) through early and effective intervention, supporting families so that children's needs are met, risks to their well being are diminished, and they are able as far as possible to be maintained within the family.

There were three main elements to the family support services offered:-

- Enhancing parenting capacity through building rapport, providing parenting education, skills based training and understanding and meeting parents' own agendas and needs.
- Linking families to informal community services and indentifying relevant opportunities and supports within their local area. A range of community development projects and services were available in centres throughout the county run by both statutory and not for profit agencies.
- Individual work with children on areas such as self esteem, loss and separation, coping with domestic violence and other identified challenges. Services were tailored to meet identified needs and for example a group was provided for young people whose parents had mental health difficulties in response to recognition by professionals that this was one of the significant contributory factors to the care situation of a number of child. The group provided a forum for young people to share their experiences, discuss their thoughts and feelings and develop coping strategies. It provided insight into the impact on children in these situations with some children demonstrating significant adverse consequences while others appeared relatively unaffected. This demonstrated that individual resilience as well as the nature and severity of the illness were important factors in the extent to which parents' mental health impacted on young people.

In Roscommon a range of services were provided, all of which targeted families in which children were suffering the consequences of neglect. These included:-

- The Monksland Family Support Service in Athlone has been operating for more than 10 years. It provides both centre based activities and outreach services to families experiencing difficulties, building on their strengths and working in partnership with parents in order to reduce the risks to children and prevent avoidable entry into the care system. The project particularly targets parents who experience difficulty in meeting the most basic of their child’s needs, as well as fathers and young lone mothers. The service was designated a Springboard Project in 2005 and is based on the premise that families have the capacity to solve their own difficulties and should be supported in identifying informal resources. Family support work recognises the rights

and wishes of children as well as those of their parents. Similar services were provided by a Family Support Coordinator who had been in post since 2009.

- The Family Preservation Service (also known as Mol An Oige Project, Boystown Model and Building Skills In High Risk Families) is a short term, intensive, in-home programme to rebuild parental strengths and enhance parenting skills to prevent the placement of children outside the home. Workers complete an in depth ecological assessment of each aspect of family life including the individual, family, school, peers and community. A family support/treatment plan is drawn up in partnership with parents and takes account of the referrer's concerns about risks to the children and their needs as well as the parents' agenda and needs. The programme is based on the principle that all behaviour is learned so problematic behaviours can be unlearned and replaced with more functional behaviours. Workers can spend up to 10 hours a week in the family home working alongside parents to enhance their parenting knowledge and skills. This model is based on an American programme and 24 workers from a range of disciplines participated in the formal training in 2007 so that this approach could be used consistently by those providing support and therapeutic inputs to families and their managers. Only 14 of the 24 staff trained are still involved in the project. The programme is currently offered by the Monksland Family Support Project Workers and the Child Care Leaders, and some additional individual professionals in a range of disciplines, all of whom find it a challenge to meet the requirement to see families several times a week while managing a full case load.

  Statistics were provided to show that 38 families had participated in the scheme from its inception in 2007 to 2010 and there have been particularly good outcomes in a number of cases. Outcomes for families fall into two categories, those that were successful in removing the family from the child protection case conference system through addressing the referral issues and then those where the model showed evidence that there was no parental capacity to meet the children's needs. The project is being evaluated by the National University of Ireland, Galway with a final report due in 2011.

- Common Sense Parenting is a skills based parenting programme that teaches practical skills and effective ways to increase children's positive behaviours and decrease negative behaviours. In Roscommon it is open to all families with children living at home and those parents with substantial access to children in care. Programmes are provided at venues throughout the LHO as six x 2 hour group sessions.

- The Marte Meo Method is a video-based interaction programme that provides concrete and practical information to parents/carers on supporting the social, emotional and communicative development of children and adults in daily interaction movements. It

encourages adults to build children's language by naming actions as well as encouraging adults to be alert to their children's actions and words and allow them to lead on initiatives. A review of videos provided by CCCLs demonstrated how the model develops the child's language and confidence as well as enhancing the parent child bond.

While the Marte Meo Method is available to families throughout Roscommon, other therapeutic family interventions are limited in the south of the county.

- Two Family Support Workers (Family Aides) provide practical support for families, assisting with building routines. This service is particularly important in situations where children are being neglected as they can provide practical help and support, assisting with cooking, bathing and housework.

- The Home Management Advisory Service is unique to the former Western Health Board and assists parents with tasks such as budgeting, shopping and planning low cost healthy meals.

- A Family Welfare Conference Service was established in Roscommon in January 2002 and the Coordinator provides a county wide service. Family Welfare Conferences (FWCs) were predominantly convened in cases involving family support, child protection, and children in care. They operate from a strengths bases perspective whereby families are facilitated to create and develop their own family plans to address specific identified concerns identified by social workers or other professionals. Children can participate appropriately, if adequately prepared and properly debriefed afterwards.

  During the feedback workshop the Reviewer suggested that the Family Support Service in Roscommon was overly complex with specific processes for referring to each programme and that it was underfunded with inequitable access to services across the LHO. It was recommended that the range of therapeutic processes and models be evaluated in terms of cost effectiveness and outcomes for children and that services were streamlined with a common point of entry for all referrals.

Waterford

By contrast with Roscommon the extent of Family Support Services within Waterford was extremely limited. The HSE's Squashy Couch centre provided preventive counselling and antenatal and postnatal support for teenagers. The LHO provided funding for a small range of community based family support services which included community facilities such as Barnardos in Ballybeg and St Brigit's Family Resource Centre. Both offered a range of quality services and supports including crèche and play facilities, parenting education and support

and were held in high regard by PHNs and Social Workers as well as being perceived as a valuable resource within the communities they served. However there was limited liaison with the services and more neglecting families could have availed of opportunities to benefit from the centres. Barnardos had also been contracted to provide a Family Welfare Conferencing service specifically focusing on families with children with disabilities and this was still at an early stage of development. There was also a range of projects for adolescents at risk including a teenage drug prevention scheme and back to education supports. The LHO also funds a range of early years services allowing young children to access free day care places.

Family Support Workers (FSWs) were attached to each social work team and supervised by the SWTLs. Family Support Workers (FSWs) work alongside parents to teach a range of home making and parenting skills, providing a role model, support and encouragement for parents. This input is particularly important with neglecting families and provided there is a contract with parents with clear outcomes, can be a really effective form of intervention. Social Workers and other disciplines spoke highly of the FSWs and the service they historically provided. There was considerable concern about the extent to which the service has been eroded, due to embargos on recruiting replacement staff and more recently the demands on FSWs to provide transport and supervision for an increasing number of access arrangements for children in care with their families of origin. The staffing complement at the time of the Review was 8 part time FSWs (4.84 WTE) with one FSW almost totally dedicated to transporting children to and from school and access with a total time commitment of around 7 hours a day.

Dublin South East

In Dublin South East the Family Support Service was managed by a Coordinator whose post was graded at Professionally Qualified Social Work level and despite the level of supervisory responsibilities, efforts to have it re-graded as a Senior Practitioner Post in 2001 were unsuccessful. The team comprised 7 staff including I full time FSW, 2 FSWs each contracted 20 hours per week and 4 FSWs each contracted for 8 hours per week. All of the FSWs regularly worked hours in excess of their contracts and attempts to increase contract hours were unsuccessful. FSWs had a range of relevant background experience including Special Needs Assistant in a public school and a variety of community work and voluntary work roles. The Family Support Coordinator provided regular monthly supervision for each FSW and was both available and accessible.

Because of the geographical catchment area covered by the LHO, families are referred from across the various socio-economic spectrums and this provides the FSWs with opportunities to work with families and children with a variety of presenting needs. A breakdown of 28 new referrals for the first 6 months of 2011 indicated that 15 came from Public Health

Nurses and included support for families experiencing physical illness, child developmental delay or who needed parenting support in situations such as multiple births. There were no overt child welfare or protection concerns in these families. The remainder of referrals including child welfare and protection concerns came from a variety of sources including Social Workers, Psychologists, a Home School Liaison Officer, and child and adult mental health services. In some of these cases there were challenges with engaging families despite the professionals recommending family support to achieve better outcomes for children. In 3 situations the service was declined by parents and in another it was withdrawn after non-engagement following the setting up of a support contract.

FSWs enjoyed the challenges of working with children in different families and circumstances and the opportunity to help parents appreciate their children, promote attachments between parents and babies and make a difference in the lives of children. FSWs who were in post in 2006/2007 completed a Marte Meo communication skills training course. The sessions covered supportive communication, developmental problems, analyzing film material of themselves with families and looking at what supports are required to assist and activate development in daily communication moments. Ongoing training is encouraged and supported and the techniques are useful in helping parents to establish a positive cycle of communication with their children. The summer project which has run annually since 2004 takes place for one week in August and caters for children aged 4 to 10 years, identified from within the social work team as those children most in need of a summer camp with daily activities.

FSWs were asked to identify families where their intervention had brought about significant change in families. They identified a number of scenarios, most of which involved non-nationals and families who were challenged by serious health issues including a mother who was wheelchair bound and had no extended family support. The challenges of working with families with different cultural and religious beliefs and practices included a refugee mother with no English and a child with severe autism. Coordinated support from across disciplines combined with the mother's motivation to do what was best for her children resulted in excellent outcomes. Understanding and respecting the family's cultural and religious traditions was an important part of gaining their trust and working successfully with them.

FSWs reflected that most of the successful outcomes were not in child neglect situations but in situations where parents who were motivated to care for their children had to overcome extreme hardship. They recognised that it is often more difficult to achieve positive change in neglect cases and they identified families where despite years of involvement there had not been adequate progress. The most frustrating situations identified by FSWs include those where, despite ongoing and protracted intervention, there have been no improvements in the children's circumstances. It can sometimes be difficult to determine when neglect is so serious that the children's safety is compromised and workers have to

guard against colluding with parents. A support plan is devised for each family identifying tasks that need to be completed and establishing the roles and responsibilities of the FSW, the parents and the referrer. Many families can demonstrate they know what to do but do not take responsibility for carrying out their parental tasks on a consistent basis, such as ensuring a structure for meal times and providing basic nutritious food, ensuring they get up on time to get children to school in the morning and consistently taking them to nursery and school. When workers have such limited time with families it is frustrating when parents cancel or are not at home for the FSW's appointment. There is a policy of making at least 3 attempts to visit a family before the referral agent is informed that the service is being withdrawn.

In Dublin South East the Family Support Service worked closely with the Social Work Teams and challenges arose in working with families with no allocated Social Worker as there was no consistent worker with whom to liaise in regard to agreeing and reviewing contracts with parents. The shortage of foster carers was also a factor in determining whether to bring children into care and FSWs identified challenges with the care provided by some relative carers.

Family Support Workers felt the service could be strengthened by making more specific agreements with parents, setting out the outcomes required with rewards for achievement; holding families more accountable; and improved coordination through child protection conferences/core groups with clarity about who is taking responsibility for making sure things are followed through.

In line with national policy to support families, Dublin South East LHO also provides funding for a small range of community based family support services. Projects included community facilities such as the White House in Ballyogan afterschool project. Extern provides activities, mentoring and support services for adolescents which have contributed to positive outcomes for a number of young people. The LHO also funds a range of early years services allowing children to access free day care places.

Conclusion

The range of supports available to support children and families where neglect is a concern varied considerably between LHOs and even within LHOs access is dependent on where clients live and availability of services and transport. Services within Roscommon were generally more structured and were based on programmes which were subject to ongoing validation and evaluation. As family support within the home is perceived to be one of the more effective interventions with neglecting families, it is important that these services are properly evaluated in each of the areas.

Feedback from family support staff in a variety of settings provided graphic descriptions of the nature of daily living for children in chronically neglecting families. Workers expressed frustration at parent's lack of motivation to provide good enough care even with extensive supports. Workers were also frustrated by the repeated chances given to parents despite the lack of improvement.

FSWs often have the greatest understanding of the reality of life for neglected children and their voices which very often echo the voices of children must be heard at multi-disciplinary fora and must influence the decision making.

Impact of Staffing Issues on Services and Outcomes for Children and Families

The rationale for recording staff shortages across the Social Work Department including social care staff and family support services is to ensure recognition of the impact on the quality of service provision. This is discussed further in Section 7.

Staffing challenges and their consequences for the management of child welfare and protection cases were frequently brought to the attention of senior management locally regionally and nationally. Concerns about deficits in services were reported regionally and nationally via the interim data set returns and through the Annual Service Plans and Section 8 Reviews. Information was also documented in the National Social Work Survey (2008) which highlighted the extensive variations within Regions and recorded thousands of unallocated cases across the country. The survey indicated for example that one area had an overall social work caseload of 676 and 17 social work posts as compared to another area with a caseload of 475 cases and 44.4 social work posts. While some areas had no waiting lists for allocation others had several hundred wait listed cases.

A review of correspondence between local and regional managers in two of the pilot LHOs over the last decade demonstrated evidence of extensive efforts to highlight the inadequacy of available resources and illustrated well documented cases to secure specific posts necessary for the achievement of the service plan and for compliance with statutory obligations to children.

Identified concerns included examples of the actual and potential detrimental impact on children and families of historical embargos on staffing and not filling social work posts, including cover for sickness and maternity leave. The potential for foster care placements to break down through lack of support for children in care and their foster carers, the inability to assess child protection notifications in line with Children First and the numbers of unallocated cases on waiting lists for a service were all documented.

In October 2005 the National Standards Authority in Ireland which undertook an annual audit in Roscommon highlighted inadequate resourcing within the Social Work Department and how this impacted on support services to children in care and vulnerable families. The authority warned that failure to implement a plan of corrective action would potentially result in the suspension of registration. Only one additional Social Work post was created in response to this audit.
Attention was also drawn to the stress experienced by Social Workers due to staff shortages, increasing referral rates and high caseloads and about a need to exercise the employer's duty of care to ensure staff were adequately supported and supervised. In 2010 it was reported that average caseloads in Roscommon were 30-35 which was almost double the PA Consultancy report recommendation of 17.5-18.5 cases per worker. Limited family support services and inadequate administrative support and office accommodation were raised as a concern on several occasions.

Similarly in Waterford an internal report (Ennis Tegg 2006) concluded that Waterford Department as a whole and each team within it was significantly under resourced. The reported consequences of under resourcing included:-

- Only cases deemed to be emergency child protection were being assessed
- Cases were being waitlisted due to inability to carry out initial assessments which in turn led to children being at risk of/or subject to abuse
- Non intervention in cases where families are identified as needing support
- Failure to meet Children First obligations
- Children in care not being allocated
- Foster Carers not having Link Workers and placements not being adequately supported or monitored
- Reduced opportunity for supervision

The Report concluded "at present the HSE in Waterford is not in compliance with the Child Care Act 1991, the Child Care Regulations, the National Standards and the Children Act 2001. Compliance with Children First is also minimal in many respects and current resourcing levels are leaving children at risk of serious harm."

Responses from senior management in both LHOs did not identify funding for additional posts and suggested redirection of internal resources into the child care budget as a possibility. Despite ongoing negotiations the situation with regard to mitigating risk remained unresolved. There appears to have been no tradition of reallocating resources within regions and indeed it was not until the Social Work Survey of 2008 that substantive data was collected to compare staffing levels and workloads across the regions and throughout Ireland.

Reference has been made above to staff absences due to maternity and illness and to high staff turnover partly as a result of the national recruitment arrangements which can result in workers having to relocate from temporary posts in areas which have vacancies to permanent posts in other LHOs. Periods when cases are not allocated and frequent changes of Social Workers has a detrimental effect on the relationships with a family and children and the need to postpone family support meetings and child protection conferences can have a damaging effect on the overall outcomes of cases. Effective social work with families requires a relationship of trust which takes time to develop and children have reported elsewhere their frustration at having different Social Workers and having to 'go over the same things again and again' (Inspection of Child Protection services in Northern Ireland - December 2006). In the absence of staff, cases referred to the Social Work Department by other professionals cannot be allocated and this leads to waiting lists for abuse and neglect reports to be assessed and investigated. Team Leaders must continuously juggle resources and make decisions about risk management. This includes deciding which families do not meet the threshold for services.

The pressure on managers within the Social Work Department to manage competing priorities without access to adequate resources was significant and there was limited evidence that senior management at any level in the organisation fully understood the risks to individual children or the corporate risk of not adhering to statutory obligations. It was not until 2010 that several additional Social Workers were appointed following publication of the Ryan Report.

6 ANALYSIS OF CHILD PROTECTION AND NEGLECT ACTIVITY

This section examines the available statistics for each LHO, provided at the time of the pilot audits in late 2010 to July 2011, in an attempt to facilitate understanding of the extent of referrals categorised as neglect and how these were managed.

Referrals to the Social Work Department

Table 5 Comparison of all Referrals including Neglect Referrals in the Pilot LHOs (2005-2009)

Referrals	Roscommon Neglect	Roscommon All	Waterford Neglect	Waterford All	Dublin SE Neglect	Dublin SE All
2005	77	358	55	348	86	576
2006	146	541	236	602	87	1051
2007	163	922	176	867	92	705
2008	271	1146	206	840	85	653
2009	298	1139	230	1109	N/A	N/A

As can be seen from the above table referrals in Roscommon and Waterford have more than tripled in the period 2005-2009. This is also true of those referrals which are categorised as neglect. Despite the fact that the population of Roscommon was half that of either Waterford or Dublin South East the referral rate for Roscommon for all referrals including child protection and welfare cases has been higher since 2006 than either Dublin or Waterford.

The number of neglect referrals within Roscommon rose considerably in 2008/2009 and the number of referrals in both Roscommon and Waterford was significantly higher than Dublin South East. The reliability of the statistics for Dublin may be questionable as the figures do not follow any trend, more than doubling between 2005 and 2006 before dropping again in 2007 and 2008.

The Social work Information System (SWIS) system has been operational in Dublin South East since 2005 and while it has several advantages, a frustration expressed by managers is that it captures information on families rather than on individual children. Figures for years 2005 to 2008 continued to be collected within Dublin South East on a child basis as there was a local resource in place to collate these statistics. Since that member of staff is no longer available, figures since 2009 are based on the numbers of families referred and cannot be compared with activity for previous years.

The next tables examine the proportion of neglect reports that are referred to CPNMT and the numbers that are included on CPNS. Attempts to collate this information were riddled with challenges as the information collected and the manner in which it is collected and retained varied considerably in the LHOs. Some aspects of the information sought were not routinely collected and was only available through liaison with the administrators of CPNS and a review of their databases.

While the reliability of some of the information remains in doubt, the tables raise many questions about the variations in the thresholds and arrangements for neglected children accessing the child protection system. Ensuring that relevant information is collated and analysed in a consistent manner which informs service planning at national, regional and local levels has already been agreed as a priority by the Office of the National Director of Children and Families Services.

Operation of Child Protection Management Teams and Child Protection Notification Systems

This section considers the operation and levels of activity in each of the pilot areas in relation to the notification of neglect cases to CPMNT.

Roscommon

Table 6 Neglect Reports notified to CPNMT in Roscommon 2005-2009

Year	Number of Neglect Reports	Number Presented at Child Protection Management Team (CPMT)	Number Notified to Child Protection Notification System (CPNS)
2005	77	58	30
2006	146	133	50
2007	163	101	58
2008	271	107	77
2009	298	171	131

These figures demonstrate that a significant number of children referred due to concerns about their neglect are referred to CPNMT (referred to as Child Protection Management Team {CPMT} in Roscommon). While the percentage of neglect cases presented to CPMT has varied considerably from year to year, with a significant increase in 2009, the trend has been for an ever increasing number of children to be notified to the CPNS as a consequence of neglect. This figure rose from 30 in 2005 to 131 in 2009.

