



**A report based on an investigation into the implementation of
Children First: National Guidelines for the Protection and Welfare of
Children.**

Executive Summary

Ombudsman for Children's Office

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Executive summary

This report is the result of an investigation into the implementation of *Children First: National Guidelines for the Protection and Welfare of Children*, which was published in 1999.

Some of the conclusions in this report are positive. It is recognised that substantial efforts have been made at various times since 1999 to implement Children First. However, some of its conclusions are negative and a number of findings of unsound administration have been made by the Ombudsman for Children against the relevant public bodies.

It is the view of the Ombudsman for Children that much needs to be done to improve protection and promote children's rights and welfare. This is not simply a matter of resources. Some of the problems identified - variable practice, a lack of internal and external scrutiny and a failure of inter agency collaboration - indicate a need for a fundamental change in culture and attitude towards child protection more generally.

This investigation examined a time period when health and social services were undergoing fundamental reform, in particular with the creation of the Health Service Executive. It is recognised nationally that the health service is a complex organisation but it is also recognised internationally that change is a constant in any health service. This report examines how children fared in the context of this wider reform.

The report concludes from this investigation that at times child protection services were not given priority in this reform process. At the same time, it is acknowledged that since the launch of this investigation that a number of initiatives, with positive potential, are currently underway. It is important that this potential is realised. To date, there has been no shortage of analysis of what the problems are, but far less action to tackle them.

The HSE is currently undertaking a Strategic Review of the Delivery and Management of Child Protection Services. It is important that this review considers all options and asks new questions. These should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.

Background to report

On 19th November 2008 the Ombudsman for Children commenced an investigation into the state of implementation of *Children First: National Guidelines for the Protection and Welfare of Children*. This is the report of that investigation.

Children First was published in 1999. It provides detailed guidance to Health Service Executive (HSE) staff, the Garda Síochána and others on child protection. Its goals are to ensure that children are protected from abuse and that their welfare is promoted.

Methodology of the investigation

As a first step, the Ombudsman for Children sought all documents from the 32 Local Health Offices (LHOs) of the HSE setting out their child protection policies and any other documents that demonstrated implementation of Children First. These were analysed by this Office in great detail. This report details the main results of this work.

The Ombudsman for Children's Office works within a limited budget. It was therefore not possible to interview every Child Care Manager – or the many others working in Local Health Offices. However investigation meetings, held with 9 Child Care Managers (CCMs) throughout the State, from both urban and rural regions, enabled the Office to get a picture of the implementation in practice. Investigation meetings were also held with the Office of the Minister for Children and Youth Affairs (OMCYA), the HSE at national level, An Garda Síochána and the trade union IMPACT.

It should be stressed that this investigation did not involve an analysis of case files. This work does need to be done, but would be more suited to an inspectorate – and one of the main recommendations of this investigation is that the Social Services Inspectorate (SSI), now part of the Health Information Quality Authority (HIQA), should undertake this work.

The results of this investigation were therefore in large part dependent on the documentation provided by Child Care Managers, the HSE and the OMCYA. It is possible that implementation of Children First is more advanced than the documents submitted suggest. It is also possible that it is less advanced.

However, for example, the requirement to have adequate local procedures is a key part of the current Children First guidelines – and the failure to have adequate local procedures is, in itself, a cause for concern and a matter against which the HSE can be properly benchmarked. Of course, this investigation took account not only of local procedures, but also of all other documents demonstrating local implementation.

Analysis of implementation and findings

At present, Children First requires the drawing up of local procedures. However, half of Local Health Offices either do not have proper local procedures or have only recently drawn them up.

Some may argue that this does not matter, so long as practice is good on the ground. But, of course, without internal audit of case files or external inspection, we cannot know that practice is good.

Also, local procedures are a fundamental requirement of the Children First Guidelines (1999). Good local procedures give those dealing with child protection guidance on implementing Children First – and are also full of useful local information on services and contacts. Also, the HSE has a role to encourage others to adopt local procedures. That important function is compromised if – contrary to the current Children First – they do not

have local procedures themselves. The Ombudsman for Children concludes that the failure to have local procedures throughout the State involved **unsound administration by the HSE** within s.8 of the Ombudsman for Children Act 2002.

The Ombudsman for Children notes that the revised Children First no longer requires the HSE to have local procedures. But for so long as they were required, they should have been created.

