

Roscommon Child Care Case

Report of the Inquiry Team to the Health Service Executive

27/10/2010

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Preface

I am today presenting this report to the Health Services Executive. This report deals with matters pertaining to the Roscommon Child Care Case and in particular to the terms of reference of the Inquiry established by the Health Services Executive in relation to that case. I want to express my gratitude to my colleagues on the Inquiry Team: Ms Leonie Lunny, Mr Paul Harrison and Mr Gerry O Neill for their work and dedication during this inquiry.

At the centre of this case are six children and young people. The Inquiry Team was conscious at all times of these children and young people and of their well-being. We are aware that they have been deeply affected by both the distressing events in their past lives and by the wave of publicity and comment that followed the sentencing of their mother in January 2009 and their father in March 2010. The Inquiry Team is likewise aware that the publication of this report will give rise to further publicity. It is not disputed that there is a proper public interest in this case and a need for the facts of the case to be reported. However, the Inquiry Team would ask all those involved in reporting and commenting on this case to be fully cognisant of the effect that such reporting has on each and every one of the children and young people concerned.

The children have been in the care of the Health Services Executive for six years. Good, solid work by the Health Services Executive staff and a small number of outside personnel has helped these children and young people since they were received into care. They are well settled in secure and caring foster homes and are progressing well. That sense of security is essential to allow children and young people to begin to speak about their experiences and to get necessary therapeutic help. Their resilience and care for each other as children has been remarked on by many witnesses to the Inquiry. They have all made good progress in key areas of their development. The young adults have found a loving home with relatives who tried very hard over many years to alert the professionals working with the A family to their plight. It is vital that they are all now allowed the space and the privacy to grow and develop as children and young people.

These children were denied their most basic needs for security, food, warmth, clothing and the loving care of their parents. They were abused by their parents in their home where they had every right to feel safe. Neglect and emotional abuse have been described as remaining “on the margins of child protection¹” even though the consequences for the well-being of children who suffer chronic neglect are well documented. Indeed there is no reference to emotional welfare in the definition of welfare in Section 2 of the Guardianship of Infants Act 1964. An amendment such as this would help to strengthen the recognition of the importance of a positive emotional environment for the healthy development of children and strengthen the ability of the statutory services to seek the protection of the Courts for children suffering emotional abuse, which is always present where children are neglected or abused.

¹ Iwaniec. D. (2006) The Emotionally Abused and Neglected Child.

Recourse to the Courts is seldom the first option when neglect is identified. Indeed it can be difficult to secure Court Orders to protect children from neglect and emotional abuse. Often the first and correct course of action is to provide sustained planned and targeted family support that is focused on identified outcomes in order to make the family a safe environment in which children can grow up. However, when positive change is not achieved and maintained it is critical that the Health Services Executive (HSE) exercises the positive duty of the State to protect the children from harm and ill treatment.

Credible evidence of what is happening for each and every child in the family must be gathered. To ensure that full information is presented to the courts, it is important that the harm a child is suffering or likely to suffer is identified through an ongoing comprehensive assessment of their needs. In tandem with that assessment, information should be gathered on the capacity of the parents or guardians to change within the child's formative development years.

Children cannot wait indefinitely. The services put in to support the A family, although very well intentioned, failed on many occasions to respond fully to the chaos of their daily lives, failed to recognise the risk indicators that arose and, as a consequence, failed to respond appropriately to the needs of the children.

The six children at the centre of this case were denied their voice on many occasions. Their voice was not heard in the High Court in Autumn 2000 when the parents were successful in preventing a shared parenting arrangement with their relatives from going ahead. No application to protect them as set out under the Child Care Act 1991 (as amended) was heard in the District Court until 2004. Case Conferences and other meetings that should have had the interests of these children as their central focus were often diverted into dealing with other issues. Finally in 2004 these children in effect rescued themselves when they could no longer be silenced.

Child welfare and protection work is challenging. Child welfare and protection work carries risk. It is not easy to get it right and no person or system will get the balance right all of the time. Most of the services involved with the A family were hopeful that there could be change. That hope is essential to the delivery of services to families experiencing difficulties. However hope needs to be informed by some evidence of change and of life getting better for children.