CPMT in Roscommon has been operational since 2000 and meets twice each month, with one meeting held in Roscommon town in the south of the county and a second meeting in either Boyle or Castlerea, alternating between the 2 offices in the north of the County. This forum is chaired by the CCM and the Children Act Services Manger deputises when required. Members include the Assistant Directors PHN, a Psychologist, the Head of Speech and Language Therapy, PSW and the Children Act Services Manager, who coordinates the range of family support services in the LHO. Up until 2002 the Senior Area Medical Officer was a regular member of CPMT and since that post became vacant there has been no regular medical input. The Team Leaders and Social Workers present new cases for consideration and bring existing cases to CPMT for review.

The determination as to which cases are presented to CPMT is made by the SWTL in conjunction with the allocated Social Worker on the basis of an initial assessment. The initial assessment is presented by the Social Worker to CPMT and the SWTL sets out the proposed course of action. Advice is given as to case management and a decision made by CPMT as to whether the case should be notified to the Child Protection Notification System, which automatically triggers a Child Protection Conference, which is the decision making forum for acceptance on to the CPNS. Cases which are not notified to the CPNS will either be closed, referred for family support or continue to be managed by the Social Worker with inputs by other professionals.

Waterford

Table 7 Neglect Reports notified to CPNMT in Waterford 2005-2010

Year	Number of Neglect Reports	Number referred to CPNMT	Number Accepted on CPNS in year
2005	64	46	33
2006	55	20	11
2007	236	28	27
2008	176	13	13
2009	206	5	N/A
2010	230	13	N/A

The percentage of neglect cases which have been referred to CPNMT has varied considerably from year to year as noted in table 5 above and the reasons for this are not clear. What is significant is that while two thirds of all neglect reports in 2005 were referred to CPNMT and in 2006 almost a third, it appears that less than 10% of the increasing numbers of neglect reports have been referred in recent years. In 2009 only 5 out of a total of 206 children reported to the Social Work Department for neglect were referred for

inclusion on the CPNS. It is also apparent that in 2007/8 virtually all children referred to CPNMT have been included on the CPNS and this suggests that the decision-making around inclusion on the CPNS is actually being determined at SWTL level. This is due in part to the number of cases on a waiting list for allocation for initial assessment by a Social Worker. As cases are not considered by CPNMT without an initial assessment it is not possible to be confident that all children who meet the criteria are being discussed at CPNMT. This concern was raised by the former Acting PSW in reports provided to senior management in 2007/8 and the situation does not appear to have been resolved.

In Waterford CPMNT is chaired by the CCM and members includes the Assistant Director Public Health Nursing, a Senior Psychologist and the PSW.

CPNMT determines whether a child is accepted onto the CPNS and under which category. It also determines an appropriate timescale within which cases should be reviewed and indicates a review date to the referring SWTL. Discussion about the CPNS review activity demonstrated that due to workload pressures, there are delays with regard to Social Workers providing CPN3 update forms and reviews not proceeding until these are available. An analysis of cases open to CPNS in February 2011 suggested that several children on the CPNS had not been subject to a review in over a year and local and regional managers were alerted to the need for this situation to be addressed.

Although scheduled to meet each week with the exception of the third week in the month, CPNMT met only once or twice a month in 2010/2011. In March 2011 CPMNT enlisted support from the Regional Child Care Training Unit of HSE South East to facilitate a review of its purpose and function as well as the roles of its members. This confirmed that arrangements in Waterford were broadly compliant with the HSE South East Guidelines and it identified that CPNMT needed to reach agreement about membership, the acceptability of designates and the need for a quorum at each meeting. Since the facilitated review with the Training Unit, action has been taken to strengthen administrative support and provide a more detailed record of case discussions.

Dublin South East

Table 8 Neglect Reports notified to CPNMT in Dublin South East (2005-2010)

	Number of Neglect Reports	Number referred to CPNMT	Number Accepted on CPNS in year
Year	86	13	13
2006	87	30	30
2007	92	18	18
2008	85	3	3
2009	18	17	17
2010	41	13	13

All CPNMT notifications are child based. Figures for reports in 2009/10 are inconsistent as the information from SWIS is based on the number of families. There was also considerable discrepancy in Dublin South East between the figures held on SWIS and those held by the CPNS administration. As can be seen from table 8 all of the children presented at CPNMT for neglect were accepted on the CPNS and the annual figure has fluctuated considerably.

CPNMT in Dublin South East is chaired by the Acting CCM and comprises the Acting PSW, Senior Area Medical Officer, Principal Psychologist, Acting Director PHN and Speech and Language Therapy Manager and is attended by SWTLS. Although CPNMT is scheduled to meet once a month and a review of the minutes indicates that it met on 8 occasions in 2010. Attendance was generally good and the most regular attendees were the Acting CCM, Principal Psychologist and Acting PSW.

In Dublin South East CPNMT determines whether a child is accepted onto the CPNS and under which category. It also determines an appropriate timescale within which cases should be reviewed and indicates a review date to the referring SWTL. Systems are in place to ensure that children open to the CPNS are subject to regular review and CPN3 update reports are provided in relation to each child scheduled for review.

Table 9 Number of Children Open to the CPNS as at 31 December 2010 by Category of Abuse

Category	Roscommon	Waterford	Dublin South East
Neglect	33	6	15
Emotional	15	5	1
Physical	4	8	3
Sexual	3	18	0
Total	**55**	**37**	**19**

Table 9 demonstrates that at the end of 2010 the number of children open to the CPNS in Dublin South East was relatively low. Figures for the other two pilot sites were considerably higher with almost 3 times more children open to the CPNS in Roscommon. A breakdown by category of abuse demonstrates that while neglect was the most common reason for children's inclusion on the CPNS in Roscommon and Dublin South East, sexual abuse was the highest category in Waterford.

Child Protection Conferences

Children First (1999) requires a Child Protection Conference (CPC) to be held *'when it appears on the completion of an initial assessment that a child is at ongoing risk of significant harm'* and *'when decisions of a serious nature are being considered which require the input of a number of professionals from different disciplines and agencies'*
The conference provides a forum for all the professionals working with children and their parents, as well as the parents and the children themselves, to come together to consider the risks and concerns identified, explore the family's strengths and informal/formal coping mechanisms and through the formulation of a Child Protection Plan, take decisions about how to reduce risks and better safeguard children.

Table 10 Child Protection Conferences

Year	Roscommon	Waterford	Dublin
2005	99	34	Not available
2006	92	41	Not available
2007	113	77	34
2008	99	83	20
2009	107	90	24
2010	108	129	9

While the number of CPCs in Roscommon has remained fairly consistent averaging around 100 per year, there has been a significant increase in the number of CPCs in Waterford where activity has almost quadrupled from 34 in 2006 to 129 in 2010. This large increase in the number of CPCs in recent years is consistent with the increased rate of reports in both LHOs. The pattern in Dublin SE in terms of case conference activity represents a downward trend with only 9 conferences in 2010.

Parents are routinely invited to attend CPCs except where their involvement would preclude the best interest of children. In 2009 the average percentage of parental attendance was 75% in Roscommon and Dublin South East while the higher rate of 95% in Waterford was evidence of good practice in encouraging and supporting parental attendance. In situations where parents were not invited this was due to concerns about the risks to the children or because their attendance would have been disruptive and may have prohibited proper focus on the needs of the children.

There are no statistics for attendance by children at CPCs and they are not generally invited in any of the pilot LHOS. Managers were only able to recall a small number of situations when older children had attended conferences. Experience elsewhere of children being supported to attend case conferences illustrates that they found the experience to be beneficial (DHSSPS,NI 2006).

Legal Action- Applications for Care Orders and Supervision Orders

The Child Care Act (1991) Section 16 places a duty on Health Boards to make application for a Care Order or Supervision Order in respect of 'any child in its area who requires care or protection which he is unlikely to receive unless a court makes a Care Order or a Supervision Order'.

The grounds for making a care order are set out in Section 18.
"Where, on the application of a health board the court is satisfied that -

(a) the child has been or is being assaulted, ill-treated, neglected or sexually abused, or
(b) the child's health, development or welfare has been or is being avoidably impaired or neglected, or
(c) the child's health, development or welfare is likely to be avoidably impaired or neglected

and that the child requires care or protection which he is unlikely to receive unless the court makes an order under this section, the court may make a care order in respect of the child."

The Roscommon Inquiry report states that "it can be difficult to secure Court Orders to protect children from neglect and emotional abuse". This is a widely held perception among Social Workers and other professionals in all three LHOs and examples were provided of the number of Interim Care Orders made and the difficulty in getting full Care Orders, pertaining until children are 18, even in situations where the neglect has been evidenced over a number of years. An example was given of a case which required 13 hearings during 9 of which Court Reports were required and evidence was given. At the time of the Review it was anticipated that two weeks would be required for the full Care Order hearing. The number of successful applications for Care Orders has however increased steadily as demonstrated by the figures below and most applications including protracted ones appear to have been ultimately successful. There were a number of exceptions where in the opinion of the Reviewer the refusal to grant Care Orders left children vulnerable to ongoing and unacceptable risk. Some legal advisors representing the HSE in care applications confirmed that Judges appeared more willing to grant Care Orders where there is evidence of physical abuse and sexual abuse rather than in circumstances where children have been neglected and this seems to be more evident in situations where parents have physical or mental health challenges and where the neglect was not wilful.

Table 11 Children Subject to Care Orders at 31 December

Year	Roscommon	Waterford	Dublin	Total
2005	30	79	30	139
2006	40	80	35	155
2007	44	75	54	173
2008	51	84	58	193
2009	77	107	58	242
2010	90	136	61	287

Supervision Orders, made under section 19 of the Child Care Act are short-term legal measures which provide authority to the HSE and usually include directions which are intended to secure the cooperation of parents with aspects of a child protection plan for example ensuring social work access to the family home, requiring parents to attend parenting programmes and/or bring children for health and other specialist appointments. The review of cases demonstrated more frequent use of Supervision Orders in Roscommon and Waterford and there was evidence that these have been used to good effect in a number of recent cases.

Table 12 Children Subject to Supervision Orders at 31 December

Year	Roscommon	Waterford	Dublin South East	Total
2005	5	1	0	6
2006	2	4	5	11
2007	17	5	16	38
2008	14	4	0	18
2009	23	17	3	40
2010	23	20	0	43

Conclusion

The overall activity within the Social Work Service has grown significantly since the HSE assumed operational responsibility in 2005. It would be important for service planning purposes to collate information for them in the same currency as previous years. The above tables demonstrate that:-

- Child Welfare and Protection Reports have increased in all 3 areas with more dramatic increases in Roscommon and Waterford
- Neglect Reports have tripled in Roscommon and Waterford
- The annual number of CPCs held increased in Roscommon and Waterford and decreased markedly in Dublin South East
- The number of children subject to Care Orders has increased from 30 to 90 in Roscommon, from 79 to 136 in Waterford and from 30 to 61 in Dublin South East

During the same period there was reportedly only a limited increase in the staffing establishment within the social work service in all 3 areas until additional posts were funded as a result of the Ryan Report in 2010.

7 REVIEW OF CASES

Selection of Cases

In each LHO an initial sample of neglect cases was identified by SWTLs to allow the Reviewer to become familiar with the structure and content of case files, which varied between areas. SWTLs were asked to identify complex cases in which neglect was categorised as the primary reason for social work involvement. They were asked to include examples of families in which there had been major difficulties involved in protecting the children and cases in which the SWTL felt intervention had resulted in positive outcomes for the children. The purpose of social work services for children and families is to support families to care adequately for their children. When professionals working with children across a range of settings identify child protection or welfare concerns they are required under Children First to notify these concerns to the HSE. Social Workers have a lead role in investigating concerns and work with families and other disciplines to ensure children are protected from abuse and neglect. When parents are unwilling or unable to comply with protective arrangements which ensure their children receive adequate care, decisions may have to be made which involve alternative care arrangements.

Detailed consideration of the case files for the pilot sample was supplemented in many cases by briefing meetings with the PSW and/or SWTLs. This facilitated a better understanding of local policy, procedures and professional practice as well as the rationale for decision making. Following the review of the pilot cases, feedback was provided to the Principal Social Worker and SWTLs on individual cases using the audit template. (Appendix 4). This format provided a system for capturing information on family characteristics, analysing the nature and extent of interventions and providing an analysis of various aspects of practice.

Liaison with the Administrator for the CPNMT/CPNS took place in each LHO to familiarise the Reviewer with the CPNS database and with the numbers and characteristics of families currently open to CPNS and subject to ongoing review at CPNMT.

It was determined that a sample of 30 cases per LHO including the pilot cases would provide a representative cross section of neglect cases along the continuum of assessed risk and that these would include examples of:-

- Cases known to each of the social work teams
- Referrals which had not been subject to an initial assessment and were on a duty waiting list
- Cases in which an initial assessment had been completed and which were awaiting allocation

- Cases which had been open to CPNS for more than 2 years demonstrating long term involvement with families
- Cases which had been subject to Child Protection Conferences
- Cases in which legal proceedings had been instigated

In total case files were reviewed in relation to 101 families including 96 cases in which child neglect was a predominant concern, four relative carers and 1 non relative carer in which there were concerns about whether on balance there was capacity to adequately meet all of the children's needs. The cases involving potential neglect by carers were mostly historical and had been identified by SWTLs as representing the difficulty with finding a balance between caring for children within their extended families and so keeping them in their own locality, avoiding changes of schools and respecting their wishes regarding placements, with supporting family carers and ensuring good enough levels of physical and emotional care. All but one child had already been moved to an alternative placement during the time of the Review.

It is important to recognise that SWTLs in each area were willing to share cases in which they recognised with hindsight that decision making could have been more child centred.
The Reviewer had the advantage of extensive experience of supervising, quality assuring and auditing child protection cases in many statutory agencies, as well as the benefit of objectivity, not knowing any of the children or families involved. The Reviewer also had opportunity to assess the totality of the historical and current information available on the sample cases without the pressures of having to respond simultaneously to a range of other equally concerning cases.

While it would be impractical for the HSE to replicate the rigour of these independent pilots in each LHO, what it seeks to achieve through a managed and quality assured national audit of neglect is to disseminate the lessons from the pilot audits and use the agreed audit template and methodology to identify cases characterised by chronic neglect in which children are at continuing risk. It will also be a significant starting point in the introduction of governance arrangements to improve future practice in the management of cases of child neglect.

Characteristics of Families in which Neglect was a Concern

Although collation of information about family characteristics was not part of the original project proposal, the Reviewer undertook an analysis of the circumstances in families where neglect was the primary concern. This information should be compared and contrasted with the research findings on neglect in Appendix 3.

The figures below do not include details of the 5 relative and non relative carers.

Table 13 Number of Children per family

Number of Children per family	No of Families Roscommon	No of Families Waterford	No of Families Dublin	Total No of Families	Percentage
1	4	5	10	19	20%
2	3	12	5	20	21%
3	9	5	7	21	22%
4	5	5	5	15	16%
5	4	3	2	9	9%
6	2	2	1	5	5%
7	3	0	1	4	4%
8	0	0	1	1	1%
9 or more	0	2	0	2	2%
Total	**30**	**34**	**32**	**96**	**100%**

Family size varied considerably. While approximately two thirds of the families in both Waterford and Dublin have 3 or less children this was the case for just over half of the families in Roscommon. There were two very large families in the Waterford sample with nine or more children in each.

Table 14 Status of Parental Relationships

	Single Parent Families	Parents married or in long term relationships	Total Families
Roscommon	8	22	30
Waterford	16	18	34
Dublin	18	14	32
Total	**42**	**54**	**96**

Whereas approximately half the families in Waterford and Dublin were headed by single parents there was a notable difference in Roscommon where in the majority of families the parents were either married or in long-term co-habitational arrangements. In a small number of situations the mother had children with several different partners and one or more of the children were not the biological children of her current partner.

Roscommon also differed from the other two areas in relation to the fact that almost half of the families in the sample of cases were not native to Co Roscommon and many were from other parts of Ireland or from Europe and had no extended family in the area. Most of the families in the Waterford and Dublin samples were local to the area, although staff in both areas commented on the challenges of working with non nationals, many of whom had limited English and different cultural norms in relation to child rearing and discipline.

Table 15 Parental Characteristics

	Alcohol Misuse	Drug Misuse	Domestic Violence	Total Families
Roscommon	16	4	13	30
Waterford	18	10	10	34
Dublin	22	12	20	32
Total	56	26	43	96

In view of the high correlations between parental substance misuse and neglect, information on the prevalence of alcohol and drug misuse was included in the review of cases, as well as the incidence of domestic violence, with the following findings:-

- Parental alcohol misuse was a factor in 62% of families in the overall sample, and in more than half of the families in each area.
- Misuse of drugs was more common in Waterford and Dublin and this included parents who were on methadone maintenance programmes.
- Concerns about domestic violence were particularly prevalent in the Dublin sample where domestic violence was a reported feature in almost two thirds of the sample cases.

Other features worthy of note included:-

- Parental mental health issues also featured in approximately 2 thirds of the Dublin sample.
- In more than half of the cases the standards of hygiene and physical conditions were unacceptable. There were several cases in each LHO where the home conditions were described as "filthy", "dirty" or "unfit for living" and others where the physical state of repair of the home made it hazardous or unsuitable for children.

- Non attendance at medical and other specialist appointments with speech and language therapists, psychology and CAMHs was also a feature.
- Other trends included poor school attendance, inadequate supervision and poor stimulation of younger children, lack of boundaries for older children, concerns about the lifestyle of some mothers and complaints regarding late night parties and homes being frequented by adolescent and adult males.
- As found in studies elsewhere, these were often complex families in which there were multiple concerns and in some cases there was evidence of inter generational norms being perpetuated

Practice Issues

Recording

An examination of social work records provided the main source of information in all 3 LHOs. PHN records were also considered in four cases brought to the attention of the Reviewer by Directors of Public Health Nursing. All three PHN Directors identified the need for an integrated and expanded child health record to replace the current model.

There was a reasonable structure to most of the case files in all the areas although their nature and composition differed. In Dublin records were captured on the Social Work Information System (SWIS), in Waterford they used the RAISE computerised system while in Roscommon there was no computerised system and many of the case notes were handwritten.

The social work records usually included reports from other disciplines such as Public Health Nurses, Speech and Language Therapists, Schools, Psychologists as well as assessment reports from a range of private providers. In Waterford reports that were provided to Child Protection Conferences were often read out at the Conference and retained on the Child Care Manager's files. Copies were not usually provided to the SWTL for inclusion on the social work record. As the social work file represents the composite record on individual children it is important that all relevant reports are stored on that file and that these help to inform the interventions with families.

In the absence of a standard format for recording essential information on children and families each LHO had devised its own system for collating information about family composition and the involvement of other agencies. This information was generally accessible either through contact sheets, referral records or more coherently in a report for a Child Protection Conference or Family Court. In more recent referrals there was increasing use of the new Intake Record and this and other standard business processes will create a common approach across LHOs, provided the necessary computer hardware and electronic

programmes are accessible for all staff and arrangements are in place to monitor compliance.

The standard of recording varied within and across teams and where some records demonstrated process and evaluation of interventions, this was less evident in others.

Examples of good practice were noted in each area and these included:-

- The use of transfer reports within teams and when cases were transferring to another LHO
- Well structured files for children in care included all appropriate documentation and a current photograph of the young person as well as a summary of important people in his/her life, interests and hobbies and an easily assessable copy of the most recent care plan and review minutes.
- Ring binders which included all court reports and the most recent psychiatric or psychological evaluations of the young person, his/her parents and the foster carers/relative carers' assessment.
- Comprehensive assessments and evidence of co working among Social Workers and Psychologists on parental capacity assessments

There were some examples of comprehensive, well structured reports for Child Protection Conferences and Courts. However many reports were not sufficiently evidence-based and others lacked a social history along with a summary of historical interventions with the family and their outcomes. The use of chronologies would have helped to demonstrate the chronic, pervasive and longstanding nature of the neglect of some children. Inclusion of the actual dates when children were left unattended, the number of missed health and therapy appointments, the days missed at school and the reports of other professionals such as teachers and nurses in relation to inappropriate clothing, head lice, children presenting as smelly and dirty would all have helped to build a picture of the impact of neglect for the child.