Two particular problems with many local procedures are the failure to adopt the definitions and the failure to adopt the basis set out in Children First for reporting child protection concerns. The Guidelines require these to be adopted as set out in Children First – and this Office concludes that the failure to do so in many parts of the State was **unsound administration by the HSE** within s.8 of the Ombudsman for Children Act 2002.

The Office has also found considerable divergences in practices regarding assessment of child protection reports but recognises that efforts are underway to resolve these matters. It is recognised that health and social services were subject to fundamental reform with the creation of the Health Service Executive and the Health Information Quality Authority in the middle of the last decade. However, it remains the case that it was not until 2008 that the Office for the Minister of Children and Youth Affairs and 2009 that the HSE moved to address these important concerns about the child protection system.

This Ombudsman for Children is greatly concerned that in most parts of the State there is no 24 hour access to the Child Protection Notification System (CPNS). This means that the Garda Síochána and Accident and Emergency departments in hospitals cannot check out of hours if a child about whom they have concerns is on the CPNS. Given the importance of this issue and that it was required by Children First, this Office concludes that this involves **unsound administration** within s.8 of the Ombudsman for Children Act 2002.

The investigation also confirmed the findings of previous reviews that Garda/HSE cooperation is not working as required by Children First. While many areas have informal cooperation, this can be dependent on personal relationships. Further, in almost no part of the State are joint action sheets implemented. These sheets are meant to record who is responsible for what when a child protection concern being dealt with by the HSE is also the subject matter of a criminal investigation by the Garda Síochána.

This Office has no power to investigate An Garda Síochána. But it concludes that the failure to operate Garda/HSE cooperation as required by Children First, in particular as regards joint action sheets, is an **unsound administration by the HSE** within s.8 of the Ombudsman for Children Act 2002. To the extent that the failure to implement Garda/HSE cooperation is due to industrial action, this Office believes that the lack of transparency regarding the industrial action involves an unsound administrative action by the Department of Health and Children for reasons outlined below.

Staffing and resources

The number of social workers in the State increased from 1390.3 to 2237.5 between 1999 and 2005. That is an increase of 61%. This might lead one to believe that Ireland now has

large amounts of social workers. However, it appears that Ireland was starting from a low base and the State still falls far behind its nearest neighbours. According to figures from 2005, the Irish rate was one social worker per 1,828.6 persons. In Northern Ireland, the figure was one social worker per 660.6 persons. In Scotland it was one social worker per 962 persons and in Wales one social worker per 1,325 persons.

This Office therefore welcomes the commitment in the implementation plan for the Ryan Report to fill up to 270 posts currently vacant, but notes that this will still leave the number of social workers well below that of, for example, Northern Ireland.

Since this Office initiated this investigation, the HSE undertook and completed in April 2009 the *National Social Work and Family Support Survey*. This unpublished report has been reviewed by the Ombudsman for Children's Office. The survey gathered an array of much needed baseline data on child protection and family support services in Ireland, and comes on top of earlier work to improve data collection. One of its important purposes is to identify gaps and help match resources to need.

This is an important initiative, since at present resources do not always match need. For example in the 2008 Review of Adequacy some of the most striking examples of this anomaly were as follows:

- Galway had the highest number of reports to the social work department in the State. Dun Laoghaire had the 31st highest. Both had the same number of social work posts.
- Wexford had the 3rd highest number of reports in the State, but only the 20th highest number of social work posts.
- Cavan/Monaghan had the 4th highest level of reports in the State, but only the 23rd highest number of social work posts.

Child Care Managers

There have been a number of issues identified with the role of Child Care Manager (CCM). In most parts of the State, excluding Donegal, Cork (South Lee, North Lee, North Cork, West Cork), Kerry, Sligo/Leitrim and Mayo, it appears that the Child Care Manager does not have line management responsibility for social work teams.

Of greater concern is the fact that in many parts of the State, Child Care Managers do not have guaranteed rights to information on cases.

The designation Child Care Manager is therefore in most parts of the State essentially misleading, with many Child Care Managers holding responsibility without authority.

Child Protection Notification Service

Children First requires that "all relevant services and agencies" have 24 hour access to the Child Protection Notification Service (CPNS). This may include medical practitioners, senior

nurses, social workers, designated Garda officers and senior staff in the probation and welfare services. There is significant concern around the role of the Child Protection Notification Service (CPNS), whether it is a systems tool for social work departments, whether external professionals can access it, variation in the grounds for the name of children being put on or taken off it, and lack of a national system.