The Inquiry Team fully understand the inherent and difficult challenges of child welfare and protection work. Clear gaps in the system are apparent - gaps that the children of family A fell through. There is an opportunity now to learn from the circumstances of this case. The Inquiry Team believes that this report can inform and assist all those working in child welfare and protection work and lead to better services and protection for children suffering neglect and abuse.

Norah Gibbons
Chairperson Roscommon Child Care Inquiry
21/07/2010

Acknowledgements

The Inquiry Team would like to acknowledge the assistance of the following who provided services to the team:

- Members of the A family who met with the Inquiry Team whether formally or informally.
- Relatives of the A family who met with the Inquiry Team.
- The staff of the Western Health Board and others who attended for interview with the Inquiry Team. We acknowledge that this was difficult for many people.
- Ms Josephine O’Gorman who provided invaluable assistance to both the Inquiry Team and to witnesses who attended.
- Ms Amanda O’Reilly and Ms Elizabeth O’Gorman who provided administrative support to the Inquiry Team.
- Ms Sheila Grimes, Barnardos, who supported the Inquiry Team throughout the period of the Inquiry.
- The administrative staff in the Dublin Mid Leinster HSE area for their help in making office and meeting space available to the Inquiry.
- Gwen Malone and colleagues who provided stenography services for the Inquiry Team.
- The Inquiry Team was fortunate to have the opportunity to meet with and discuss relevant issues with Geoffrey Shannon, Child Law Expert, Pat Dolan Professor, Child and Family Research Centre at NUIG and Margaret Beaumont, Psychotherapist. The Team is most appreciative of their willingness to share their expertise and knowledge with us.
- Finally, independent legal advice was provided by Lavelle Coleman, Solicitors and we thank Dave Coleman and Stephanie McCarthy for their expertise and attention to detail.

Introduction

On the 22nd of January 2009 Mrs A, a mother of six children, was sentenced in Roscommon Circuit Court to seven years in prison following her conviction for incest, neglect and ill treatment. The presiding Judge, Judge Miriam Reynolds, (RIP) said the children were failed by everyone around them and that she was concerned that, while the former Western Health Board had been involved since 1996, the children had not been taken into care until 2004.

The case was widely reported and caused immense public concern. Mr Barry Andrews, TD, Minister of State for Children and Young People, announced later that evening that he had been in contact with the Health Services Executive (HSE) and had been informed that a preliminary report into the circumstances surrounding the case was already underway. This report was to be delivered to him within forty eight hours and on the basis of this report he would decide further action. This report was provided to the Minister and in due course to the Inquiry.

On the 24th January 2009, Ms Laverne Mc Guinness, National Director of Integrated Services Directorate in the HSE, announced the setting up of an investigation into the management of this case from a care perspective. She stated *“There is no doubt that these children have been let down badly by society... We need to make sure that we do everything we can to ensure in as far as possible, that no other child, has to face such an unspeakable tragedy ever again.”*

The Roscommon Child Care Inquiry was established by the HSE.

Ms Norah Gibbons, Director of Advocacy at Barnardos was appointed as Chair of the Inquiry. The other members of the Inquiry were Mr Paul Harrison, a National Child Care Specialist, HSE, Mr Gerry O’Neill, Local Health Officer, HSE and Ms Leonie Lunny formerly Chief Executive of the Citizens Information Board. The two HSE members did not have any previous knowledge of the case and had not worked with personnel involved with the case.

The terms of reference of the Inquiry were to:

- examine the entire management of the case from a care perspective,
- identify any shortcomings or deficits to the care management process,
- make a report on the findings and any learning arising from the investigation. See Appendix 1.

The inquiry was an independent investigation by the HSE and did not have compellability of witnesses. It did not provide for legal costs to witnesses. The team began its work on the 11th February 2009.

The Minister for Children welcomed the setting up of the investigation but reserved his and the Government's right to carry out any further investigations deemed necessary. At the time the investigation was established further criminal charges were pending in this case and the matter was therefore sub judice. In the Central Criminal Court on March 5th 2010 Mr Justice Barry White sentenced Mr A to fourteen years in prison following his conviction on February 15th 2010 for rape and sexual assault.

Structure of Report

Chapter 1 sets out the methodology and the principles which guided the Inquiry.