The language used in professionals' reports did not always fully convey the full horror of children's living circumstances. Words such as "dirty" and "unhygienic" do not adequately describe the situation endured by some children in homes where beds were saturated in urine, there was no heat, there was dog excrement in the living room and bedrooms, a worker's shoe stuck to the carpet, mouldy food had adhered to kitchen counters and the toilet was black with dirt and excrement.

The fact that practice was variable both within and between teams in each LHO suggests the need for training in recording practice and closer supervision by SWTLs as well as regular audit by PSWs and the new ISA Children and Family Managers.

Assessment

The Initial Assessment process is central to the implementation of Children First (1999) and the forms and guidance developed nationally in cooperation with all the health boards in 2002 were based on the Framework for Assessment developed by the Department of Health in London. This has been replaced in 2011 by the introduction of a national standardised process for initial assessments and Social workers have been trained in its use.

The purpose of the Initial Assessment is to establish whether a child has been harmed or is at risk of further harm; whether their safety and welfare is at risk; the nature and level of intervention required; and to assist exploration of other sources of help both formal and informal that would help the family to care adequately for their child. As well as an assessment of the child's needs in terms of health, education, emotional behavioural development, identity, family and social relationships and social presentation, the Initial Assessment also requires a parental assessment with includes the level of basic care provided, the environmental condition of the home and any history of abuse or neglect within the family. It also requires assessment of factors such as parents' mental health, substance misuse, domestic violence, criminal behaviour and their willingness to use help and support.

Initial Assessments were routinely carried out in all cases in Roscommon where, following initial screening, there was a child protection concern including neglect. While there was a similar commitment in Waterford the extent of the waiting list meant that Initial Assessments were only carried out following initial screening when these could be allocated to a Social Worker. A reported 700 unallocated cases in 2011 meant that following initial screening and the determination that Initial Assessment was indicated, many cases had not been allocated. This was a similar figure to that reported in the Social Work Survey (2008).

By contrast Dublin South East did not routinely use an Initial Assessment policy or format. Consequently while there was still a commitment to assessment many of the assessments considered for this Review lacked structure. Information collected through network checks and liaison with other disciplines was not always appropriately collated and analysed.

In each area there was strong evidence of consultation with disciplines such as PHNs, Schools, Psychologists and Speech and Language Therapists, many of whom provided reports. Psychologists' reports routinely included a synopsis of the family background and personal history of the client.

There was less evidence of the more comprehensive assessments which are often required in more complex cases such as those which are subject of Case Conferences or Court

Hearings. There was no consistency as regards the assessment framework used within each LHO. One team in Roscommon used the Neglect Framework developed by Howarth (2001) and while teams in both Dublin and Waterford had been provided with training on the Trinity Sheffield Assessment framework developed by Buckley et al (2006), there was limited evidence of its use in the cases examined.

Parental Capacity Assessments have become almost a requisite component of applications for Care Orders and increasingly there appears to be an expectation that these are completed by Psychologists rather than Social Workers. Sourcing and resourcing these assessments represented a challenge for managers in all three LHOs. The Roscommon Psychology Department was unable to provide such assessments as it was significantly understaffed compared to other departments across the country. In both Waterford and Dublin it was clear that while these assessments were not always seen as a priority for Psychologists they were prepared to assist when they could be accommodated within the overall workload. Overall there was confidence among professionals that Child Care Leaders and Social Workers as well as some experienced family workers were competent to undertake Parental Capacity Assessments and that these could be augmented where necessary by psychological testing.

During the time of the Pilots (2011) work was underway through the Heads of Psychology in Ireland Group to agree a standard format and provide appropriate training in its use. Private Assessments were costly and consideration of a number of these in the cases reviewed found the quality to be variable. In addition to a standard format there is a need for specific contracts with providers and mechanisms for quality assuring assessments commissioned from private providers.

Case Management & Review

There was a strong commitment to family support in each LHO and to the use of a variety of approaches to build on strengths within families.

The nature and extent of services available varied from area to area and the programmes and approaches used also varied considerably. The fact that Family Support Workers and Community Child Care Workers/Leaders were not protected from the recruitment embargo meant that these services had diminished over time in all the LHOs. As there are considerable benefits to in-house training and support for parents in families where standards of care and hygiene were below an acceptable level, this reduced availability impacted adversely on neglected children.

In several cases the social work teams have continued to support families with high levels of services including Family Support Workers despite the fact that parental motivation,

compliance and investment was not evidenced and where there had been very little improvement for the children. Often cases appeared to be monitored through interventions by a range of agencies and through formal multi-disciplinary meetings such as strategy discussions and Child Protection Conferences. This was compounded in cases where parents engaged with case conferences and appeared to be cooperative for a time but did not follow through on the commitments made in the CPC or strategy meetings. In some situations parents were afforded multiple opportunities to improve the quality of child care with little evidence of progress. Previous research and inspections (see Section 4 and Appendix 3) have highlighted the danger of failing to acknowledge and factor into decision-making the lack of parental motivation to change and non-compliance with agreed plans.

There was limited evidence of the use of written contracts with parents to include the specific outcomes expected and the timeframes in which these had to be achieved.

There was also evidence in some cases of unrealistic expectations of parents' ability to change and this was particularly apparent in cases of parental addiction. Although there was involvement by Addiction Counsellors and by non HSE Addiction Programmes with some of the families in the sample, few reports were evident on the case files considered, although more reports may have been held on the CCMs' files.

In approximately half of the cases reviewed, the need for more authoritative social work seemed to be indicated. There needs to be a stronger statement of the statutory authority of HSE, which is exercised primarily through its social work department, to protect children at risk of neglect and other forms of child abuse. This should take cognisance of attachment theory and the ages of the children involved.

In a small number of cases, managers acknowledged to the Reviewer that with hindsight children should have been in care much sooner due to the chronic nature of neglect and its detrimental impact on the children. The Reviewer recommended legal intervention in respect of a number of children in each LHO.

Listening to and Involving Children

There was evidence of quality one-to-one work with children in all three areas once cases had been allocated to a Social Worker and in recent years this was more evident for children within the care system. Community Child Care Workers, Child Care Leaders, Family Centre Project Workers and Access Workers undertook direct work with children in a variety of child protection and neglect cases. Regular structured therapeutic sessions provided opportunity for children to build trust and for workers to undertake 'keep safe' educational work, life story work and provide support for children who had been traumatised and in some cases for those who had been bereaved. Family Support Workers also had

opportunity to talk with children and observe their home circumstances and relationships within the family. Staff who worked directly with children expressed frustration that despite their attempts to represent the children's circumstances at professionals meetings, other agencies and those working with the parents sometimes failed to keep the children's interests central to the decision making.

While there were some good examples of children participating effectively in Family Welfare Conferences in Roscommon and Dublin South East where the Family Welfare Conference Service was well established, this service has only been operational in Waterford in conjunction with Barnardos since 2010 and only a small number of families had benefited at the time of the review. There was limited involvement of children including older children in Child Protection Conferences in any of the three LHOs. Staff members were only able to recall a small number of situations when older children had attended conferences. Experience elsewhere of children being supported to attend case conferences illustrates that they found the experience to be beneficial (NI Inspection of Child Protection 2006).

The overall impression was that mechanisms for ensuring that decision makers were aware of the extent of deprivation experienced by children and their feelings about their circumstances were not sufficiently robust. The voices of children and their advocates were not always given sufficient weight leading to drift in decision making and deferral of actions to promote their safety.

Management & Governance Issues

Supervision

A strong commitment to supervision by both SWTLs and PSWs was evident in all three LHOs. Increasingly case specific supervision forms were evident on case files. In Waterford these were retained on the RAISE computerised system. Some supervision notes demonstrated reflection and analysis while others were more a check list of action points.

Supervision could be further enhanced by SWTLs and PSWs routinely reviewing case files as part of a regular audit process. This should involve a check of requisite documentation as well as mentoring in relation to the quality of social work records and encouragement for staff to record their analysis and case planning. It would also serve to ensure that pertinent information and reports are carried forward to the most current file and that a summary of the current status, family background and history of social work involvement was easily accessible.

Interviews with Senior Managers across disciplines identified the following concerns:-

- The absence of any arrangement for supervising or quality assuring practice and decision-making at a level above the CCM and the PSW.
- The absence of local, regional or national led audits of practice prior to this Review
- The isolation experienced by senior professional managers across disciplines in terms of opportunities to liaise with colleagues in the region and nationally to share ideas, discuss practice and policy issues and to agree common approaches
- Concerns about the capacity to deliver high quality service while carrying vacancies in key posts

Thresholds

The key issues which appeared most likely to influence the outcome for children are thresholds for various levels of intervention and the availability of appropriate and skilled resources as well as regular audits of adherence to procedures and monitoring of outcomes for children.

There were various levels at which thresholds for accessing services were an issue. These included:-

- Threshold for allocation to a Social Worker

The thresholds for allocating cases and for retaining them as open to social work was, in the opinion of the Reviewer, and in the opinion of staff and managers, to be too high in many cases in all three areas. While initial screening was usually carried out within appropriate time limits, staff shortages resulted in cases being managed on a waiting list for Initial Assessment or following Initial Assessment, on a waiting list for allocation. Although the extent of the waiting lists varied considerably in each area the review of cases in all areas revealed that many children who had been reported due to concerns about neglect were not receiving a service.

Referrals in relation to physical abuse and sexual abuse were more likely to be allocated for an immediate response than those involving neglect even when there had been several previous referrals about the same child or children. The Review identified families where there were between 20 and 30 referrals by a range of different agencies before their case was formally allocated to a Social Worker. When staff left, previously allocated cases were returned to a waiting list and it may have been months before a new worker was identified.

In each area the threshold for allocation appeared to be inextricably linked to the availability of Social Workers and to the prioritisation of children in care cases as required by national

performance indicators. This meant that many neglected children who remained in the family home continued to be vulnerable.

Participation by other disciplines within the HSE and by other agencies in Children First training had resulted in appropriate referrals about neglect and abuse to the social work service. There was generally evidence in the cases examined that attempts have been made to moderate the risks within their own resources prior to referral. Confidence in the social work system had been eroded in some areas by perceived inadequate responses to referrals and long waiting lists for allocation of cases which, in the view of other professionals, left them and the children involved vulnerable.

- Threshold for Referral to CPNMT and Notification to CPNS

CPNMT in all three LHOs was chaired by Child Care Manager and membership included the PSW, Director/Assistant Director PHN, a Senior Psychologist and in two out of three areas the Head of Speech and Language Therapy. There appeared to be no consistency to the operation of CPNMT and different arrangements were in place in each area.

In the opinion of the Reviewer CPNMT worked most effectively in Roscommon where Social Workers, supported by SWTLs, presented all Initial Assessments with a risk assessment and proposals for case management including a recommendation as to whether or not the case should be included on the CPNS. Although this was not how CPNMT was envisaged, this arrangement provided a mechanism for Social Workers to become competent in short focused case presentations and to benefit from experienced multi-disciplinary input and opinion. Many Social Workers with experience of working in other LHOs spoke favourably of this system indicating that it provided shared responsibility and shared accountability.

CPNMT was the mechanism for inclusion on the CPNS in all three areas until more recently when there was movement towards this decision being taken by CPCs in line with the new national policy. It was also the policy in all three areas that cases open to CPNS be subject to regular review although this worked more effectively in some areas than others. Concern was formally expressed by the Reviewer to local and regional managers in one LHO about the number of cases that had not been reviewed for more than a year.

There was generally good evidence of multi-disciplinary collaboration and the use of strategy meetings and professionals meetings was evident in all areas.

- Threshold for Child Protection Conferences

The threshold for CPCs was in the opinion of the Reviewer too high in Dublin South East where there was very limited conference activity in 2010 and 2011. While in Waterford

there has been a huge increase in conference activity in recent years there had been a considerable delay in arranging CPCs in respect of some children. The availability of a deputy chairperson in Roscommon helped to ensure the timely convening of CPCs. While many SWTLs demonstrated considerable competence in chairing strategy discussions and professionals meetings these did not have the same expertise, authority or credibility as CPCs. There was a lack of clarity in all three regions as to how the national policy for child protection conferences (2010) was to be implemented locally, with CCMs indicating they were raising resourcing issues and other challenges at national level. There was no evidence of the policy being applied in any coherent fashion by the time the audit had been completed.

- Threshold for legal intervention

Experience in court was a major influence in determining thresholds for applications for care proceedings. It was a generally held view that it was difficult to secure Care Orders in neglect cases and that courts were more willing to grant orders where there was clear evidence of physical violence and/or sexual abuse. Courts regularly required the HSE to provide additional resources to families even when the experience over time had demonstrated non take up of resources by parents or non-compliance with the previous child protection plans. There were also examples of courts directing the provision of health services for children including paediatric assessments and CAMHs as well as commissioning a range of expert opinions on parental mental health and parental capacity.

SWTLs in Dublin reported that they no longer had access to the experienced legal advisors who previously represented them. Inconsistency in judicial decision-making was commented on in all of the areas and reflected the need for training and accountability within the Judiciary.

The threshold for granting Care Orders was generally high within the sample of cases reviewed. Proceedings were protracted and the Reviewer was of the opinion that decision-making about access did not always reflect the best interests of the child.

Resources

In all three areas there was evidence of a historical lack of suitably qualified social work staff and resources to cope with both the greatly increased volume of referrals and the statutory obligations in relation to child protection and children in care. The national imperative to ensure that all children in care had an allocated worker and that relative and non-relative carers had been properly assessed and approved was being implemented to good effect during the course of the Review. In two out of three areas all children in care were allocated to a Social Worker regardless of which team was carrying the case and the work

with children in care, particularly in recent times was of a high quality in most of the cases examined. In the third area most of the children in care had been allocated. In all 3 LHOs maintaining this commitment presented real challenges and the knock-on effect of prioritising these cases was impacting on the capacity within Duty and Assessment Teams to manage new referrals and undertake initial assessments.

Senior professional staff in Roscommon and Waterford produced historical documentation in which the case for additional social work staff had been made at local and regional level over more than a decade. In both areas professional managers had identified the serious implications of understaffing including breaches of statutory child protection obligations and of duties to children in State care. Similarly at national level, deficiencies were evident in annual Review of Adequacy Reports and these were submitted to the Department. It was evident from the review of cases that there were periods when children within the child protection system had not been allocated to a Social worker and that some children had been without Social Workers after placement in care.

The resources situation in Dublin South East was less clear as most of the current managers had only been appointed since 2008 and many were still in acting positions. The A/PSW and SWTLs reflected many gaps in staffing over the past few years as a consequence of delays in appointing staff and failure to cover for sickness leave and maternity leave. The child population, workload levels and indices of deprivation were all lower in Dublin South East than in the other 2 areas but there were several relatively deprived areas with high incidences of families with young children and virtually no community resources.

Overall there was a sense of overwhelm within each of the areas and a frustration at not being able to build and sustain a social work workforce. Some were coping better than others and this was generally related to the extent to which there was adherence to policy and procedures including initial assessment. Some Duty and Assessment teams could have been managed more effectively and efficiently and organisational changes were taking place during the course of the Review.

Identifying and supporting neglected children requires a robust multi disciplinary approach and many of the other disciplines were experiencing challenges as a consequence of staffing embargoes and lost posts.

- PHNs have a critical role in supporting parents and identifying children at risk of neglect and abuse. Their current generic responsibilities for the entire population, including the chronically sick, high caseloads and the fact that they will no longer be required to have midwifery training limits their capacity to provide the level of service and the specialism required to work effectively with neglecting and resistant families who are likely to avoid

contact with professionals. Supervision arrangements for PHNs are not commensurate with their responsibilities

- The staffing levels in Psychology and CAMHS services varied considerably with Roscommon Psychology Service falling well below the level of the other 2 LHOs and raising questions as to how the department could be fit for purpose.
- There was an absence of specialist paediatric input into the developmental assessments of individual children whose basic needs were not being met
- Parental capacity assessments are increasingly being sought by the Courts as part of the evidence to support Care Order applications. Decisions will need to be taken as to the agreed model for such reports and how these can be provided, including prioritisation within Psychology departments, joint working and training and support for SWs and CCCLs
- The extent of acting up arrangements undermines the stability of departments and relies on the goodwill of staff who agreed to take on responsibility in the short term and find themselves still in acting posts several years later without being paid at the appropriate level. In Dublin South East the entire nurse management team were all in acting positions

Training

Training resources are generally limited with a variety of operational arrangements in place. While Roscommon had a dedicated part time training post, services for Dublin South East and Waterford were provided by training teams apparently based on historical boundaries of former health boards. There was evidence of good liaison with trainers and attempts to identify and respond to training needs.

All three LHOs reported that training opportunities have reduced significantly over the past few years due to various embargos, difficulties in identifying cost-neutral venues and restrictions on travel. The priority has been Children First training including basic and foundation level courses, which have been well attended by all disciplines. Historically neglect and failure to thrive were covered as part of more general training on child abuse, although some years ago recognised experts had been contracted to provide specific training on neglect, emotional abuse and failure to thrive. However there had been no specific emphasis on neglect training in any of the three pilot LHOs until after publication of the Roscommon Inquiry report and a national drive to disseminate the learning.

In the absence of a national framework for more comprehensive assessment, trainers in each area have offered a variety of tools and frameworks which would facilitate structured and coordinated analysis of strengths and risks across a range of domains. The former South East Health Board was involved in the Trinity/Sheffield project (Buckley et al 2006) to develop an assessment framework and Waterford was a pilot site. Training on the structure of Court Reports and on giving evidence has been provided in the past by Legal Advisors and

the aspiration is that this will be jointly delivered by a Legal Advisor and Social Worker in the near future, as part of a national initiative. Trainers and staff all recognised the need for a national training strategy and, as noted in the recommendations, were clear on the priorities and objectives.

In view of the high levels of alcohol addiction, domestic violence and mental health problems which characterised parents who neglected their children it will be important to ensure that all relevant staff have appropriate training in understanding and working effectively with parents exhibiting these challenging behaviours. They should also be familiar with the relevant literature on the impact of parental addictions for children and be trained in working effectively with children, individually and in groups. Training for all disciplines should include evidence based research on the impact of neglect and inadequate attachments on all aspect of a child's emotional, physical and psychological development.

Auditing and Monitoring

While professional supervision is one of the most important mechanisms for quality assuring practice, it is not sufficient on its own, as the supervising SWTL and to a lesser extent the PSW may have close involvement in the decision-making and management of the case. While supervision procedures were well embedded in practice and there were mechanisms in place to monitor their implementation, the only other examples of audit by either senior professional managers or general managers were a recent audit of files for children in care in Dublin Mid Leinster Region and an annual audit of adherence to Standard Operating Procedures in child protection and family support in Roscommon. These later procedures were developed by the former Principal Social Worker in 2000 and combined with a hands-on CPNMT and excellent collaborative working relationships between the CCM and PSW provided a model for good governance.

Some aspects of child protection practice within both Waterford and Dublin South East LHOs were not compliant with either Children First or with guidance issued by former health boards and this was a particular concern in relation to cases notified to the CPNS. There were no governance arrangements in either LHO to monitor adherence to procedures and when issues regarding non compliance were raised locally and regionally, these were not addressed.

Performance management at all levels of management tended to focus on achievement of National Performance Indicators and failed to respond to a variety of concerning statistics such as:-

- High waiting lists for allocation for Initial Assessments
- Waiting lists for allocation following recommendations in Initial Assessments

- Unallocated children who were open to the CPNS
- Overdue reviews of children open to CPNS

There was limited evidence that existing governance mechanisms such as monthly meetings between senior professional managers and general managers, impacted to any large extent on either general or case specific issues. Cases were discussed at senior level but there was limited evidence in many cases of actions being taken which provided additional safeguards for children.