Furthermore while it was agreed that there needed to be 24 hour access to the Child Protection Notification System, it did not say how that would be ensured, especially in cases where the CPNS was not computerised.

At present it is only in the former Southern Health Board Area (Cork/Kerry) that there was evidence of external 24 hour CPNS access.

An industrial relations issue

A particular difficulty with the implementation of Children First arose in the area of the former Eastern Regional Health Authority (ERHA), comprising Dublin, Kildare and Wicklow. Members of the Trade Union IMPACT were concerned at the administrative burden that they perceived that Children First imposed.

IMPACT entered into negotiations with ERHA. Together they reached a Prioritisation of Work Agreement in 2002. It set a number of priorities. While it listed child protection as a priority, it did *not* mention Children First.

Given that IMPACT had raised concerns about Children First in the negotiations, the fact that the prioritisation agreement did not mention Children First meant that IMPACT took from it that the administrative aspects of Children First did not have to be performed.

The position arrived at was one where it was obvious that each side would walk away with the interpretation that suited it. ERHA – and later the HSE – could and did deny that it had agreed to the non-implementation of Children First's administrative aspects. But IMPACT could and did equally claim that ERHA – and later the HSE – had agreed to the non-implementation of Children First's administrative aspects. By failing to be clear on this, uncertainty hung not only over the administrative aspects of Children First, but Children First more generally.

One of the factors that prevented some areas within the former ERHA region from developing local procedures implementing Children First was this industrial relations issue. In some areas, this problem was eventually overcome by avoiding stating that the local procedures were part of the implementation of Children First. But in other areas, important paperwork – such as on initial assessments of children at risk and Garda notifications – is still not completed.

The OMCYA Review

The industrial relations dispute was known to the Department of Health and Children. It was mentioned both in responses to the questionnaire issued by the Interdepartmental Group in

2003, and in responses to the Office of the Minister for Children and Youth Affairs' review of Children First, which was announced in October 2005 and concluded in July 2008.

Yet nowhere in the analysis of submissions published with the OMCYA Review in July 2008, or in the Review itself, was the industrial relations dispute mentioned – despite the real effects of the dispute.

This Office concludes that the failure of the OMCYA to be transparent about the industrial relations dispute in the OMCYA review and analysis of submissions was an **unsound administration by the Department of Health and Children through the OMCYA** within Section 8 of the Ombudsman for Children Act 2002.

What the Review did conclude was that the initial impetus to implement Children First had lost momentum. This Office believes this was particularly true in the almost three year period of the OMCYA Review itself. The findings of the Review regarding difficulties with the implementation of Children First were also consistent with those of previous reviews, including that in many parts of the State Garda/HSE cooperation was not working as required by Children First and that the Regional Child Protection Committees (RCPCs) and the Local Child Protection Committees (LCPCs) were not meeting.

The OMCYA Review concluded that child welfare and protection issues should be considered at national level by a High Level Group. That High Level Group met six times in 2008, but not at all in 2009. This was despite the large numbers of issues, especially interagency issues, requiring work identified by the OMCYA Review, such as difficulties with HSE/Garda cooperation and a lack of information sharing more generally.

Two HSE Reviews

Separately, the HSE conducted two reviews of its own. The first was a short report of focus groups with social work professionals. The second emerged following the publication of the Ferns Report. It made 29 separate recommendations to improve implementation.

What all these reviews had in common – and all national reviews that have happened since – is that they did *not* involve an examination of case files to see how Children First was really being implemented.

This Office only has evidence that one region of the State did this in 2003/04. This was the former Southern Health Board (Cork/Kerry). The findings of this audit were worrying. For example, screening of child protection reports was taking an average of 21 days - which meant that urgent cases might not be speedily identified. Initial assessment was taking an average of 95 days – again a very long period. Furthermore the Audit revealed that 75% of files had no record of the outcome of an assessment. By contrast, Children First requires that outcomes always be recorded. These findings show why internal auditing involving examination of case files needed to be conducted across the State. But, except in Cork/Kerry, it did not happen.