Chapter 2 sets out certain contextual issues regarding County Roscommon including a demographic profile, staffing arrangements in respect of social work services and the child care organisation and structure.

Chapter 3 provides a history of the involvement of the Western Health Board/Health Services Executive with the family and the services provided to the family. In addition this chapter sets out some observations of the Inquiry Team on practice and other matters in this case and where this occurs it is clearly outlined. There is very limited information available to the Inquiry on the period 1989 to 1996. Some personal information is excluded to protect the privacy of the children and young people, except where it is essential to identify management gaps and learning.

Chapter 4 sets out the findings of the inquiry.

Chapter 5 sets out the recommendations of this inquiry. The recommendations aim to inform the delivery of effective services to children and young people.

Appendix 1 HSE confirms investigation to examine the events surrounding the Roscommon Childcare Case.

Appendix 2 Inquiry procedures for interviewees.

Appendix 3 Confidentiality Agreement for those accompanying witnesses.

Appendix 4 Text for Addressing Companion/Representative at Interview with the Inquiry Team.

Appendix 5 *(redacted protected court material)*

Appendix 6 *(redacted protected court material)*

Appendix 7 Relevant sections from previous Inquiry Reports.

References

CHAPTER 1

Methodology

The Inquiry team decided that it would focus primarily on the period of time between the birth of the first child in the family in 1989 and October 2004 when the children were taken into the care of the Health Service Executive under Section 13 of the Child Care Act 1991.

The Inquiry Team was asked to review this case almost five years after the children came into care. It is accepted that all inquiries of this nature are inevitably carried out with the benefit of hindsight. However, the Inquiry Team also had the benefit of reviewing both the official records which represent a contemporary account of interventions at the time and hearing the verbal accounts of those involved in the case.

The Inquiry Team was fully aware that there were no written nationally agreed standards in operation during the period examined in relation to many aspects that were considered in this case: for example, assessments, case recording, record keeping and the supervision of staff among others. In 2010 this is still the case. The standards, by which the Inquiry Team approached its work therefore, were those of good practice based on professional training, experience and where appropriate on Children First: National Guidelines for the Protection and Welfare of Children (1999). Prior to 1999 other guidance was issued at various points². In addition good practice must always respond to the needs and circumstances of each case.

The analysis of the case and the findings reached by the Inquiry Team reflect the time frame of the case, while the recommendations are concerned with present policies and practice.

In undertaking this Inquiry the team was very conscious of the great pain and suffering the children and young people in this family have endured to date. This suffering was greatly compounded at the time of their mother's sentencing in court and the publicity surrounding the case after that event. The Inquiry Team made every effort to minimise further distress to these children and young people in conducting the inquiry and in the production of this report. Except where it is essential every effort has been made to avoid providing personal information that could identify individual family members.

² Memorandum on Non-Accidental Injury to Children, Department of Health 1977, Department of Health, Guidelines on Procedures for the Identification, Investigation and Management of Child Sexual Abuse, 1987, Notification of Suspected Cases of Child Abuse between Health Board and Gardai, Department of Health and the Garda Síochána, 1995.

Files

All files in the HSE pertaining to the family were requested and 68 files were delivered to the Inquiry team. The files received by the Inquiry Team did not include the diaries or supervision notes of social work managers although there were notes on the social work file of a small number of supervision sessions where this family were discussed. An index was prepared outlining the contents of each of the files received. The files were reviewed by the team and an outline chronology of interactions between WHB/HSE personnel and the family was established. Although the family was in receipt of services from 1989, following the birth of the first child, the bulk of material provided to the Inquiry related from 1996 onwards. A social work file, covering the period prior to 1996, was found to be missing in 1996 and has never been located. Files supplied also contained information on a number of other services provided to the family.