Inter-disciplinary/Interagency challenges

While communication generally took place between Heads of Services there were limited opportunities for liaison between front line staff. Managers were identifying some challenges with accountability in the roll out of primary care teams and in some areas GP attendance levels were low. Most professionals welcomed the new multidisciplinary arrangements and hoped that Social Workers could become more aligned with the Primary Care Networks. This was unlikely to be possible due to the drive for increased specialism within children and families social work.

In Dublin South East the CCM had been influential in bringing together the DPHN and Acting PSW to discuss interface issues and this led to a joint staff meeting for all Social Workers and PHNs. As a result of the focus groups, conducted during this Review, managers were exploring opportunities to share the core functions of each discipline's responsibility to support neglected children and their families and to better understand each other's roles. In particular Allied Health Professionals recognised the need for closer liaison with Social Workers to identify children known to their respective services.

Inability to access timely paediatric advice and appointments was a recurring theme and this was a feature even for children in the care of the HSE.

The findings from this sample of around 100 cases, involving over 300 children was consistent with findings from inspections and serious case reviews in identifying parental substance misuse as a factor in more than 60 per cent of families. However there was limited evidence of this being addressed within the HSE's mental health and addiction services and Social Workers and PHNs were not trained to work effectively with this group of parents. Experience elsewhere demonstrates the need for specialist services which can achieve outcomes for parents within appropriate timescales for children. These include Family Drug and Alcohol Courts operating within several local authorities in England.

The HSE contracts with a range of voluntary organisations to provide services including family centres, crèches, foster care placements, residential facilities, mentoring for

vulnerable young people, CAMHS, private psychologists and addiction services. The service level agreements and contractual obligations were often not sufficiently robust to quality assure the services provided and ensure value for money.

The plethora of programmes being provided to support families either directly by or on behalf of the HSE needs to be rationalised and conform to a number of criteria including for example:-

- Programmes with a track record of success
- Programmes with a rigorous research base
- Programmes which are easily replicable in other areas.

Service level agreements should be explicit and evaluated in terms of volume and outcomes.

The HSE has to work closely with An Garda Siochana in accordance with jointly developed protocols in a range of situations where children are at risk. These include child protection notifications, interviewing children who allege physical and sexual assaults and following up Section 12 removals of children by Garda. The unmanageable volume of Garda notifications in some areas, social working staffing shortages, the absence of trained Social Work Investigative Interviewers and the thresholds applied by the Director of Public Prosecution in relation to prosecuting cases of parental neglect are all issues which need to be further explored by the new Children and Families Support Agency, an Garda Siochana and the Office of the Minister for Children and Youth Affairs

8 FOCUS GROUPS AND INTERVIEWS

The terms of reference for the Review of Practice and Audit of the Management of Neglect included the need to involve all disciplines, and staff and managers at all levels in the process. This was achieved through a series of workshops, focus groups and interviews involving over 200 staff. Between 50 and 90 staff and managers in each LHO contributed to the review process and their feedback was of great assistance in achieving a better understanding of each profession's contribution to child protection and neglect and of the strengths and challenges within the inter-disciplinary arrangements.

The General Manager and Heads of Disciplines in each LHO participated in an initial planning workshop at the start of each audit. In Dublin South East the ISA Manager was also involved. As noted in the introduction, this group advised in the planning of the Review process and assisted with the identification of individuals and groups of staff who should be involved. A separate workshop was conducted with the PSW and SWTLs in each LHO to brief them on the proposed review and secure their assistance with the selection of cases for the audit.

Focus groups were conducted with all the relevant professional groups including:-

- Directors/Assistant Directors Public Health Nursing
- Public Health Nurses
- Area Medical Officers
- Social Workers
- Child Care Leaders and Access Workers
- Family Support Service Staff/Home Management Advisors
- Psychology Service
- CAMHS (except Dublin South East)
- Speech and Language Therapists
- Physiotherapists and Occupational Therapists in Dublin South East
- An Garda Siochána representatives of each policing division

Interviews were conducted with:-

- ISA Manager for Dublin South East/Wicklow (formerly LHM Dublin South East)
- Lead Local Health Managers in HSE South and HSE Dublin Mid-Leinster and a telephone interview with the Lead LHM in HSE West
- General Managers
- Principal Psychologists
- Senior Area Medical Officers

- Heads of Speech and Language Therapy
- Child Care Managers
- Principal Social Workers
- Heads of Physiotherapy in Waterford and Dublin South East
- Legal Advisor in Waterford
- Addiction Counsellor and Head of Home Help Service in Roscommon
- Trainer in Roscommon and telephone consultations took place with Managers/Staff in each of the Training Units.

Several privately employed Guardians ad Litem participated in a focus group and consultation also took place via a telephone interview with the manager responsible for coordination and quality assuring the Guardians ad Litem appointed by Barnardos.

Relatively common themes which emerged in the various groups and interviews are collated below. Much of the feedback was consistent with the Reviewer's findings arising from the review of cases and most of those who participated welcomed an opportunity to share their ideas for strengthening services.

The focus groups revealed considerable knowledge and awareness among professionals regarding the nature of neglect and its potential consequences for children. This included:-

- Poor physical, emotional and mental health and delayed development
- Dysfunctional attachments
- Disrupted education and problems in school
- Damaged self esteem, self perception and self worth
- Poor coping strategies
- Reduced job prospects
- Higher risk of alcohol /drug misuse and dependency issues
- Poor relationships with family, peers and partners
- Socially isolated/stigmatisation

There was recognition of the need to break the cycle of neglect by supporting parents to improve their care and many examples were provided of professionals intervening in appropriate ways when parents were resistant. There was however a lack of confidence expressed by some staff across disciplines about their role and authority and about their skills in engaging with parents and in particular resistant parents.

Strengths

While there were obviously local variations a number of common strengths were identified by focus groups and interviewees.

- Strong commitment to ensuring staff in all disciplines complete Children First training
- Responsive trainers who facilitated requests for training on specific issues in so far as these could be accommodated within the current financial restrictions
- Staff across disciplines demonstrated a capacity to empathise with the feelings of children who live in emotionally and physically neglectful environments
- Experienced PHNs who were skilled in recognising neglected children and referred appropriately to specialist services
- Frequent and accessible referral clinics run by Area Medical Officers
- Excellent work with neglecting families by the range of Family Support Services within each area
- Good working relationships between Principal Social Workers, Child Care Managers and other Heads of Services within the LHO although in 2 areas there was evidence that issues regarding interagency practice had not been resolved.
- Good working relationships between PSWs and Garda Superintendent/Inspectors
- An emphasis on direct work with children and young people, much of which is undertaken by Child Care Workers, Family Centre Workers, Family Support Workers and Access Workers who reported a commitment to listening to children and ensuring their views were represented to the appropriate decision making fora
- Good outcomes from Triple P and Incredible Years Parenting Programmes in Waterford and Dublin South East and Common Sense Parenting programme in Roscommon.
- Considerable appreciation and support for the new standardised business processes.
- An expanding Psychology Service within Dublin South East which is involved with many of the more complex neglecting families
- A growing commitment by all disciplines to following up on children's non-attendance at appointments
- Recognition of the importance of CPNMT and attempts to ensure its effective operation. The most robust model was in Roscommon, where CPNMT was viewed favourably by all disciplines including Social Workers and perceived as accessible, structured, well attended and supportive

Challenges

The following challenges were identified:-

- The impact of Inquiries on the staff involved and the uncertainty experienced by staff and managers when Inquiry reports were not shared
- The impact of publication of the Roscommon Inquiry on the children concerned, on the morale of staff involved and on public perception of the HSE
- The historical and current lack of capacity within social work teams to respond to referrals from other disciplines and resultant delays in screening referrals, and delays in allocating cases for assessments and intervention
- The extent of turnover in social work posts combined with the absence of cover for sickness and maternity leave, which impacts on continuity in work with children and families
- Perceived emergency situations such as referrals about physical and sexual abuse are more likely to be prioritised than cases involving ongoing neglect
- A lack of understanding among other disciplines as to the prioritisation criteria for allocating cases to Social Workers and frustration about the lack of feedback on referrals.
- Uncertainty among some staff in Allied Health Professionals about their skills in raising concerns about neglected children directly with parents
- Tensions with staff in some voluntary organisations who appear to place an over emphasis on protecting the family unit even when this is not in the best interests of the children involved.
- The absence of inputs from Adult Mental Health Services including realistic assessments of parental motivation to tackle addictions.
- The criteria for accessing CAMHS Services, and waiting times particularly in Dublin South East.
- The absence of community based resources such as Family Centres in some areas.
- The reduced number of Child Care Workers which has impacted on their availability to work with children, leading to waiting times of several weeks.
- Concern that while the national and regional drive to ensure all children in care have an allocated social worker and care plan with regular reviews is entirely appropriate, there has not been due attention at national level to the consequences for referrals at the front end of the service
- The need for national leadership and for structures and processes to facilitate standardised practices across the country in all disciplines has been an issue for many years, and the gaps in national guidance leaves staff locally feeling isolated and vulnerable
- Difficulties in accessing appropriate specialist professional advice in complex cases
- The training embargo of recent years and its impact on all professionals in limiting their continuing professional development and opportunities to keep up to date with current best practice and in particular the absence of training specifically on neglect and attachment.

- The lack of specialism within Public Health Nursing and the high case loads which make it difficult for PHNs to have the time and expertise needed to engage in meaningful work with families
- Challenges in providing regular supervision for PHNs who have an important role in identifying and supporting neglected children.
- The inadequacy of the child health record, especially for use with children in need and at risk
- The instability created by numerous acting positions within a number of disciplines including Social Work and Public Health Nursing
- The inequality in regional resources and the impact of recruitment embargoes on services for example the Psychology Service in Roscommon.
- Dissatisfaction with the national recruitment strategies which result in delays of over a year in filling some posts and failure to ensure an appropriate skills mix within teams.
- The absence of structures for professional supervision and mentoring of senior professional staff as well as arrangements for consultation on complex cases.
- Difficulties in securing GP involvement in CPCs.
- The lack of an Out of Hours Social Work Service outside of Dublin.
- Inability to access the CPNS out of hours.

Social Work Departments

There were a number of additional areas of significance identified by staff within the Social Work Departments and Family Support Services.

Strengths

- The number of social work posts has increased markedly in the past 2 years
- Specialisation within teams has enhanced practice but has still to be fully implemented in some LHOs.
- Induction programmes and protected caseloads are in place for newly qualified workers
- There is a commitment to regular supervision which includes reflective practice and opportunities for staff development
- Most children in care are allocated regardless of which team is carrying the case but this is proving difficult to sustain
- Link workers have been assigned for most relative as well as non relative carers and most relative carer assessments have been completed or allocated
- Standard business processes are providing a structure for the work

Challenges

- An increased volume of referrals, including high numbers of neglected children, which are not being assessed within appropriate timescales
- Lack of clarity nationally about realistic caseload size.
- The need for a nationally agreed assessment framework.
- Unrealistic demands by the local Courts in terms of court appearances and reports which impacts on the day to day work with other children and limits capacity to respond to new referrals
- The number of assessments and expert opinions sought by Courts in Care Order Applications.
- Tensions with Guardians ad Litem in relation to demands for services
- Intergenerational patterns of neglectful and chaotic families and the extent of dependency on methadone maintenance programmes.

Guardians ad Litem

Guardians ad Litem welcomed the opportunity to have an input into the Review process and confirmed that the majority of families with whom they are involved are characterised by neglect. They emphasised the importance of well constructed and balanced court reports which consider the impact on the child of sustained neglect and abuse and demonstrate with reference to research findings, the concept of cumulative harm. Reports are more effective if they are balanced and identify the positive factors within the family as well as the negative impact on children of parental neglect.

Guardians indicated they would welcome the opportunity to collaborate with the relevant Departments, the HSE, Legal Advisors and the Judiciary to achieve greater consistency, enhance practice and jointly explore training needs.

9 AGREEMENTS & RECOMMENDATIONS

At the conclusion of the review of cases a workshop for Heads of Services was facilitated in each LHO to share feedback on the findings in relation to the multi disciplinary management of neglect and identify strengths and weaknesses in relation to each aspect of service provision. Regional Leads (latterly Regional Directors) and the Chair of the National Steering Group also participated in the workshops. Managers were encouraged to respond to the findings and identify how each level of management as well as the various professional groups could strengthen existing services and hence improve the outcomes for neglected children. The level of commitment made by these managers is the best evidence of the extent to which the pilot Reviews of Practice and Audits of Management raised awareness and understanding of their individual and joint responsibilities for neglected children. The proposed changes would also benefit the wider population of children in need of care and protection. The agreements reached in these LHOs will be of interest to other LHOs and to those with lead roles nationally and are therefore reported here in some detail.

A number of other common themes emerged leading to the Reviewer making some additional recommendations for action at each level of the organisation.

National Level

The pilot audits identified the extent to which deficits in resources, training, governance arrangements and interagency protocols impacted on the effectiveness of services and consequently on the outcomes for children. Nationally there has been recognition of the massive change programme required within Children and Family Services and the need for the National Office to be fit for purpose and provide strong leadership and strategic direction. At the time of writing this consolidated report (April 2012) work is progressing rapidly towards the establishment of the Children and Families Support Agency in 2013 and appointments have been made at both Regional and ISA levels to create a single line of accountability from individual Social Workers to the National Director/Chief Executive Officer. This structure should more adequately support service delivery and will need to be complemented with strong interdisciplinary arrangements and protocols, so that all of those with responsibility for child welfare and protection continue to play the requisite roles identified in this Review. Significant work has also been undertaken to achieve standardisation of approaches to child protection and welfare services through planned implementation of policies, procedures and standard business processes, including a common assessment framework. This was fully rolled out during 2011 and there was increasing evidence of use in the later cases considered. Mechanisms are being developed for quality assuring adherence to policies and for reviewing practice through audit and review at all levels.

The revised Children First: National Guidance was issued in July 2011 and was augmented in late 2011 by a Child Protection and Welfare Practice Handbook (HSE 2011) which contains detailed advice on all aspects of supporting children and families including the management of child neglect. There has also been close collaboration with OMCYA and HIQA on achieving realistic standards for child protection which are to be introduced in the autumn of 2012.

The Office of the National Director for Children and Family Services has confirmed an ongoing commitment to integrating the learning from the 3 pilot audits of neglect in Roscommon, Waterford and Dublin to achieve the broader commitment to a national audit of neglect.

At feedback workshops in each LHO the Chair of the National Steering Group for the Neglect Audit stressed that the immediate concern in each locality was to ensure progress in any cases considered as part of the Review, in which it could not be determined that children were adequately safeguarded. It was also a priority to achieve clarity on the numbers of referrals which were unallocated and agree a plan to address waiting list referrals.

Recommendations

It is recommended that the Office of the National Director:-

- Ensures social work departments maximise the efficiency and effectiveness of existing resources and are adequately resourced to discharge their statutory functions
- Collaborates with relevant senior managers to ensure that Social Work Departments have access to appropriate assessments and interventions from Psychologists, CAMHS, Allied Health Professionals and other specialists in assessing and responding to the needs of neglected children
- Develops and resources a National Training Programme which includes the nature and impact of neglect, attachment theory, the nature of alcoholism and working effectively with alcoholic and drug dependent parents, professional recording and report writing
- Explores structural arrangements in Northern Ireland and the UK which facilitate liaison between all involved parties in the Court process to achieve best outcomes for children with a view to developing appropriate models in Ireland
- Develops, in conjunction with OMC&YA, appropriate interfaces with the judiciary nationally and locally and creates an agenda for discussion which should include the following:-
  - Thresholds for applications for Supervision and Care Orders
  - The purpose of Supervision Orders and the consequences of breaches
  - The nature of assessments required by the Court
  - Standards of proof required for full Care Orders
  - The Court's role in securing permanency

- Joint training for professionals and judges on attachment theory and the impact of neglect, including the influence of alcoholism, drug addiction and domestic violence on children's emotional and psychological development
- Monitoring of outcomes of court proceedings to consider whether thresholds are consistent across the country
- The development of Court Users' Committees or equivalent which enable local liaison between judiciary, legal representatives and professionals
- The role, training, supervision and accountability of Guardians Ad Litem

Regional Level

The former Regional Lead positions for Children and Family Services were replaced with full time management positions during the timescale within which the pilot audits took place. Each of the newly appointed Regional Directors responded to specific issues within their area, including for example considering options for mentoring and supporting PSWs. More generally work was underway to collate accurate information, analyse trends and create business intelligence to inform resource planning and management. Arrangements were being developed to enable Child Care Managers and Principal Social Workers across the region to meet formally together to jointly consider policy and practice issues, and there was regular liaison with ISA/General Managers pending the appointments of Children and Family Services Managers.

Regional Managers also identified a need to:-

- Integrate the learning from the pilot audits to assist with a process of self audit and regulation in line with the HSE's quality assurance agenda
- Integrate the learning from the successful strategies already in place in relation to targets and standards for children in care and extend the governance arrangements for children in care, to include child protection and in particular neglect
- Provide an urgent and informed impact statement on resource deficits within Children and Family Services to the Regional Director of Operations/Office of the National Director
- Evaluate the quality of regional services
- Maximise resources within Children and Family Services across the Region through a review of current arrangements and restructuring of management responsibilities as well as the development of an appropriate workload management tool
- Review the placements of children in private services to determine if their needs could be met within relative care or within the statutory provision and hence achieve savings for reallocation

- Liaise with colleagues nationally to review the deficit in places in Special Care and High Support Services and improve the standards within those services
- Develop agreed regional thresholds for child protection conferences and court proceedings
- Liaise with legal services to develop more effective working relationships

Recommendations

The Regional Director of Operations should in conjunction with the Regional Director for Children and Family Services, ensure:-

- That the needs of vulnerable children and families are understood and resourced in line with legislative and statutory responsibilities and that services for children across disciplines receive appropriate attention and priority within the wider health and social care responsibilities of the region.
- There is transparency and equity in the allocation of resources throughout each region and the HSE nationally is made aware of any significant breaches in statutory responsibility and proposed actions to address these through performance management arrangements.
- That Heads of Services in each ISA receive supervision, support and training which is commensurate with their responsibilities for children at risk due to neglect (and abuse).
- That structured arrangements are established at both ISA and regional level to ensure effective liaison and coordination between social work and all relevant disciplines

Local Level - General Managers

The roles of General Managers changed significantly towards the end of the pilot audits as the LHOS were consolidated within ISAs and preparations were underway to transfer responsibility for social work services from General Mangers to ISA Managers for Children and Family Services in May 2012.

The following are examples of the commitments given by general management across the three areas. At the time of writing each LHO was at a different stage in implementing these agreements and managers will need to work closely together to ensure effective structures and protocols for interdisciplinary working in order to effectively discharge their joint responsibilities.