Also, this Office concludes that the failure to put in place appropriate quality assurance mechanisms, in particular through audit of case files, involved **unsound administration on the part of the HSE** within Section 8 of the Ombudsman for Children Act 2002.

Every year, the HSE is obliged by s.8 of the Child Care Act 1991 to publish a report on the adequacy of services offered for children and families in each of its functional areas. This Office is concerned that the review of adequacy for 2008 did not actually involve reviewing adequacy in each functional area of the HSE and concludes that this involves **unsound administration** on the part of the HSE within s.8 of the Ombudsman for Children Act 2002.

Recent steps

During the course of this investigation, a number of steps are now planned or underway to advance Children First's implementation. These include:

- the completion of revised Children First Guidelines by OMCYA in December 2009. These are due for publication this year;
- a HSE taskforce to standardise implementation of Children First that commenced work in February 2009; and
- a commitment by the OMCYA that inspection by SSI will resume in September 2011.

These are welcome. But the fact remains that in the period from 2003 up to, but not including, 2008 there was no appropriate mechanism for driving forward Children First's implementation on interagency matters. This Office concludes that this involved **unsound administration on the part of the Department of Health and Children**, within Section 8 of the Ombudsman for Children Act 2002.

Equally, within the HSE there was no mechanism to drive forward implementation pending the commencement of the Taskforce in February 2009. Again, this Office concludes that this involved **unsound administration** within Section 8 of the Ombudsman for Children Act 2002. Similarly, this Office finds **unsound administration** in this regard by the former health boards in the period from 2003 to their disbandment on 1 January 2005.

LIST OF FINDINGS UNDER SECTION 8 OF THE OMBUDSMAN FOR CHILDREN ACT 2002

1. The Review of Adequacy 2008 conducted by the HSE is contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 as the HSE failed to ensure determination of adequacy in any meaningful way in each of its functional areas.
2. This Office concludes that the failure in the period from 2003 up to (but not including) 2008 to put in place appropriate mechanisms at Department of Health and Children level to drive forward interagency implementation of Children First involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002. Responsibility for the unsound administration as regards interagency matters lay with

the Department of Health and Children to the extent that it related to problems such as with Garda/HSE cooperation, variable implementation by health boards in the period prior to the creation of the HSE and the failure to ensure interagency cooperation more generally – for example through Local Child Protection Committees (LCPCs) and Regional Child Protection Committees (RCPCs).

3. Separately, up until the establishment of a HSE Taskforce in February 2009, this Office concludes that insufficient efforts were made to drive forward implementation of Children First by the HSE internally, such as failure to ensure that Local Health Offices had local procedures, and that this involved unsound administration by the HSE in the period since its creation.
4. In the period from the disbandment of the Health Boards Executive (HeBE) Resource Team in late 2002 to the disbandment of the Health Boards themselves on 1 January 2005, this Office concludes that there was unsound administration by the Health Boards in failing to resolve collectively problems that had arisen with Children First, including regarding its variable implementation.
5. This Office concludes that the failure by the HSE (and the Health Boards with the exception of the Southern Health Board before 1 January 2005) to put in place appropriate quality assurance through internal audit of case files more widely than in one part of the State (Cork/Kerry) and more frequently than once in a decade involves unsound administration and is therefore within s.8 of the Ombudsman for Children Act 2002, especially having regard to the worrying nature of the findings of the Cork/Kerry audit.
6. This Office concludes that the HSE in failing to ensure that Local Health Offices all have local procedures acted contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.
7. This Office believes that in its analysis of submissions to the Office of the Minister for Children and Youth Affairs (OMCYA) review and in the OMCYA review document itself proper mention should have been made of the real industrial relations issues that had arisen in the former Eastern Regional Health Authority (ERHA), given their effects on the ground. This Office concludes that the failure to be transparent about the industrial relations dispute in the OMCYA review and analysis of submissions involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 on the part of the Department of Health and Children through the OMCYA.
8. The failure to ensure consistent definitions of abuse in local procedures across the HSE involves unsound administration by that public body within the meaning of s.8 of the Ombudsman for Children Act, 2002.
9. The failure to ensure clarity and consistency regarding the basis for reporting child abuse concerns across the HSE in local procedures involves unsound administration by that public body within the meaning of s.8 of the Ombudsman for Children Act, 2002.