Witnesses

At an early stage two members of the Inquiry Team met with senior personnel of HSE West to outline the procedures the Inquiry would adopt and to answer queries posed by the attendees. A list was established of relevant personnel who had worked in the WHB/HSE, a small number of persons from other agencies and a number of family members. These people were invited to meet the Inquiry team. A total of forty one witnesses were invited to attend for interview, thirty eight of whom attended. One witness was not available to complete their interviews with the Inquiry Team within the timeframe of the Inquiry because of illness. Two family members did not wish to meet with the team and one social worker who had provided support to the family declined to attend. This person is no longer employed by the HSE. Four witnesses attended for a second interview to further assist the inquiry. The Chairperson saw the four younger children of the family informally with their foster families. Some HSE personnel exercised their right to consult with their representative bodies and sought legal advice through those bodies. Through their solicitors, the HSE personnel stressed their willingness to fully co-operate with the Inquiry. They wished to clarify matters relating to the establishment and conduct of the proceedings of the Inquiry. Many of the matters raised with the Inquiry in this regard were the responsibility of the HSE and as such were referred to the HSE and were dealt with between the two concerned parties. The Inquiry Team replied to the matters which concerned the process of the Inquiry. The Inquiry was informed by letter of May 28th 2009 that HSE personnel, notwithstanding some ongoing concerns, would attend the scheduled interviews.

Interviews

The Inquiry Team had no power to compel any person to attend before it, to answer questions or to engage in any way with the process of the Inquiry. The Inquiry Team was and remains cognisant of the stress and upset experienced by many attending for interview and conscious that involvement in any case that results in an inquiry can be a difficult and distressing experience. This is particularly so for staff who are continuing to provide services on a day by day basis. A support person attended at the venue each day to support the interviewees before and after their meetings and to generally aid the smooth running of the Inquiry. Witnesses were advised by letter of the nature and terms of the Inquiry and were advised that there was no provision for the inquiry to fund legal expenses. Each witness was given the opportunity to make a written submission to the Inquiry and most witnesses accepted this offer. Each witness was advised that they were entitled to invite a colleague or representative to attend with them. A total of fifteen interviewees were accompanied during their meeting with the Inquiry Team.

At the commencement of their interview, each interviewee was informed of the procedures under which the interview would be conducted and a copy of those procedures are contained in Appendix 2. Where an interviewee was accompanied, the companion was informed of the conditions under which they were attending the meeting and were asked to sign a form indicating they understood and accepted the confidential nature of the proceedings. See Appendix 3.

A stenographer attended at all interviews and each interviewee was advised that they could request a copy of their transcript.

The Inquiry Team had no legal representation at the interviews. The interviews were conducted in a question and answer format and did not incorporate formal rules of evidence or court procedure. Fair procedures were adhered to at all times.

Report

The Inquiry Team provided an opportunity to persons who might consider themselves affected by the findings of this report to review the relevant parts of the report and to offer corrections to any factual inaccuracies, as perceived by them. Such persons were also invited to make a submission in regard to any findings that concerned them and advised that such submissions would be considered by the Inquiry Team prior to the finalisation of the report.

Each submission was carefully considered and the report was amended where the Inquiry Team considered this appropriate. This report was then finalised after the completion of those steps. The Health Information and Quality Authority (HIQA)³ issued a guidance document on the review of serious incidents as this report was finalised. This report does not therefore

³ Health Information and Quality Authority (2010) Guidance for the Health Service Executive for the Review of Serious Incidents, including Deaths of Children in Care

follow the process as set out by HIQA. However, it covers all of the necessary components outlined in that guidance.

Independent Legal Advice

Lavelle Coleman Solicitors were appointed as solicitors to the Inquiry and advised on all legal matters but did not attend interviews.

Case Review Framework

The Inquiry had its own specific terms of reference which allowed it to fully complete this work. In addition it was mindful of the provisions of Children First 1999 (8.25.) which stipulates that among the specific objectives of a case management review are:

- To establish facts
- To assess decision-making and interventions made in the case
- To check whether procedures have been followed
- To check whether services provided were adequate and appropriate
- To make recommendations in light of the findings.

In addition the Inquiry utilised Learning Together to Safeguard Children (2008) as a general guide to ensure key matters were covered. This guide, issued by the Social Care Institute for Excellence, is concerned with developing a multi-agency systems approach for case reviews.

Expert witnesses

During the course of the Inquiry advice was sought from a small number of experts when advice was required in relation to some issues before the Inquiry.