General Managers recognised the contribution of many disciplines to protecting children from neglect and acknowledged the need to:-

- Review and maximise the outcomes from existing resources across disciplines.
- Understand and represent resource challenges effectively to the Regional Director of Operations.
- Develop internal quality assurance arrangements including peer audit processes and improve the overall arrangements for audit to ensure it becomes an integral function of all management roles and is informed by clinical specialists
- Work with colleagues with line management responsibility for specialist services in other programmes such as CAMHS and addiction services to achieve greater access and enhanced quality of services for children and families known to the Social Work Department
- Create, monitor and evaluate appropriate Service Level Agreements with providers of services which include business protocols in relation to referral criteria, standards and outcomes
- Strengthen arrangements for communicating, processing and managing serious issues and alerts

Recommendations

General Management within each ISA should:-

- Liaise with Managers for Children and Family Services to ensure appropriate handover of responsibilities and agree ongoing liaison arrangements.
- Communicate the findings of the Review to all those who participated
- Consider strengthening the skills mix within the PHN service to allow PHNs to specialise in supporting children in families who need additional support and those in which there are child protection concerns

Children and Family Services Managers should ensure that:-

- The recommendations in respect of individual cases of neglect considered in the Review are taken forward within an appropriate timescale
- A review of other neglect cases takes place in the context of the learning from this Review, in order to provide assurances on the adequacy of protection arrangements for the overall caseload of work with children and families
- The Social Work Department's waiting lists for assessment are urgently screened and prioritised by an appropriately qualified manager and that a waiting list management plan is invoked. Other involved disciplines should be advised of the status of each case and assisted in managing cases that cannot currently be allocated to a Social Worker
- Other unallocated cases in any of the Social work teams are reviewed and prioritised.
- Children notified to CPNS are discussed within appropriate timescales and that all children open to CPNS are reviewed in line with procedures

- Internal multi-disciplinary case reviews take place in those cases in which the need for this was identified by the Reviewer

Professional Managers in Children's Services, including CCMs and PSWs agreed on the need to implement the learning from the Review of practice and gave a commitment to:-

- Strengthen monitoring and auditing arrangements including reviews of case files.
- Ensure regular audit activities by PSWs, SWTLs and Family Support Service Coordinators
- Achieve appropriate specialism within Social Work teams and maximise the use of existing resources
- Introduce systems to more effectively and efficiently manage referrals
- Reconfigure and rationalise Family Support Services and have a single entry point for referrals.
- Consider skilling up Child Care Leaders/Workers and other staff to undertake parenting assessments, with support from the Psychology Service
- Develop the governance function of CPNMT and introduce a template for the minutes of child protection conferences

It is recognised that many of these issues are now being led nationally. However all social work managers have a responsibility to effectively and efficiently manage and quality assure their services while at the same time contributing to national debates and audit requirements.

At the time of writing, progress was at different stages in the pilot LHOs and in one area the absence of a PSW was a significant constraint while in the other 2 areas there was an Acting PSW. CCMs had not been replaced in 2 LHOs while the CCM in another was covering the whole ISA while decisions are being taken nationally about how case conferences and are to be chaired.

Recommendations

Social Work Managers should ensure that:-

- Record keeping is more coherent to facilitate easy retrieval of pertinent information
- Child Protection Conference and Court Reports are more purposeful, structured, evidence based and contextualised within a summary of the entire history of contact with the family. The desired outcome of legal proceedings must be clear. The focus should remain on the child and on the impact of parental addictions and behaviours on the child's short and long-term physical, emotional and intellectual development.
- Standard business processes including initial assessment are routinely implemented and to an appropriate standard

Public Health Nursing and Allied Health Professionals

The role of PHNs as the providers of universal services to infants and young children makes them uniquely placed to identify those children who are receiving sub optimal care and to provide support to parents either directly or by referral to other specialists or community based services. The Primary Care Team model of service delivery was being rolled out at the time of the pilots and managers were keen to build on the strengths in that system. When it became clear that the need to achieve specialism within social work services militated against the aspiration to have social work within the community based primary care arrangements, PHN and AHP managers recognised the need to proactively build relationships between their teams and social work services. This will become increasingly important when social work for children and families move to the new Agency.

Heads of services in PHN and AHPs were committed to:-

- Ensure an integrated approach to child health and development and child protection within Primary Care Teams and promote the child protection responsibilities of all disciplines.
- Undertake audits as appropriate, and as issues arise, to inform change
- Increase opportunities for supervision of PHNs by Assistant Directors
- Review the operation of the 'Buddy System' in some areas whereby experienced PHNs/AHPs are partnered with less experienced colleagues
- Develop thresholds for targeted home visiting in situations where neglect or other child protection or welfare issues are a concern.
- To provide joint training across disciplines on the content and purpose of assessment with a view to avoiding duplication and achieving complementary holistic assessments.
- To ensure centile charts, which are routinely completed by PHNs on infants and children, are shared with Social Workers and others as part of the assessment
- To tackle non attendance by children at specialist appointments
- To work with PSWs to agree local eligibility criteria for children and families social work service and communicate these to other disciplines and agencies
- To extend the delivery of Triple P Parenting programmes as a family support initiative
- To maximise the use of the voluntary sector in supporting neglected children
- To agree a common language and to work towards a culture where information available to different disciplines working with the same client is shared appropriately
- To provide peer review whereby Heads of Service provide each other with feedback on their services
- ensure greater focus on neglected children and that all staff are trained in Children First

- Review long term cases and ensure AHP staff consider the needs of all children in the family from the point of view of neglect and not just the disabled child
- Improve the Primary Care Teams' Service to children within the integrated Service Area by jointly organising liaison and in-service training with the aim of improved communication between AHPs and the Social Work Department and better understanding of roles within the Primary Care Team Services

It should be acknowledged that the involvement of AHPs in focus groups increased as the pilot reviews progressed and therefore some of the agreements noted above came about in the final pilot in Dublin South East. They do however have relevance for all areas in the future.

Adult Mental Health and Addiction Services

An area which in retrospect did not receive sufficient attention during the Review is the role in protecting children by those providing services for parents with substance misuse and mental health difficulties.

Recommendation

It is recommended that given the high incidence of these issues in the population of neglected children, that a specific review is carried out of the arrangements for implementation and monitoring of the discharge of child protection responsibilities by adult mental health professionals.

10 CONCLUSIONS & NEXT STEPS - PROPOSAL FOR PEER LED AUDIT

The findings of the Roscommon Child Care Case Inquiry raised concern that this might not have been an isolated case and that there might be more widespread practice and governance issues in the management of cases of neglect both in Roscommon and throughout the country.

The Inquiry team suggested that a national audit of cases of chronic neglect be undertaken to identify any families in which neglected children might be at risk due to failure to undertake adequate assessments and to take decisive action to improve their circumstances.

The purpose of the pilot audits was to identify the strengths and challenges for social work practitioners and managers as well as for other disciplines within Local Health Offices in the management of neglect. It was also to design and test a methodology which facilitated professional guidance and support in relation to individual cases, which could be applied in a national peer led audit.

Findings demonstrated the extent of child neglect within social work caseloads and on waiting lists for allocation. Consideration of 100 cases on a continuum from initial referrals right through to children in care as a consequence of chronic neglect demonstrated synergy with the findings of the Roscommon Inquiry and also resonated with national and international research findings.

These pilot audits uncovered considerable confusion about the State's role and about the threshold criteria for instigating child protection and legal procedures in relation to neglect. It also demonstrated that while the emphasis on providing Children First training for other disciplines and agencies was paying off in terms of appropriate referrals, there was inadequate capacity within Social Work departments to respond. Physical and sexual abuse allegations were more likely to receive a service than neglect even when there were multiple referrals from different sources about the same children.

The purpose of the pilots in 3 areas including Roscommon was to identify a model for taking forward the Roscommon Child Care Case Inquiry Report recommendation that there should be a national peer led audit of neglect. The pilots endorsed the need for continuing scrutiny of neglect practice within each LHO to ensure neglected children actually received a service as well as to identify allocated cases where despite involvement by Social workers and other professionals children were at continuing risk. The pilot audits confirmed that the methodology was appropriate and capable of being replicated so long as the audits were carried out by professional managers who had been adequately trained and were quality assured by the Independent Reviewer.

Findings included:-

- As noted in the Social Worker Survey there are significant variations in staffing levels between LHOs within regions and each LHO uses different models for providing services
- Neglect cases including chronic neglect are prevalent within each team's caseload
- Neglect is the most common reason for inclusion on the Child Protection Notification System (CPNS)
- Neglect cases are often open to CPNS for a number of years and inclusion within the system does not necessarily improve the circumstances for children. This raises issues about the need for training in neglect not just for practitioners but also for those senior managers who chair and regularly contribute to CPCs and to oversight of the CPNS.
- A sample size of 30-35 per LHO provided a good spread across the continuum of neglect cases, from cases on the duty waiting list to children in care as a consequence of neglect
- Cases identified by Social Work Team Leaders were often the most serious and chronic cases, and social work managers welcomed the Reviewer's input into these cases
- Additional families in which chronic neglect was a significant concern were identified by other disciplines who were frustrated by the thresholds for allocating cases to social workers
- The involvement of senior management across disciplines is essential, as the Review identified issues in the management of neglect within many disciplines, particularly Public Health Nursing, AMOs/Paediatricians, Psychology and CAMHS
- The process of engaging with Principal Social Workers, Social Work Team Leaders and Social Work staff was important and facilitated the integration of learning when feedback was provided by the Reviewer
- Findings demonstrate the need for action to resolve practice and governance issues at local (team and service level as well as general management), regional and national level
- There are limited opportunities for supervision, mentoring and support of professional managers

In relation to practice the pilot audits identified that generally:-

- Thresholds for allocation of neglect cases to Social Workers are too high
- There is often a lack of understanding of the cumulative risks of long-term neglect and their significance for longer term development in children
- While there are some common characteristics of neglecting families there are also a range of characteristics making it difficult to typecast families. There was no clear profile in terms of family size or whether children lived in single or 2 parent family situations.
- Family dysfunction was often associated with chronic alcohol and substance misuse; domestic violence and/or mental health challenges and this is consistent with research findings.

- Inability to provide an appropriate level of nutrition, hygiene and organised daily living, including ensuring school attendance and attendance for routine medical and dental care, were common features of neglecting families.
- Attempts to support parents often masked a lack of focus on the harsh reality of everyday life for neglected children
- Social Workers often do not demonstrate the authority to require families to make positive changes as part of a contractual commitment
- There is at times an apparent absence of strong and timely legal back up - related to uncertainty about the State's role and authority (eg drink driving parents or parents under the influence of drugs including alcohol while in charge of minors). As is the case with research elsewhere, neglected children often had to experience another form of maltreatment such as physical or sexual abuse before being removed from home.
- Very few parents are prosecuted for criminal neglect despite coming to police attention for a variety of concerns such as alcohol and drug abuse, leaving children unattended and failing to provide proper care and supervision. In some high profile cases prosecutions have taken place after Care Orders were granted
- Paediatric developmental assessments are often missing or inadequate and there is no clear duty on HSE medical personnel, Area Medical Officers or paediatricians to provide appropriate and timely assessments
- The role of Child Adolescent Mental Health Services (CAMHS) is often limited, ambiguous and does not always address the impact of the neglectful environment on the child's emotional well-being and longer term mental health prognosis
- Communication challenges exist across disciplines and can remain unresolved for prolonged periods.
- Experiences in court and judicial decision-making influence thresholds for initiating care proceedings which are often too high
- There are challenges around the quality of court reports and expert testimony provided by Social Workers and others
- There are major challenges with the HSE interface with the courts specifically around thresholds for legal proceedings and the treatment and expectations of professional/expert witnesses

Preparation for National Peer Review Audit

It is imperative that the HSE develops a culture of audit in relation to neglect and other aspects of child protection. Opportunity exists to build on the findings of the pilot reviews to support localised audits of neglect.

The National Steering Group met in November 2011 to consider the feedback from the pilots and to consider options for the national audit of neglect. The proposal and options are set out in detail in Appendix 5. The Steering Group determined that the Audit Tool

worked well and that the final version used in Dublin South East would represent the agreed template (Appendix 4)

It was agreed that Regional Managers would commission and oversee audits within each LHO and support the implementation of recommendations.

Three models were considered including:-

Option 1 - Peer Led Audit by PSWs/CCMs
Option 2 - Peer Led Audit with Involvement of SWTLs
Option 3 - Internal Audit

Each option would be quality assured by the Independent Reviewer to ensure that professional managers undertaking the review were appropriately trained in understanding the consequences of neglect for children; appropriate thresholds for intervention; contracting with parents and others to bring about improvements for children; strategies that are effective; and recognising/responding to drift in chronic cases so that more robust safeguards can be implemented.

Following considerable discussion about the relative benefits and challenges, learning opportunities, and availability of reviewers with the requisite skills, it was agreed that Option 3 was the most viable approach but that this would need considerable oversight.

While it was acknowledged that the national audit of neglect could only take place once the new ISA Children and Family Services Manager had been appointed, a proposal was developed to test the methodology within HSE West. (Appendix 5)

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APPENDIX 1

LEGISLATIVE AND POLICY PROVISIONS

The main legislative and policy provisions governing the protection of children in Ireland include:-

United Nations Convention on the Rights of the Child (1989)

The guiding principles of the Convention are:-

- All children should be entitled to basic rights without discrimination (Article 2)
- The best interests of the child should be the primary concern of decision making (Article 3)
- Children have the right to life, survival and development (Article 6)
- The views of children must be taken into account in matters affecting them (Article 12)

Articles 19, 34 and 36 of the Convention cover a range of rights to protection and include statements in regard to ensuring children are safeguarded against all forms of abuse, neglect and exploitation. This includes the right to the development of their full physical and mental potential.

The Convention was ratified by Ireland in October 1992.

The Child Care Act (1991)

The Child Care Act was enacted in 1996 and its purpose was to 'update the law in relation to the care of children who have been assaulted, ill treated, neglected or sexually abused or who are at risk'. The main provisions of the Act include:-

- The placing of a statutory duty on Health Boards to promote the welfare of children who are not receiving adequate care and protection up to the age of 18.
- The strengthening of powers of the Health Boards to provide child care and family support services. Section 8 of the Act imposes a requirement on Health Boards to conduct an annual review of adequacy of its child care and family support services. This requirement is recognition by Government of the need to accurately determine and measure the needs of children across the State in order to effectively plan the services required to address identified need.
- The improvement of the procedures to facilitate immediate intervention by Health Boards and An Garda Siochana where children are in danger.

Children First, National Guidelines for the Protection and Welfare of Children (1999)

Children First provides comprehensive child protection policies and procedures. It states that 'the HSE has responsibility for operating a comprehensive child welfare and protection service, putting in place and promoting written procedures and practice guidance and providing leadership and commitment to interagency cooperation and training'.

Section 4.3 sets out the roles and responsibilities of the children and family services and states specifically that the HSE has responsibility for:-

- Resourcing child protection services in line with policies
- Operating within clear management structures
- Providing training and supervision for all staff undertaking child protection and welfare work
- Developing and maintaining standards and operating a quality control system

The principles underpinning Children First stress that the welfare of children is of primary importance, and that where conflict exists between the rights and needs of children and those of their parents, the child's welfare must come first. This can be difficult to reconcile with the additional principle that:-

- Children should only be separated from parents/carers when **all** alternative means of protecting them have been exhausted. Re-union should **always** be considered

Similarly the definition of neglect in Children First sets a high threshold for significant harm, which requires the child's needs to be neglected to the extent that his well being and/or development are **severely** affected.

National reviews of compliance with Children First have revealed considerable challenges with compliance and significant variations in interpretation and practice across the former Health Boards, and since 2005, across HSE regions.

A revised and updated version of Children First was issued for consultation during the period of this Review and was launched in July 2011, after the audit of cases had been completed. The practice and management of neglect in each of the areas has been evaluated in the context of the 1999 national guidelines.

(Children First) Initial Assessment Form and Guidance (2002)

Central to the implementation of Children First has been the Initial Assessment process. The guidance on Initial Assessment was developed nationally in cooperation with all of the Boards in 2002 and included a standard Initial Assessment Form.

The purpose of Initial Assessment is to establish whether a child has been harmed or is at risk of further harm, whether their safety and welfare is at risk, what type/level of intervention is required and to explore whether there is any other help the family may need in order to care adequately for their child.

The guidance requires that a separate Initial Assessment Form should be completed in respect of each child where more than one child is the subject of a report although not all sections of the form need to be completed.

The assessment of the child should be based on any interviews which have taken place with the child, parents and family members as well as information obtained from key professionals and agencies. The various dimensions to be considered include assessment of the child:-

- Health education
- Education
- Emotional and behavioural development
- Identity
- Family and social relationships
- Social presentation
- Self-care skills

A parental assessment should also be undertaken to take account of:-

- The parents response to concerns and their explanation of any incident
- The parents understanding of the child's needs and ability to meet those needs
- The level of basic care provided in relation to ensuring safety, emotional warmth, stimulation, guidance, boundaries and stability
- Strengths and weaknesses in the family including external supports
- The parents willingness to use help and support
- Factors such as mental health, substance misuse, domestic violence, criminal behaviour
- The environmental condition of the home and any history of abuse or neglect within the family

The Initial Assessment Form is comprehensive, guides the worker towards an evaluation of information collated and facilitates recommendations. It should be signed off by both the Social Worker and their Line Manager.

National reviews of compliance with Children First have revealed considerable challenges with compliance and significant variations in interpretation and practice across the former Health Boards, and since 2005, across HSE regions. Achieving more consistent practice has became a national priority prompting the design and roll out of standard business processes during 2010 and 2011 as noted below.

A revised and updated version of Children First had been issued for consultation during the period of this Review and was launched in September 2011, after the Review had been completed. The practice and management of neglect in the pilot Audits has been evaluated in the context of the 1999 national guidelines.

The National Children's Strategy, Our Children - Their Lives (2000-2010)

Ireland's first National Children's Strategy included an ambitious series of objectives designed to achieve the Vision of ' an Ireland where children are respected as young citizens... cherished and supported by family and the wider society....'

Chapter 5.2, and specifically Objective F, of the Strategy states that, in line with the State's obligations under Articles 19, 34 and 36 of the UN Convention**,** 'children will be safeguarded to enjoy their childhood free from all forms of abuse and exploitation'. In this Objective, the Government sets out a range of child protection initiatives including legislative provisions and the establishment of the Irish Social Services Inspectorate (SSI). Funding constraints and delays in establishing the Inspectorate on a statutory basis has limited the Inspectorate's activities to the inspection and registration of residential services with some inspection of foster care services. There is no provision at present for a formal review of child protection services.

The National Strategy has three central goals namely:

- Children will have a voice (through appropriate participation)
- Children's lives will be better understood (through appropriate research)
- Children will receive quality support and services to promote all aspects of their development

Agenda for Children's Services: A Policy Handbook (December 2007)

The Agenda for Children's Services builds on existing policies and directs policy makers and managers at all levels to ensure services are evidence-based, accessible, effective and sustainable. It emphasises the importance of a whole systems approach to meeting the needs of children and calls for a better focus on outcomes for children and families in both their current circumstances and in the future.

The Agenda was drawn up by the Office of the Minister for Children (OMC), now Office of the Minister for Children and Youth Affairs (OMCYA) which is unique in public service management in that it unites the three policy divisions of the Departments of Health and Children; Justice, Equality and Law Reform; and Youth Affairs for the purpose of achieving better outcomes for children. Specifically OMCYA is tasked with enabling all parts of public service management to work strategically together at national and local levels to achieve more effective and efficient delivery of children's services".

The Agenda for Children is based on the premise that supporting families is the most effective way to safeguard children.

A key objective of the Agenda for Children's Services is to provide the means for the HSE to evaluate their service delivery against this strategic direction.

HSE Infrastructure and Governance Arrangements

National Children and Families Steering Group

In recognition that there was considerable variation in policy and procedures across the country, the HSE established the National Children and Families Steering Group in 2006 to bring about standardisation and coherence to the practice and delivery of children's services across the HSE. It was chaired by the Assistant National Director with the lead role for Children and Families and comprised the lead LHMs for Child Care for each Region and the Regional Specialists.

The Steering Group worked on behalf of the entire HSE, with each member leading on specific aspects of work. Papers agreed by the Steering Group went to the National Management Team for PCCC for approval and subsequent dissemination of agreed policies took place through the Lead LHM. The Group met monthly, often by teleconference and managed a significant agenda of issues concerning all aspects of children's services. Their work included the development of a template for the Review of Adequacy Report, the development of a Risk Register for Child Care and the National Case Transfer Policy.