10. This Office believes that the failure of the HSE to ensure 24 hour external access to the Child Protection Notification Service in most of the State involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.
11. While this Office has no power to investigate an Garda Síochána, it is satisfied that in a number of instances – notably concerning joint action sheets and notifications – responsibility lies in particular with the HSE. To the extent that this flows from industrial relations difficulties, the lack of transparency regarding such difficulties involves unsound administration by the Department of Health and Children for reasons already stated. To the extent that it does not – and it appears that there are other reasons for non implementation of, for example, joint action sheets - such as a belief that they serve no useful purpose - this Office believes that the failure to implement such important requirements is also an unsound administrative practice by the HSE within the meaning of s.8 of the Ombudsman for Children Act 2002, not least because the failure to coordinate Garda and HSE action is unlikely to ensure effective protection of children.

LIST OF RECOMMENDATIONS

1. It is recommended that resources be better matched to need around the State in social work departments to ensure equitable service provision through evidence based resource allocation.
2. Given the well documented cases of clerical child sex abuse and the systemic failure to report such cases, the Ombudsman for Children's Office recommends that the application of the revised Children First Guidelines to churches be made explicit in the Guidelines themselves.
3. It is important that family support services, locally and nationally, are properly planned for with appropriate strategies in place and it is recommended that all necessary steps be taken to this end, whether under the auspices of the revised Children First Guidelines or not.
4. This Office is aware that the HSE is undertaking a Strategic Review of the Delivery and Management of Child Protection Services. It is important that this review considers all options and asks new questions. That should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.
5. It is strongly recommended that the High Level group established by the Office for the Minister for Children and Youth Affairs meet frequently to resolve all outstanding interagency policy issues regarding Children First identified in the context of the OMCYA review.
6. It is recommended that SSI, upon recommencing inspection of child protection work and consistent with its normal practice in other fields, examine case files to get a true picture of the state of implementation in practice.
7. This Office recommends that efforts be made on all sides to resolve all outstanding industrial relations issues affecting the implementation of Children First.

8. It is strongly recommended that work to standardise processes and improve how data is recorded by the HSE be continued as a priority. This should include clarity on screening and initial assessments; clarity on what cases should be included on the Child Protection Notification System (CPNS), when to close a case on CPNS, as well as clarity on the non-removal of cases from CPNS.
9. Following on from the Murphy Report, it is recommended that all necessary steps be taken to ensure that the criteria for the storing of information are broader than solely on grounds of alleged victim. At the very least it should apply to all new cases if it is not feasible to do so retrospectively.
10. Though not a requirement of Children First, it is recommended that consideration be given to the creation of a national Child Protection Notification System, rather than only a local one.
11. Though not a requirement of Children First, this Office strongly recommends the rolling out of an out of hours service throughout the State as a priority and that all necessary funding should be provided to this end.
12. It is noted that the current role of Child Care Managers is under review and it is recommended that issues of access to information by Child Care Managers and ability to direct staff be fully considered in that context.
13. This Office can see merit in the proposal for a dedicated child protection service in an Garda Síochána and recommends consideration of this proposal.
14. It is strongly recommended that joint liaison structures be established between the HSE and the Garda Síochána in all areas where they are outstanding.
15. The Ombudsman for Children's Office is also concerned at reports that Garda notifications are not being completed and recommends that the Social Service Inspectorate (SSI) and an Garda Síochána Inspectorate jointly inspect whether this is the case.
16. It is also recommended that the SSI and an Garda Síochána Inspectorate jointly inspect the implementation of Children First's requirements on Garda/HSE cooperation more generally, including the early holding of strategy meetings.
17. It is recommended that all necessary steps be taken to ensure that a list of all convicted sex offenders in the area can be given to each Local Health Office so that it can assess risk to any children. It is also recommended that current practice in this area be examined as part of the joint SSI/Garda Síochána Inspectorate inspection recommended above.
18. It is recommended that record keeping be sufficient to record decisions taken and to guide future actions and that sufficient resources be put in place to ensure this.
19. It is recommended also that practices regarding record keeping be inspected by SSI.
20. It is recommended that SSI, when it resumes inspection of child protection services, inspect in particular implementation of protocols on the transfer of files.
21. It is recommended that the High Level Group provide further guidance on information sharing and data protection. This should not await any forthcoming legislation on this issue.
22. It is also recommended that the HSE provide further training to professionals on their duty to report abuse, including regarding retrospective cases.