Social Work and Family Support Survey 2008

The survey collated comprehensive information about children's services across all Regions which included:-

- data on child welfare and staffing levels, practices, team structures, the size of caseloads, the management of unallocated cases, risk rating of cases, assessment frameworks used in child welfare and protection social work departments in each of the 32 local health offices in the HSE
- demographic and deprivation data that may impact on the levels of activity in child welfare and protection social work teams
- Social work data for each LHO

The objective of the survey was to increase understanding of the activity within each child welfare and protection department in the context of local economic and demographic factors and assist managers to make more informed decisions regarding service developments and resource use and allocation.

Data provided for the survey demonstrated a marked increase in the number of child abuse and child welfare cases to reported social work departments between 2002- 2006. Child abuse referrals increased by 41% and child welfare reports by 59%. The report acknowledges that many cases combine a variety of welfare and protection issues and the significant increase in minority populations requiring services was noted.

While there had been an increase nationally in the number of social work posts available, budget allocations and employment ceilings were barriers to getting additional posts sanctioned and 66 WTE social work posts had been lost throughout the country as a result of a national embargo on recruiting in December 2007.

The survey highlighted significant differences across the country in:-

- The structure of teams
- The size of case loads
- The models for assessment, risk analysis and for data collection

It noted high caseloads, waiting lists of cases to be allocated and challenges with the retention of Social Workers.

It was also clear that social work departments had different frameworks for categorising referrals in terms of welfare, neglect and abuse and that while attempts were being made

to provide early intervention to support families, priority was inevitably given to higher risk families where there were serious concerns about abuse and neglect.

The survey concluded that action was needed to:-

- Develop a performance monitoring programme for social work
- Develop a single standard framework for assessment of need
- Define an appropriate caseload for each Social Worker having regard to experience and the complexity of each case
- State the outcomes expected from social work interventions
- Introduce an equitable resource allocation model based on needs having regard to demography, deprivation, child care indices and the current allocation/distribution of resources

The survey revealed that of the total children in care at December 2006, neglect was the most common reason for admission (27%).

The survey involved considerable commitment from social work staff and their managers and represented the most comprehensive analysis of the social work role with families and children undertaken to date. The data collected was used to inform the HSE's bid for additional resources as a consequence of the Ryan Report and resulted in significant allocation of funding for new Social Workers.

Concerns about the adequacy of governance arrangements led to PA Consulting Group being commissioned to undertake a national review of child protection arrangements in 2008. Their recommendations are summarised in Appendix 2 and include the need for significant re-structuring of service delivery.

In December 2009 an Assistant National Director for Children's Services was appointed and in January 2011 the HSE appointed a National Director for Children and Families reporting directly to the Chief Executive Officer.

During 2010 the HSE developed a range of standard business procedures for child care which are in the process of being implemented across the country, in conjunction with a national computerised information system. Work is ongoing on the development of national policies and procedures for all aspects of children's services. A revised version of Children First: National Guidance for the Protection and Welfare of Children was launched in July 2011 with an accompanying Practice Handbook.

APPENDIX 2

SUMMARY OF PA CONSULTING GROUP'S REPORT TO THE HSE (2009)

'Inspiring Confidence in Children and Family Services: Putting Children First and Meaning It'

HSE commissioned the PA Consulting Group to review its arrangements for the delivery and management of children and family services. The key findings were published in a report dated August 2009 and included the following:-

- **There is an urgent requirement to set and communicate direction for the service**.
  The HSE needs an overall strategy and service model that will provide guidance to local managers and practitioners on how they should be delivering services for children.

- **There are significant variations across LHOs in how *Children First* is being managed and delivered.** Depending on where children at risk live in Ireland they can expect to receive different services from the Local Health Office.

- **More visible leadership is required across all levels of the service as well as tighter management.** The current management 'style' tends to be reactive, crisis-driven and focused on individual cases. There is a lot of management 'traffic' around individual cases which does not always result in better outcomes.
  To inspire confidence within the HSE and externally, tighter management is required on resources, quality of practice, outcomes for children.

- **Structures for delivering the service need to be simplified and clearer**. It is unclear where responsibility, authority and accountability lines for children and family services particularly at local level. There are inherent tensions between the PSW and CCM roles.

- **Supports to social workers and their managers are under-developed**. Social work managers have a clinical governance role but also a key role in supporting their staff. The scale of professional supervision and continuing professional development is inadequate at present to support social work professionals.

- **There is inconsistent practice in implementing child protection and supports.** There are significant variations in how risk is assessed and thresholds between different levels of service.

- **The service is not managed based on current intelligence**. The HSE currently produces a wealth of data on how children and family services are being delivered. However, this is not being routinely used by managers across the service to provide intelligence on how the service is being delivered, how resources are allocated and what outcomes the service is delivering for children.

PA recognised that there is no 'quick fix' remedy, rather the need for a clear sensible change programme that inspires confidence within and outside the HSE.

Governance and Management Structure

The current management structure can be traced back to the Health Boards and did not fundamentally change with the establishment of the HSE. Changes have been 'grafted' to the structure as needs arose.

The model in most LHOs is that both PSW and CCM report to the General Manager (GM). The PSW tends to have most of the line management responsibility with the CCM having minimal line management role. The PSW and CCM roles work well where there are strong relationships but it contains inherent tensions that are unhelpful and must be addressed.

Fundamentally, there is no clear line from Senior Management to front-line delivery.

The concept of 'lead role' by an Assistant National Director without operational responsibility has helped to address some complex issues such as residential care and unaccompanied minors. However it is not an effective way of securing service change as the roles often do not have the authority needed to deliver services.

There are questions as to whether the HSE is using some roles e.g. specialist, senior practitioner, strategy role, to best advantage. This is a considerable, under-utilised resource.

There are no formal escalation procedures and very weak performance structures. There is a tendency to micro-manage on the basis of individual cases which can generate a lot of unhelpful 'management traffic'.

Social work is the backbone of the children protection service. The profession feels under-valued and routinely undermined. This is particularly acute when interacting with the courts.

Unnecessary Variation

The level of inconsistency evident in how child protection services are delivered is unhelpful and weakens confidence in what is being delivered for children and their families. This degree of variation is both a symptom of the lack of a national service model for children and family services and a legacy from the different practices that prevailed in the Health Boards. In particular there are variations in:

- How cases are allocated and the length of time children can expect to wait. In effect, 'unallocated' cases represent a waiting list
- How children and their exposure to risk of abuse is assessed. Social workers apply a number of assessment frameworks but there is no common assessment framework.
- Different definitions and 'thresholds' apply across LHOs. For example, a 'case' can refer to a family or an individual child. There is particular confusion as to 'threshold' levels for protection and welfare.
- **The needs of children come second to the demands of the service**. This is well documented and widely recognised in the HSE and externally.

With regard to managing services, there is a gap between the authority for budget and the authority to make decisions in relation to services.

Support for Social Workers

Professional supervision and Continuing Professional Development (CPD) are key supports for social work professionals. In some LHOs - particularly Dublin - social workers have an average of 3 - 4 years experience. This underlines the importance of both professional supervision and CPD. The HSE has developed a supervision policy for all professions which will also apply to social workers. This focuses on individual supervision. However, it is unclear how senior social work managers and professionals will have access to supervision.

A key gap relates to the supports available for senior social workers. Many of them are either in senior positions and/or in post for some time and have not had structured opportunities for CPD.

Interface with the Courts

How the HSE interacts with the Courts is a 'flashpoint' of systemic weaknesses. The HSE has taken steps to improve its interaction with the Courts but it is still a significant area of corporate and individual stress.

Use of Data

The HSE collates data on its child protection services monthly and quarterly and this forms the basis of the Annual Review of Adequacy report. In 2008 the HSE conducted an extensive survey of social work and family support. PA Consulting Group's Review of the data shows that:

- resourcing is not influenced by the indicators of child population need

- the child protection workforce is still largely based on staffing levels from the old Health Boards
- there is huge variation in the approach to case definition with 'welfare' being the reason for referral in 6% of cases in LHO and 96% in another
- the variation in the proportion of cases allocated varies from 100% in one area to 26% in another
- **Despite the wealth of data, there is an absence of management information.** Data is not collected and interpreted to distil key messages. Managers are not routinely using existing data to inform their approach to service planning and delivery.
- **Desired outcomes and performance indicators are not defined**. The service would benefit from a clear, shared definition of success for children articulated into meaningful metrics that the service can use to monitor and manage delivery.

Looking Forward - Foundations for the Future

The HSE is reconfiguring its services at national, regional and local level. The structure agreed at national level is the starting point and the post of Assistant National Director of Children and Family Services is a key new role which will provide leadership to drive the necessary changes.

PA's proposals take account of the Ryan Commission Implementation Plan. Six principles are identified including:

- A structure capable of delivering change
- Child focussed
- Simple and clear structure - with clear points of authority, responsibility and accountability
- Confident - clarity and consistency
- Taking responsibility and being accountable
- Intelligence led

The Recommendations include:-

- Development of a coherent service model reflecting the Agenda for Children's Services and including guidance on:-
  - Early intervention
  - Family supports
  - Permanency planning
  - Crisis management including out of hours services
  - Children in care and aftercare
  - Working with other agencies

- Ensure a child centred service delivery based on identified need with appropriate resourcing to address need, stronger multi-disciplinary fora and stronger communication between disciplines and between agencies as well as strengthened professional supervision and CPD.

- Improved performance management including:
  - Streamlined interface with the Courts System
  - Immediate management information based on existing data
  - Clear budget and expenditure reporting
  - An appropriate workforce model

The report identifies key roles for Managers at National and Local level.

The Assistant National Director would have responsibility for

- Development of strategy and service model
- Development of learning culture including CPD and professional supervision
- Development of intelligence
- Drive programme of change
- Sets performance objectives

The Manager for Children and Family Services (at GM level)

- Provide clinical and management leadership
- Provide leadership in setting and delivering local goals as agreed with LHM and in line with National goals set by the AND.
- Be critical connector with other HSE services including primary care teams and Primary Care Networks
- Be principal point of contact for other agencies
- Provide local co-ordination of HSE interaction with the Courts
- Be responsible for resources and budgets
- Oversee and report on performance
- Have responsibility for quality assurance including supervision and CPD

APPENDIX 3

AN OVERVIEW OF RELEVANT RESEARCH ON NEGLECT AND FINDINGS FROM INQUIRIES

The neglect of children, its aetiology and consequences has been the subject of considerable study and neglect continues to represent some of the most complex situations which challenge professionals across the range of disciplines whose responsibility it is to safeguard children. This chapter examines the prevalence of neglect, how it is defined and what the available evidence tells us about its causes and impact. It also draws on the findings from child abuse inquiries, serious case reviews and current research to highlight practice issues in working with neglect and ways of improving our current response.

Prevalence of Neglect

Neglect is the most frequently reported form of maltreatment in the USA, Canada, Australia and in the United Kingdom, accounting for more than 40 per cent of reports of maltreatment (Moran 2009). In Ireland in 2000, 40% of reported child abuse was categorised as neglect and in 2008 this figure remained similar at 38%. (HSE Social Work Survey 2008).

Definitions of Neglect

There is broad consensus that child neglect is complex and multifaceted. Early definitions focused on physical neglect, such as inadequate living environment, personal hygiene or nutrition but these have since expanded to include multiple categories such as supervisory neglect, abandonment or desertion, and educational or medical neglect as well as psychological and emotional neglect (Howarth, 2007). Unlike physical or sexual abuse, in which specific abusive acts are directed towards a child, neglect is typically defined by the absence of provision for a child's basic needs.

Minty and Pattinson (1994) define neglect as "a persistent failure to meet a child's essential needs by omitting basic parenting tasks and responsibilities. The basic needs that are not usually met are those for adequate food, clothing, shelter, cleanliness, stimulation, medical care, safety, education and love and control, in spite of parents having the resources to meet these needs at a basic level." They suggest that parental resources are at the heart of a determination as to whether neglect is apparent.

Crittenden (1999) defines neglect in terms of cognitive rather than socio economic factors and identifies 3 types of neglect:-

- Disorganised neglect- where parenting is entirely inconsistent, with parents going from crisis to crisis
- Emotional neglect- where the parent is unable to share feelings
- Depressed neglect - where the parent is withdrawn, passive and helpless and therefore unable to respond to the child's physical or emotional needs.

Many researchers believe it is difficult to differentiate between emotional abuse and neglect, indicating that both regularly feature together in families. Ney et al (1994) found that neglect rarely occurs in isolation and is often a precursor to other forms of abuse. Emotional Neglect is defined by Iwaniec (1996) as "hostile or indifferent parental behaviour which damages a child's self esteem, degrades a sense of achievement, diminishes a sense of belonging, prevents healthy and rigorous development and takes away a child's well being".

The term failure to thrive is used to describe an infant or young child whose growth falls substantially behind that of his peers and often results from inadequate diet and/or maternal deprivation. Health Visitors in the UK tend to define children whose weight is on or below the third centile as failure to thrive.

In Ireland neglect is defined within Children First (1999):-

- *Neglect can be defined in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, medical care.*
- *Harm can be defined as the ill-treatment or the impairment of the health or development of a child. Whether it is significant is determined by his/her health and development as compared to that which could reasonably be expected of a child of similar age.*
- *Neglect generally becomes apparent in different ways over a period of time rather than at one specific point. For instance, a child who suffers a series of minor injuries is not having his or her needs met for supervision and safety. A child whose ongoing failure to gain weight or whose height is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived of intellectual stimulation.* ***The threshold of <u>significant</u> harm is reached when the child's needs are neglected to the extent that his or her well-being and/or development are <u>severely</u> affected****.*

The definition is unchanged in the draft revised Children First Guidelines of 2011.

Causative Factors in Neglect

Many researchers have attempted to understand the causation of neglect. Polansky (1981) suggested that the root cause of child neglect is to be found in the psychological and developmental deficits of parents. Egami et al (1996) found that anxiety disorders are more strongly associated with neglect than abuse and that neglectful mothers tend to exhibit higher levels of depression. There is now broad consensus that no one risk factor is likely to cause maltreatment, but rather its occurrence is more often associated with the presence of multiple risk factors (Asmussen, 2010). Key risk factors widely cited within the literature include: socio-economic deprivation, parental background, poor mental health, lack of social support, neighbourhood poverty, substance misuse, domestic violence and attitudes towards physical discipline (Asmussen, 2010, Bunting et al. 2008). However, despite an increased understanding of the causes of maltreatment, there are relatively few studies which explicitly examine neglect.

Connell-Carrick, (2003) provides a valuable overview of the literature specifically relating to neglect as well as illustrating the ways in which neglectful families differ from physically abusive families. This review identifies poverty, a large number of people living in the home, and single parent status as associated with neglect, as was unemployment, young maternal age, and low levels of education. Large family size also correlates positively with the occurrence of neglect because it impacts upon the resources available for each child. Poor physical conditions are known to commonly feature in neglectful families and Scourfield (2000) found that Social Services had a pre-occupation with dirt, mess and smell in the identification of neglect and this led to home conditions being cited as the primary grounds for implementing child protection inquiries.

Alcohol and substance abuse are commonly cited risk factors within the literature and it is widely recognised that neglect more often occurs in families which are experiencing multiple adversities (Bovarnick, 2007). Parents who misuse alcohol and other drugs often have multiple problems which impact on their capacity as caregivers and it is the combination of these factors that increases the risk of harm to children (Connors et al 2004) Substance abuse is usually considered to be a risk factor for disruption in primary care giving or neglect (Nelson et al 1993) and children born to substance using women are disproportionately at risk (Nair 1997). Fisher et al (1995) found that 89% of children on a Child Protection Register in a local Authority in Britain came from families whose parents misused alcohol and/or drugs. Despite concerns and the consequence of increased care proceedings, Forrester (1995) found very few substance misuse professionals were involved with families. Knoll & Taylor (2003) acknowledge the difficulties in working with substance misusing parents in term of engagement and working effectively in an interagency context. They stress the need to "identify the extent to which children's' needs are not being met and the consequences for their welfare and development". Tunnard (2002) stresses that

professionals who work with adult drinkers need to recognise their needs as parents and emphasises the need for joint training, as well as clarity of roles and responsibilities, for multi-agency approaches to be effective. In Northern Ireland the Regional Hidden Harm Action Plan (2008) aims at minimising the effects of parental alcohol and drug misuse on an estimated 40,000 children.

Child age was also identified as a risk factor for neglect with younger children more likely to be victims of neglect than older children. Various studies have confirmed the importance of the early interactions between a parent and child, demonstrating that these can be influential in the onset of neglect. Iwaniec (1996) describes the features of a hostile parent child relationship that constitutes emotional neglect and can lead to maltreatment. These include lack of eye contact, verbal contact and appropriate touching, ignoring or rejecting the child, physically neglecting to attend to the child's needs and inflicting psychological pain.

There is significant evidence to suggest that some aspects of neglect are inter-generational and factors such as parental unemployment, general disorganisation and lack of support networks typically perpetuate neglect. Connell Carrick (2003) found that neglectful parents had fewer individuals in their social networks, received less tangible and emotional support from members, and saw them less often than non-neglecting mothers. Connell Carrick also indicated that neglectful parenting practices may be related to low intellectual capacity with an estimated 72 per cent of neglectful mothers suffering intellectual impairment compared with only 5 per cent of physically abusive mothers.

Moran (2009) notes that gender has a strong role to play as it is usually the mother who will be seen as neglectful if the child is not adequately cared for or supervised, even in intact families. Likewise Bovarnick's (2007) review of the literature observes that the available research largely focuses on mothers with the role of fathers in neglect remaining largely unexplored. The need to engage with fathers in preventing interventions is recognised in the NSPCC's recently launched 'All Babies Count' initiative (NSPCC 2011).

Impact of Neglect for Children

Although research which focuses on the effects of neglect, is less readily available than for other areas of child maltreatment a number of reviews highlight the range of short and long-term outcomes for children and young people. Most recently Lazenbatt's (2010) review on the impact of abuse and neglect on the health and mental health of children and young people has highlighted how persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and

educational progress. Neglected children are disproportionately likely to be socially withdrawn and have feelings of incompetence (Finzi, Cohen and Sapir 2000).

Evidence also shows that that maltreatment may inhibit the appropriate development of certain regions of the brain (Glaser, 2000). A neglected infant or young child may not be exposed to stimuli that normally activate important regions of the brain and strengthen cognitive pathways. The connections among neurons in these inactivated regions can literally wither away, hampering the child's functioning later in life. As a result, the brain may become 'wired' to experience the world as hostile and uncaring. This negative perspective may influence the child's later interactions, prompting the child to become anxious and overly aggressive or emotionally withdrawn. Persistent neglect can lead to serious impairment of health and development. Hildyard and Wolfe (2002) conclude that child neglect can have severe deleterious short and long term effects on children's cognitive, socio-emotional and behavioural development and these are more severe when the neglect occurs during the first two years of life.

Lazenbatt (2010) also noted that neglect and other forms of abuse may also be associated with neuromotor handicaps, such as central nervous system damage, physical defects, growth and mental retardation, and speech problems (Chester, 2006). Children who experience rejection or neglect are more likely to develop antisocial traits as they grow up and are more associated with borderline personality disorders and violent behaviour (Schore, 2003). Abused and neglected adolescents are estimated to be at least 25 per cent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems (Kelley et al., 1997).

Moran's (2009) review of the literature on child neglect concludes that neglected children have learning and academic problems, tend to be inattentive and uninvolved in learning, often have language delays, have difficulty maintaining positive self-esteem and are often socially isolated. They are characterized by depression and withdrawn behaviour and are passive and apathetic in their approach to life, expecting to fail in whatever they do and often give up trying to succeed. Neglected children often have trouble understanding complex messages as their communication skills are poor and their experience of neglectful relationships in the family lead them to expect neglect in their relationships outside the family. In the long term, persistent underachievement in school and educational neglect deprives them of the ability to support themselves in the future and to participate fully in society.

Lazenbatt (2010) observes that children who live in homes where domestic violence occurs are 15 times more likely to be physically abused or seriously neglected compared to the general child population. Singer et al (1998) indicate that child witnesses to domestic violence are, on average, more aggressive and fearful and more often suffer from severe

anxiety, depression and other trauma-related symptoms. They live with constant anxiety and may be at a higher risk of alcohol or drug abuse, experience cognitive problems or stress-related ailments such as headaches or rashes, and have difficulties in school**.**

Findings from Inquires and Serious Case Reviews – Practice Issues

In its most serious form neglect can lead to the death of a child, as numerous child abuse inquiries and reviews of child deaths across the UK and Ireland have tragically demonstrated. Highly publicised inquiries in the UK into the death of Victoria Climbie (Laming 2003) and Baby P (Laming 2009) challenge professionals to see things from the child's perspective.

Brandon et al's (2009) detailed analysis of Serious Case Reviews conducted in England between 2005-2007 showed how neglect both directly caused and contributed to the death and serious injury of children. Neglect was most often the cause of children experiencing serious harm including accidents and house fires. It is of particular note that at the time of the serious incident, 17% of the children were the subject of a child protection plan with the major category of concern being neglect. Just over half of the children were known to children's social care at the time of the incident and for these children neglect was the most commonly identified pre-existing concern.

Neglect has also been a feature in several serious case reviews in Ireland including the report of inquiry into Kelly Fitzgerald (Western Health Board 1996) which identified the complexity of working with children who have been abused or neglected and noted the children typically have a mixed relationship with their parents of which extreme loyalty and collusion are features. It is important therefore for professionals to have an understanding of disorganised and dysfunctional attachment. Crittenden (1993) found that children whose mothers were not psychologically available to them manifested angry disobedient behaviour, yet were highly dependent on their mothers. A lack of parent child interaction is more likely than physical abuse to result in dysfunctional attachment styles. Children whose parents are unresponsive are likely to become clingy and whiney as a reflection of their anxious and insecure relationship with their primary care giver. Dingwall et al (1983) suggests that the perceived seriousness of neglect can be minimised by the 'rule of optimism' that the innate natural love between a parent and child will somehow overcome most problems.

Lord Laming's (2009) recent review of safeguarding children's services following the death of Baby P in Harringay Council (Laming 2009) called for an overhaul of children's social work, flagging up issues such as leadership, recruitment, training, learning from experience, partnership working and availability of resources.

An analysis of the implications of Inquires and Serious Case Reviews in England, specifically in relation to neglect (Dent & Cocker, 2005) provides a detailed overview of number of key practice areas commonly identified as problematic. These include:-

- **Multidisciplinary work and communication** - in cases of child neglect where the sharing of information is crucial at a relatively low threshold, maximizing dialogue is important. However, the evidence from practice and serious case reviews indicates that many professionals find it a difficult issue to address effectively. This can be caused by failure to recognize and thus share important information; tension or conflict in the communication; fear of breaking rules of confidentiality.

- **Bias and errors in decision-making -** Decision making, particularly in neglect is a complex process, There is strong evidence from serious case reviews that once practitioners have formulated a hypothesis they are reluctant to change their mind in spite of information to the contrary being available. Serious Case Reviews repeatedly emphasize the importance of a good assessment that includes historical information and frequent multi-professional reviews to stop 'drift'.

- **Case complexity** – Many Serious Case Reviews identify 'assessment paralysis' in which the focus of professional attention on a parent or carer's issues and difficulties takes over the whole case, to the detriment of maintaining a focus on the child. Professionals can experience an overwhelming sense of need within the family: Invariably the practical needs are the easiest to identify and address the danger is that the intervention does not tackle the fundamental reasons for the problems.

- **Keeping the child central** - Several serious case reviews have pointed to the 'rule of optimism' at play, where professionals were too ready to believe the best of parents or even over-identify with their perspective. This resulted in:-
    - a loss of focus on risks to the child and
    - a lack of assessment of parental capacity to change
    - a lack of and monitoring of intervention outcomes specifically in relation to improvements for the child.

- **Resources** - lack of suitably qualified staff and resources to provide support and interventions for families with complex needs are commonly identified difficulties. Many families struggle financially and may need considerable practical support. However, where money and other supports have been made available to parents and no change is apparent, then a hypothesis of maltreatment through the parents' own emotional impoverishment must be considered.

- **Case recording** - in many serious case reviews the risk contained within the information on file has never been grasped simply because no one person had read the file. Lord Laming emphasized the value of basic good practice in relation to recording. Fact, opinion and hypothesis testing should be easily recognizable on file, especially in the context of frequently changing personnel. At the very least a chronology of important events, of agencies involved and the dialogue between them is essential.

Brandon et al (2009) observed how working with overwhelmed, chaotic families experiencing multiple adversities such as substance abuse, mental health, domestic violence and criminality often appeared to engender similar feelings of being overwhelmed among the professionals involved. Likewise low parental expectations appeared to be shared by professionals working alongside the families, deepening over time. In these circumstances professionals often tacitly accepted domestic conditions and care-giving environments which were hazardous to the children's safety, welfare, and development. As one Serious Case Review report noted:

'The balance in cases of neglect is between allowing enough time for interventions to demonstrate some success and knowing when to call time because of lack of progress.'(Brandon et al, 2009, p69)

Lack of co-operation from the families involved was a feature of many cases and the importance of understanding the difference between active and passive co-operation is emphasised. Some children living in 'overwhelmed' families were known to be neglected, but their circumstances were not judged to reach the threshold for services from children's social care. Several Serious Case Reviews noted that staff working with low level cases on the threshold of receipt of services from children's social care, were not appropriately qualified to assess or deal with the level of complexity evident in the children who required family support services. Equally, a number of cases involved children who had a long history of agency involvement and years of high intensity services but yet received little or no help during their teenage years, despite warning signs that they were experiencing more serious problems.

Likewise findings from research, inquiries, inspections and case reviews in Ireland, North and South, have identified similar issues.

North Eastern Health Board Research 2001-2004

In an attempt to better understand and respond effectively to the needs of neglected children the North Eastern Health Board in Ireland commissioned comprehensive research into the understanding and management of neglect by professionals in a range of

disciplines. The review by Howarth and Bishop (2001) considered the characteristics of 57 cases from across the NEHB area. They found alcohol use by carers and lack of supervision of children to be the most commonly reported forms of neglect. This included children left unattended or in the care of unsuitable care givers, children who were inadequately supervised and children who were permitted to engage in harmful activities. While the study found a great deal of effective practice in terms of protecting neglected children they identified a number of areas in which policy, practice and governance needed to be strengthened. These included delays in responding to referrals, failure to use Children First Protocols, inadequate recording, difficulties in engaging aggressive or uncooperative parents, the absence of a focus and assessment of the child's overall needs, either no assessment of parental capacity or failure to analyse the impact of parental issues such as alcohol misuse, marital disharmony, domestic violence, learning difficulties, physical disability.

Howarth (2001) devised a framework for assessing child neglect in the context of the childs basic needs for:-

- Intellectual stimulation
- Basic care, food, clothing, warmth and hygiene.
- Medical care
- Supervision and safety
- Attachment and affection

Guidance for the assessment framework includes the need for observation and direct work with each child as well as, assessing parental capacity including a realistic appraisal of the impact of parenting issues on their ability to meet the developmental needs of the child. Howarth stresses the need to not only collate information across disciplines but to analyse that information and use it to make decisions and plan relevant interventions with the explicit purpose of addressing identified unmet needs.

A subsequent study (Howarth & Saunders 2004) was commissioned to assist more effective multi-professional understanding and interventions with neglected children.

Its recommendations included:-

- Agreement on a common assessment framework for neglect.
- Consistent use of Children First protocols for both assessment and case planning.
- Child protection plans and family support plans which include clear aims and objectives and define what is to be monitored, how and by whom.
- Audit by senior managers to ensure the service provision is commensurate with the needs of the child.
- Review of situations of violence and threat to workers and appropriate debriefing and support.

- Caseloads that are commensurate with the experience, knowledge and skills of the worker.

The study also identified the following multi-disciplinary training needs:-

- Ways of engaging families and children in the process to ensure the assessment is child focused
- Assessing parenting capacity including strengths and weaknesses of both parents rather than focusing on mothers.
- Training on ways of working with aggressive and uncooperative parents.
- Communicating with children to ascertain their wishes and feelings and to assess the impact of neglect on their lives.

The Inspection of Child Protection Services in Northern Ireland (DHSSPS, 2006)

The inspection which took place in a number of Health and Social Care Trusts during 2004 - 2006 concluded that 'there was clear evidence of repeated failures to undertake timely and appropriate assessments and to provide child protection intervention, resulting in children being left at risk...'

Of particular relevance to the management of neglect, the Inspection found:-

- There was often insufficient challenge by social services and the police to families characterised by repeated domestic violence and excessive misuse of alcohol.
- Some children remained in families where due attention was not always afforded to their basic health, developmental and educational needs.
- Excessive family support failed to bring about needed improvements in their situation.
- The needs of parents with learning disability or mental illness were addressed sometimes at the expense of physical and emotional care being provided to children. The particular needs of children within families characterised by learning difficulties and/or mental health problems were often not fully understood.

The Inspection recommended that the management of cases must reflect an appropriate balance between working in partnership with parents to avoid family breakdown and using the authority of the Trust to effectively intervene to challenge harmful situations and safeguard children (p 46). Written contracts with parents should be used routinely to specify the work plan and clearly state the standards and improvements expected of them (p 47).

The Inspection also noted that failures to adequately safeguard children were not just attributable to deficiencies in practice. Major deficiencies were identified in governance arrangements, accountability, workforce planning, staff supervision and support as well as auditing and monitoring of statutory responsibilities by Area Health and Social Services Boards and local Trusts. As a consequence the Minister for Health, Social Services and Public Safety initiated a fundamental reform of child protection services in Northern Ireland to include robust governance and performance management systems, the development of a single assessment framework, agreement on thresholds for access to children's services and the strengthening of community child protection teams.

In a joint submission to the Northern Ireland Assembly in November 2009, NSPCC and Barnardos (NI) expressed concern at the level of neglect of children and the need for greater priority to be given to tackling neglect through a range of interventions.

Treatment and Interventions to Protect Children

The extent of neglect evidenced within serious case reviews demonstrates that outcomes for many neglected children across the UK and Ireland have been poor and that much more needs to be done to effectively address this multi faceted problem.

Iwaniec (1997) suggests that a combination of family work and day care support can reduce the consequences for children in severely neglectful families. Stevenson (1998) suggests that successfully working with neglect requires:-

- A holistic assessment of deficits in the child's upbringing
- A realistic approach in working in partnership with parents
- An acceptance of the need for long-term work
- Flexible and intensive provision for children and specialised work between social work, other professionals and schools

Dubowitz (1999) advocates focusing on whether the basic needs of the child are met rather than the intentions or behaviour of the parents.

Gardner's (2008) in-depth research builds on the policy and research developments of the past decade, drawing together professional experiences and perspectives with expert opinion to highlight the key elements of the systematic response needed to deal with the multi-faceted nature of neglect. These elements include interalia:-

- agreed information-sharing and recording of concerns about child neglect
- assessment and risk analysis specific to child neglect, linking identified problems to relevant services.

- greater precision in legal and procedural terms and thresholds
- each local authority having an inclusive strategy for addressing neglect, including a crisis response
- good quality information for children, parents and concerned others, with identified contact points
- universal and targeted provision for children and parents (separately and together) that addresses specific components of neglect

A thorough sensitive assessment process will help to determine the nature and extent of risks to children as well as identifying any protective factors. With substance abusing parents, Tunnard (2002) stresses the need for coordinated multi-agency interventions which tackle both the parents' needs and the children's needs and may include alcohol reducing strategies, parenting programmes, provision of quality childcare and educational opportunities for children as well as individual family and group counselling.

Attempts to improve the effectiveness of interventions are on-going across the UK and Ireland. In her investigation on behalf of the Department of Health in England and Wales Munro (2010) identified the following risks in a number of serious case reviews and these which resonate strongly with the findings of the Roscommon Inquiry:-

- Resistant and unwilling parents and/or children.
- Parents who intimidated and threatened workers.
- Difficulties in engaging and relating to fathers.
- Challenges for workers in building trust and listening to children.
- The need to avoid collusion with parents and to overcome the rule of optimism.
- The unwillingness of Adult Services to see their clients as parents and to contribute to the assessment of harm to children.

Conclusion

It is evident therefore that the challenges involved in combating neglect are similar throughout Ireland and the United Kingdom and that opportunities exist to integrate the learning from relevant experiences and serious case reviews. Professionals clearly need greater awareness, understanding and training in relation to the identification and management of child neglect as well as enhanced skills in working with defensive and resistant parents as well as parents who misuse alcohol and drugs. Managers need to have more robust governance arrangements in place to quality assure services, including mechanisms for ongoing monitoring and audit of the efficacy of inter disciplinary arrangements in individual cases. Findings in relation to the cases reviewed in the pilot audits resonate strongly with the research and findings from Inquiries.

APPENDIX 4

Audit Template

Review of Neglect Cases in HSE

Name of Family			File Number/
			Social Worker
Address			SWTL
			CCL/Family Support
			Worker
Other services Involved:	Psychology	❒	Family Doctor
	CAMHS	❒	
	Speech & Language	❒	Public Health Nurse
	Garda	❒	
	Other	❒	

Family Composition

Name	Relationship	Age & DOB	School/Work

	Yes	No	
Essential information -Easily accessible on file	❒	❒	**Comments**
Previous history summarised	❒	❒	
Outcome of Preliminarily Inquiry clear	❒	❒	
Initial Assessment completed	❒	❒	**Date(s)**
Further Assessment	❒	❒	**Date(s)**
Does assessment contain all relevant information?	❒	❒	**Identify Gaps**
Evidence of appropriate consultation with relevant professionals	❒	❒	
Inter Disciplinary Case Planning Meeting	❒	❒	**Date (s)**
Evidence of a Family Support plan	❒	❒	**Date (s)**
How were parents engaged in plan			
Family Welfare Conference held	❒	❒	**Date(s)**
Child notified to CPNMT	❒	❒	**Date(s)**
			Outcomes
Child Protection Conference	❒	❒	**Date(s)**
Child Protection Plan Evident	❒	❒	

How were parents engaged in Plan?

Are outcomes to reduce neglect SMART? ❒ ❒

(Specific, Measurable, Achievable, Realistic Time lined)

Review Case Conference ❒ ❒ **Date(s)**

Is Plan processing appropriately? ❒ ❒ **Identify any Blocks**

Is Child Adequately Safeguarded at Present? ❒ ❒ **Identify Risks**

Application made for Supervision Order ❒ ❒ **Date Granted**:

Care Order ❒ ❒ **Date Granted:**

Outcome of Court Proceedings

Are any of the following a factor in the neglect:-

Alcohol Misuse ❒ ❒

Drug Misuse ❒ ❒

Parental Mental Health ❒ ❒

Domestic Violence ❒ ❒

Are the Family native to Dublin? ❒ ❒

If not where did they move from?

Immediate Action Needed Yes ❒ No ❒

If yes, specify

Practice Issues Identified

Record Keeping

Assessment

Case Management and Review

Listening to and Involving Children

Recommended Actions

-
-
-

Evidence of Supervision/Dates

Case Summary

Summarise case history, including when first referred to social work and chronology of key events

APPENDIX 5

Discussion Paper
National Audit of Neglect
To be Conducted by Quality Assured Peer Review Process

Background

The Roscommon Child Care Case Inquiry (2010) found that, despite involvement of a range of disciplines and services, there was a failure to identify the extent and severity of the neglect and abuse suffered by each of the children. As a consequence of the Inquiry there has been widespread recognition of the need for a better understanding of the nature and impact of neglect at all levels of the HSE more effective intervention's and enhanced governance arrangements which together result in improved outcomes for children.

Recommendation 5.2.2 of the Roscommon Inquiry Report states that:-

- The HSE should develop and implement a national policy of audit and review of neglect cases
- An audit of current practice of chronic neglect cases should be undertaken in Co Roscommon in the first instance
- Experienced Senior Practitioners from another HSE area, undertaking practice audits within an agreed national audit of practice framework, could identify cases where drift rather than active planning and management had occurred and recommend any appropriate changes
- (The audit) would identify best practice models for dealing with the cases and develop national standards to guide practice

In order to ensure that the review of neglect cases in Roscommon proceeded as a matter of urgency, the HSE commissioned an independent consultant in September 2010 to undertake an Audit of Practice and a Review of the Management in cases of Neglect. It was envisaged that this would represent a pilot for the national audit process.

Lynne Peyton is a Child Care and Management Consultant with extensive experience of auditing and quality assuring children's services. She has been a senior manager in both the statutory and voluntary child care sectors and since establishing her consultancy in 2001, has provided independent advice on a range of projects throughout Ireland. She was a core member of the Inspection of Child Protection Services in Northern Ireland which reported in 2006, has conducted reviews of child protection and family support practice on behalf of a range of agencies and has chaired and facilitated a number of serious case reviews.

It was subsequently determined by the National Director of Integrated Services Directorate that the pilot should be extended to include two other Local Health Offices (LHOs) in which serious case reviews were due to report their findings in 2011.

National Steering Group

A steering group was formed at national level to support the pilot project. This was chaired by the Head of Quality Assurance and External Relations in the Office of the Assistant Director of Children's Services and comprised the National Specialist HSE who was a member of the Roscommon Child Care Inquiry Team and senior child care managers from Roscommon, Waterford and Dublin South East LHOs, as well as the Independent Reviewer. The group also benefited initially from input from the National Lead for Child Protection.

The audits were conducted within the three pilot areas during the period September 2010 to September 2011 and the findings presented to local and regional general management as well as to Heads of Services by way of workshops and a report. Although there were significant differences in the approaches and arrangements in place within each area there were a number of common findings which need to be addressed at local, regional and national level.

Key Findings from Pilot Projects to Review Practice and Audit Management in Neglect Cases

Work is underway to produce a composite report identifying the learning from the pilot audits. The following is only a snapshot of the emerging issues.

General Findings

- Neglect cases are prevalent within each team's caseload
- Team functions and composition differs considerably across localities with varying degrees of specialism
- Neglect is the most common reason for inclusion on the Child Protection Notification System (CPNS)
- Neglect cases are often open to CPNS for a number of years
- A sample size of 30-35 per LHO provided a good spread across the continuum of neglect cases, from cases on the duty waiting list to children in care as a consequence of neglect
- Cases identified by Social Work Team Leaders were often the most serious and chronic cases and social work managers welcomed the Reviewer's input into these cases

- Additional families in which chronic neglect was a significant concern were identified by other disciplines
- The involvement of senior management across disciplines is essential, as the Review identified issues in the management of neglect within many disciplines, particularly Public Health Nursing, AMOs/Paediatricians, Psychology and CAMHS
- The process of engaging with Principal Social Workers, Social Work Team Leaders and Social Work staff was important and facilitated the integration of learning when feedback was provided by the Reviewer
- Findings demonstrate the need for action to resolve issues at local (team and service level as well as general management), regional and national level
- There are limited opportunities for supervision, mentoring and support of professional managers
- As noted in the Social Worker Survey there are significant variations in staffing levels between LHOs within regions

Practice Findings

- Thresholds for allocation of neglect cases to Social Workers are too high
- There is a lack of understanding of immediate risks and of cumulative risks, and their significance for longer term development in children
- While there are some common characteristics of neglecting families there are also a range of characteristics making it difficult to typecast families. There was no clear profile in terms of family size, single or 2 parent families etc. However family dysfunction was often associated with chronic alcohol and substance misuse; domestic violence or mental health challenges. Inability to provide an appropriate level of nutrition, hygiene and organised daily living, including ensuring school attendance and attendance for routine medical and dental care, were common features of neglecting families.
- Attempts to support parents often masked a lack of focus on the harsh reality of everyday life for neglected children
- Social Workers often do not demonstrate the authority to require families to make positive changes as part of a contractual commitment
- There is at times an apparent absence of strong and timely legal back up - related to uncertainty about the State's role and authority (eg drink driving parents or parents under the influence of drugs including alcohol while in charge of minors). As is the case with research elsewhere, neglected children often had to experience another form of maltreatment such as physical or sexual abuse before being removed from home. Very few parents are prosecuted for criminal neglect despite coming to police attention for a variety of concerns such as alcohol and drug abuse, leaving children unattended and failing to provide proper care and supervision

- Paediatric developmental assessments are often missing or inadequate and there is no clear duty on HSE medical personnel, Area Medical Officers or paediatricians to provide appropriate and timely assessments
- The role of Child Adolescent Mental Health Services (CAMHS) is often limited, ambiguous and does not always address the impact of the neglectful environment on the child's emotional well-being and longer term mental health prognosis
- Communication challenges exist across disciplines and can remain unresolved for prolonged periods.
- Experiences in court and judicial decision-making influence thresholds for initiating care proceedings
- There are challenges around the quality of court reports and expert testimony provided by Social Workers and others
- There are challenges with the HSE interface with the courts specifically around thresholds for legal proceedings and the treatment and expectations of professional witnesses

Preparation for National Peer Review Audit

It is imperative that the HSE develops a culture of audit in relation to neglect and other aspects of child protection. Opportunity exists to build on the findings of the pilot reviews to support localised audits of neglect

The following issues will need to be addressed and resolved:-

Steering Group Composition, Role and Quality Assurance Mechanisms

Composition

- Regional representatives to include each Regional Child Care Lead
- National representatives including representative of the Office of National Director, Children and Families Services - Consideration to be given to need for representatives from Training and Legal Services
- Independent Advisor

Role

- To ensure a robust national audit of neglect takes place within an appropriate timescale and creates the foundation for a culture of audit
- To disseminate the findings of the independent pilot audits
- To ensure roll out of the national and regional agreements/recommendations of the pilots
- To ensure the integration of best practice

Quality Assurance Mechanisms

- Provision of appropriate training and guidance for peer reviewers
- Independent Reviewer's oversight to ensure consistency of approach and monitor the quality and robustness of the peer led process

Role of Regional Managers

- To commission and oversee peer led projects and ensure these are carried out within agreed protocols and timeframes
- To secure appropriate resources to support the audit process
- To formally agree the report, recommendations and an action plan for each LHO and support its implementation
- To collate and share learning throughout the region

Identification of Reviewers

It is important that neglect is not viewed as a purely Social Work concern and that the Children's Services Manager/Principal Social Worker is supported in the Review process by other Senior Professional Managers. Criteria for selection would include

- Heads of Services with relevant experience in multi-disciplinary child protection and in audit/case review processes
- Representatives of relevant disciplines for example Principal Psychologist, Director Public Health Nursing

It is important that selected reviewers have:-

- Delegated authority
- Release from day to day responsibilities to facilitate timely completion of the audit
- Training, mentoring and quality assurance support

Reporting mechanisms and accountability

- There should be clarity about reporting mechanisms for
  - the audit process
  - concerns about individual children which arise during the process including prompt access to an identified manager in the event of a need for urgent action

Reporting channels could include:-

- GM/Children's Services Manager

- Regional Manager
- National Office

Case Selection

Based on the findings of the pilot audits, it is important to review cases across the spectrum to include recent referrals for child protection and welfare which are screened as neglect through to cases in which children are currently subject to supervision orders/care orders as a consequence of chronic neglect.

For the purpose of the audit 'case' refers to a family within which there may be one or more children.

The minimum sample necessary to achieve an appropriate understanding and oversight of practice is likely to be 20 cases selected in line with the following criteria. Some of these may overlap but based on the findings elsewhere it is important to ensure all these categories are captured. In one area one of the most chronic and serious cases of neglect had been on a waiting list for allocation for more than a year. In another older children were in long-term care and the younger child at home was at very considerable risk.

Type of Case	**Number of cases**	**Estimated number of days to Review**
Cases on the waiting list for initial assessment	3	0.5 -1 (requires discussion with SWTL)
Cases on the waiting list for allocation post IA	4	1.5 -2 (requires discussion with SWTL)
Allocated/unallocated open cases known for over 2 years	1-2 per team (max 8)	5
Cases with multiple referrals/open closed several times	3 (may be included in above)	3
Cases open to CPNS for more than 2 years	2 (may be included in above)	2
Cases in which Children are subject to supervision orders/care orders or applications for same	2	3
Total	20	13-15

In all cases neglect will be the primary concern although other forms of abuse may also be evident.

Administrative Support

The audit will require identified and dedicated administrative support to facilitate the collation and transportation of case files and the typing of audit proforma in each case.

Audit Tool

The Audit Tool works well and has required only minimum modification. The final version used in Dublin South East has been agreed for use in the national audit.

Reports

The purpose, nature, detail and audience for the reports will need to be agreed. It is recommended on the basis of findings and experience elsewhere that the full report should be for internal use and should support change management and practice development. It should identify the strengths and challenges and record the action plan agreed with managers within the LHO and make appropriate additional recommendations as required. In Roscommon where there was a commitment to a published report, a redacted version has been agreed.

Context

The pilot audits in Roscommon, Waterford and Dublin South East also examined the contextual issues including resources across all relevant disciplines, general management, inter disciplinary working and communication, supervision and monitoring arrangements, local policy and procedures, adherence to national business processes and the strength of national and regional leadership and support.

This occurred through an examination of local documentation and statistics as well as facilitation of focus groups with each discipline. In order for the audit to be successful and bring staff along it must be planned appropriately and organised in conjunction with local management, Heads of Services and Social Work Team Leaders. A decision will need to be taken about the feasibility of hosting focus groups.

Timetable

Planning to conduct the audits over a period of 2 years may be realistic with a rolling time table within each region.

Options

There appear to be 3 options for conducting the National Audit. The following is an estimate of the staffing requirements, dependent on which option selected:-

Option 1 - Peer Led Audit

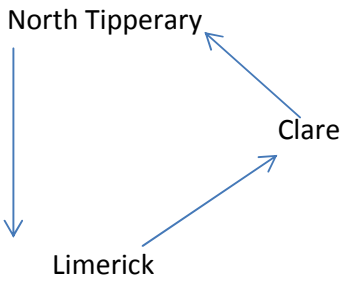
The audit and review would be conducted by PSW/CCM from a Neighbouring LHO assisted by Principal Psychologist/Director PHN.

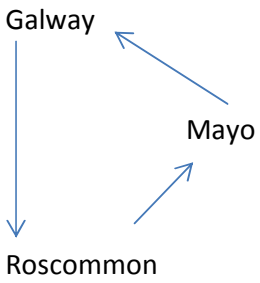
- Training and familiarisation with audit proforma and standards – 1 day

- Preparation, meeting with PSW/CCM/SWTLs/meeting with Heads of Services and recording – 1 day
- Review of local policy and procedures / staffing levels /caseloads information- 1 day
- Case selection- 0.5 day
- Review of cases and collation of information on Audit Proforma 13/15 days
  (This assumes 2 reviewers working 7 days each with admin support for typing proforma and allows for checking /editing typed forms)
  Review of findings/analysis/ feedback to PSW/SWTLs and to Senior Managers- 2.5 day
- Write up findings in report format under specific headings- 6-8 days (assumes admin support and can be completed off site)

Total days estimated is 20 for the Lead Reviewer. It would be important to have a second reviewer from another discipline assisting with the actual review of files and collaborating on the report writing and feedback. Estimate 10 days. The Independent Reviewer would provide training and mentorship (3days).

The Peer Audit process should be driven regionally, should take account of integrated service areas and should include collaboration between neighbouring LHOs to reduce travel time. Rather than a reciprocal arrangement the relationship proposed as set out below.





Option 2 - Peer Led Audit with Involvement of SWTLs

In this option Social Workers would prepare their selected files and SWTLs would complete the audit template including the case summary. The SWTL would also undertake an analysis of each of the competencies. The SWTL would also either copy relevant reports or flag the case files to identify relevant reports. The audit forms and files would be shared with the assigned Peer Reviewers (PSW/Director PHN/Principal Psychologist) from another LHO, who would quality assure the analysis and add their own findings.

Involvement of SWTLs would significantly reduce the number of days required by the external auditor and also engage SWTLs in the audit process and facilitate their ongoing governance of cases within their team.

Total days estimated:-

- Training and familiarisation with audit proforma and standards – 1 day
- Preparation, meeting with PSW/CCM/SWTLs/meeting with Heads of Services and recording – 1 day
- Review of local policy and procedures / staffing levels /caseloads information- 1 day
- Case selection- 1 day
- Review of SWTLs Proforma and indexed files - 8 days
- Write up findings in report format under specific headings- 6 days (assumes admin support and can be completed off site)

Total days estimated for the Lead Reviewer is 14 days and 8 days for the second Reviewer. The Independent Reviewer would require 4 days for training, mentoring and quality assurance.

Option 3 - Internal Audit

Similar to Option 2, Social Workers would prepare their selected files and SWTLs would complete the audit template including the case summary and analysis of each of the competencies. This would be shared with the PSW/CCM within the LHO who would quality assure the analysis and add their own findings. This process would require a more significant involvement by the Independent Advisor in order to assure the process is robust and to satisfy public expectation that there is appropriate independent oversight of the process. The analysis within a number of cases would be quality assured by the Independent Reviewer who would assist with both the initial workshops, the report writing and with the feedback to the Heads of Services.

Total days estimated for the PSW/CCM is 10 days (assuming familiarity with the cases) and 6 days for the second reviewer and 6-8 days would be required for the Independent Reviewer to provide training, mentoring and quality assurance.

Standards

During the period of the pilot audits of neglect there were no agreed standards for child protection practice and management in Ireland although formative work has been ongoing for some time. Standards are currently being developed by Health Information and Quality Authority (HIQA). For the purposes of the pilots the Independent Reviewer drew on experience from the Inspection of Child Protection Services in Northern Ireland and made

an assessment in each area of the quality in respect of a number of areas of practice including Policy and Procedures, recording and assessment etc.

It would be important for Peer Reviewers to have some outline measures against which to assess the quality of practice. The following are offered as basic standards which are relatively straightforward to assess.

- **Policy and Procedures**
  - Staff in all disciplines are familiar with Children First National Guidelines for Child Protection
  - There are local policies for operationalising the requirements of Children First and for local governance

- **Recording**
  - The structure of case files facilitates access to essential information, reports, correspondence, assessments and day to day case recording
  - Records are current and comprehensive and distinguish between facts and professional opinion and analysis
  - There is evidence of review by line managers
  - Files are signed and dated by professionals
  - Files contain chronologies of significant events and summaries at significant stages.

- **Assessment**
  - Initial Assessments are conducted in line with Children First Guidance and recorded on Initial Assessment forms
  - More comprehensive core assessments are completed when indicated and conform to an appropriate model which includes an analysis of the needs of the child; parenting capacity; and family and environmental circumstances
  - Assessments take account of relevant theory and research
  - The knowledge and expertise of other relevant disciplines is sought as appropriate and used to inform the assessment

- **Case Planning and Management**
  - There is evidence of assessment being used to inform a clear plan for current and future work
  - The plan is agreed with parents and where appropriate with older children and confirmed in writing setting out the anticipated outcomes and the responsibilities/commitments of each party and the consequences of non compliance.

- Multi-disciplinary inputs are coordinated through strategy discussions, professional meetings and Child Protection Conferences dependent upon the extent of risk
- The recommendations of Child Protection Conferences and child protection plans are SMART (Specific, Measurable, Achievable, Realistic and Timelined) and followed up to prevent drift

- **Listening to and Involving Children**
  - In line with Article 12 of the UN Convention on the Rights of the Child, there is evidence of the views of children being taken into account in matters affecting their wellbeing
  - Children are invited as appropriate to Child Protection Conferences and Child in Care Reviews

- **Supervision**
  - Supervision is provided in line with national policy and includes opportunity for review of individual cases, reflective practice and for professional development

- **Governance and Quality Assurance**
  - Mechanisms exist within each LHO to ensure that services for neglected children (and those experiencing other forms of abuse) conform to regulations, guidance and procedures and are delivered to a high standard
  - Management information is collated and analysed to inform and improve services to children and families
  - Staff working to safeguard children are supported through proper induction; ongoing relevant training and supervision; and have adequate support services and resources available to them

Conclusion

On the basis of findings from the pilot audits, the methodology is capable of being adapted for use in a Peer Led Audit Process.
It appears that the most realistic model is option 2. This has considerable advantages including:-

- It provides for a level of independence
- It fully engages SWTLs in the audit process and facilitates their understanding of their ongoing governance role
- The role of Peer Reviewers is manageable and PSWs and Heads of Services in other discipline gain expertise in auditing and monitoring in each other's LHOs

- It creates awareness among peer reviewers of the various models in operation throughout the region and allows for a regional view on best practice

Lynne Peyton
16.11.11

APPENDIX 6

Project Proposal

Project to Support an Internal Review/Audit of the Management and Practice in Cases of Neglect in HSE West

Proposal by:

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Company Profile

Lynne Peyton provides a Management Consultancy Service specialising in Children's Services Strategic and Operational Planning, Policy and Service Development, Audit and Quality Assurance.

Project Brief

The HSE wishes to undertake a national review of neglect cases using an internal self-governing process with a view to improving professional practice and instigating mechanisms for regular audits of practice. Following completion of pilot Reviews in Roscommon, Waterford and Dublin South East it is proposed that each Region is supported by an Independent External Consultant to undertake a comprehensive review and audit of neglect cases within each LHO/ISA.

Terms of Reference

- To oversee a professional/managerial Audit and Review of Practice in a proportionate and representative sample of neglect cases reported/notified to Social Work Teams in each LHO across the continuum from new neglect referrals to cases classified as neglect which are open to CPNS for more than 2 years
- To engage with managers at all levels and within relevant disciplines to review the efficiency of current arrangements
- To train SWTLs to review and audit their teams' cases using the agreed audit template and agreed broad standards

- To train PSWs to quality assure the audit process and to collate, analyse and report findings
- To train and support PSWs in leading focus groups
- To assist managers with the identification of strengths and challenges and with formulating specific recommendations for future practice at all levels in the organisation
- To quality assure the rigor of the audit process by reviewing the analysis of a number of cases
- To provide a framework for the local Audit Reports

The Proposal

Outline Project Methodology and Timeline

The methodology will be tested in HSE west in conjunction with the Regional Lead/Specialist

Stage 1 (January-March 2012) Preparation

- Clarification of terms of reference, the establishment of liaison arrangements and links with relevant individuals in the Region and the ISAs

- An initial meeting/workshop with project sponsors and attendance and Regional/ISA managers

- Introductory visits to HSE West to meet with senior management and professional heads of services involved with children to determine logistical arrangements/timeframes etc

- An examination of relevant documents, including quantitative and qualitative information in relation to the numbers of neglect cases in the Region ISAs/LHOs and the regional/local arrangements for managing neglect cases from point of referral through initial investigation, notification, child protection case conference etc.

- An examination of relevant publications and papers in regard to child neglect, including standards, operational procedures, child protection guidelines and any previous audits or inspections involving an examination of practice in neglect cases.

- A review of the strategic context including, Children First and relevant advice and guidance by DOHC and by HSE nationally;

- Identification of appropriate office accommodation and facilities for secure storage of files.

- Design of an appropriate training programme for
  (1) SWTLs to ensure confidence and competence in reviewing cases using the audit template
  (2) PSWs/ISA Managers to ensure confidence and competence in leading focus groups, quality assuring the audit process and analysing and reporting findings

Stage 2 (March - June 2012) * Rolling Programme within LHOs/ISAs

- Deliver training programme in venues as agreed with Local and Regional Management.
- Introductory visits to each LHO/ISA and assistance with a selection of neglect cases across Team.
- Liaise with local Children's Services Managers (CCM/PSW) and CPNS Administration to identify neglect cases and achieve sample.
- Agree specific dates and venues for review of files by SWTLs within each LHO.
- SWTLs each undertake examination of agreed number of case files in each Social Work Team.
- SWTLs provide completed review proforma identifying practice issues and recommendations in each case to PSW/ISA Manager along with case files.
- SWTLs provide verbal feedback to PSWs/Children's Services Manager in specific cases where risks are identified.
- PSWs to review and quality assure audit case proforma and analysis , seeking additional evidence and validation as appropriate
- PSWs to collate findings under each standard
- External Consultant is available to assist SWTLs on selected dates during this process.
- Interviews, focus groups and consultation with selected stakeholders including:-
    - LHM and individual Heads of Services (External Consultant and Regional Representative)
    - Child Care Managers and Staff including CCM, PSW, Team Leaders, Social Workers, Family Support Service (External Consultant and Regional Lead/PSW)
    - Public Health Nurses, Psychologists and CAMHS and if appropriate
    - Voluntary Sector providers
    - Gardai.

Interviews and focus groups will specifically examine:-

- the extent of neglect and the thresholds for
    - allocation to social work service,
    - notification to Child Protection Management Team
    - child protection case conference
- the extent of training provided to relevant staff about the impact of neglect

- the range of supports currently available to children in families where neglect is an issue and their effectiveness
- issues in regard to gaps in service provision, accessing services
- the effectiveness of inter-agency working in families where neglect is an issue
- Opportunity for staff in any discipline to identify cases of concern for Review by the consultant.

The role of the Regional Lead and the External Consultant with regard to facilitating Focus Groups to be clarified. Also potential for these to be facilitated by a colleague from another LHO to be considered

- A review of training in child abuse and neglect/child protection provided for staff in all disciplines (Regional Training Team)

- A review of supervision policies for social work and other relevant disciplines. Regional Lead to:-
  (1) Collate historical supervision policies
  (2) Ensure national supervision policy is operational in each LHO and confirm date

Stage 3 (June - October 2012) * Rolling Programme within LHOs/ISAs

- Consideration and analysis of findings to include the identification of any practice/systemic failings. (PSW/Regional Specialist)

- Workshops to provide feedback to LHO/ISA Manager, Heads of Services and National/Regional Project Sponsor in each LHO/ISA. (Regional Specialist/PSWs/?External Consultant)

- Preparation of draft report in agreed format by PSWs

- External Consultant to assist PSWs/quality assure reports and ensure reports include recommendations for action to enhance practice in the assessment and management of neglect and strengthen governance arrangements.

- External Consultant to assist Regional Lead/ISA Manager with development of a SMART Action Plan to drive forward recommendations in each LHO/ISA.

Stage 4 (November 2012 - February 2013) Follow up review to ensure satisfactory progress against recommendations (Rolling Programme)

Questions for HSE West pilot

1 Is the audit to be conducted on an individual LHO or ISA basis? If conducted on an LHO basis this would mean 8 exercises with a smaller sample of cases (25-30) whereas if conducted on an ISA basis there would be 4 exercises with a larger sample of cases (60-70) as it would still be important to sample each team. Given that the ISAs are so new it may make sense to conduct the audit on an LHO basis.

This decision will need to be taken regionally. I understand that the ISAs/LHOs within your region are as follows:-

- Mid West (North Tipperary, Clare and Limerick)
- Galway/Roscommon
- West (Sligo/Leitrim, Donegal)
- Mayo

2 Can you provide the organisation chart for each Social Work Department across the region so we can calculate the numbers of SWTLs, PSWs, ISA Children's Services Managers likely to need training.

3 Are there training venues within each ISA?

4 Will it be logistically easier to provide the training within each ISA or will managers travel?

5 Is it feasible to ask SWTLs to bring a neglect case with them for training purposes? This would facilitate use of the audit template and allow for a realistic appraisal of the time involved in reviewing cases. (We could limit it to cases with no more than 3 files to make it manageable).

6 Are we anticipating that the PSWs will draft the report?

7 We agreed that there should be managerial involvement by other disciplines such as psychology and PHN with the audit. Is this still feasible and how would it be accessed?

Lynne Peyton
29 December 2011