Principles

1. The welfare, dignity, confidentiality and best interests of the children and young people at the centre of this Inquiry shall be of paramount importance.
2. The voice of the child will be heard and reflected in the deliberations and conclusions of this Inquiry.
3. All persons appearing before the Inquiry Team shall have their dignity and integrity respected, and will be subject to due process at all times.
4. No person will be identified by name in the final report.
5. The Inquiry Team will be informed by contemporary literature and international best practice with regard to the methodologies adopted to undertake their enquiries.
6. The Inquiry will be undertaken in a spirit of learning focused on informing practice and improving services into the future.
7. A whole system approach will be taken with regard to the services under examination.

8. Expert advice will be sought as a means of enhancing knowledge and ensuring that conclusions reached are reflective of contemporary academic and professional thinking.
9. Matters and events will be considered in the context of the era and circumstances in which they occurred.
10. Nothing shall be done to prejudice the rights, duties and obligations of individuals, agencies and the State in the course of the enquiry; or in the publication of its findings, which the HSE has said will be made public.

CHAPTER 2: Contextual Issues Regarding County Roscommon

2.1 Demographic profile

2.1.1 Roscommon is one of the country's least populated counties, second only to Co. Leitrim. Census figures show that the population of Roscommon rose from 51,975 in 1996 to 53,774 in 2002. There was a further increase of 9.3% in 2006, bringing the total population to 58,768. In fact, the seven western counties have shown a population increase in the latest Census; and this is due primarily to inward migration. However, population growth in Roscommon is far below the regional and national average and is concentrated mainly in Athlone (Hasse; WBD 2009).

2.1.2 Unemployment rates for County Roscommon have fallen more slowly than the national average. It also has the third lowest level of local authority provision in the country. In general terms, County Roscommon is in the middle range of the overall affluence to deprivation indices and is not characterised by particular extremes (Hasse, 2009). However, many of those who met with the Inquiry Team described 'pockets of deprivation' where certain rural areas were characterised by high numbers of poor families; living in close proximity, in rural areas where the land is bad and unemployment is high. The family which is the subject of this Inquiry lived in such a rural area, adjacent to a small town.

2.1.3 For much of the period under examination (1996 – 2005) the former health board structure prevailed whereby the Western Health Board (WHB) comprised counties Galway, Mayo and Roscommon. Under the new Health Service Executive (HSE) structures the three counties remained as separate administrative entities, known as Local Health Offices (LHOs) forming part of a larger administrative region known as HSE West. For comparative reasons, therefore, it is appropriate to contrast the demographic profiles of the three counties as this has relevance to resource allocation and staffing levels.

Table 1: Total population, child population

County	Total pop.	Child population
Galway	231,670	55,306
Mayo	123,839	30,969
Roscommon	58,768	14,503

Source: Social Work and Family Support Survey, HSE, 2009.

2.1.4 Galway has both the highest population and highest child population of all Local Health Offices (LHOs) in the country. Roscommon, on the other hand, has second lowest population and child population in Ireland; with Mayo taking up a middle ranking position (HSE, 2009).

2.1.5 According to a survey undertaken by the Health Service Executive (HSE), County Roscommon does not rate highly in terms of chronic deprivation, by comparison with Galway, Mayo, and the rest of the country. In addition, Roscommon has the lowest minority population in the country (HSE, 2009).

2.1.6 However, it has been reported to us by staff that County Roscommon does have areas where there is a high influx of native Irish, who have migrated from urban centres; often availing of social housing schemes. Among this cohort are a number of very deprived families, many of whom were known to child welfare and protection services before relocating; and this has impacted on local service provision.

2.2. Organisational Structure

2.2.1 At the time of the first referral in 1989, the old health board structures applied where County Roscommon was a Community Care Area within the Western Health Board. Each Community Care Area was managed by a Director of Community Care and Medical Officer of Health who, by requirement, was a medical doctor. Each Head of Discipline reported to this Director, including social work, public health nursing, public health medicine, speech and language and other paramedical and administrative services.

2.2.2 A Senior Social Worker, of long standing, headed the social work team which, at that time, comprised four full time and one half time social worker, a community worker and a child care worker. Public Health Nurses reported to the Superintendent (later Director) of Public Health Nursing and, similarly, other professionals reported to their Head of Discipline.

2.2.3 Within social work the single-handed post of Senior Social Worker was supplemented by the creation of a Social Work Team Leader post in the mid-1990s. This is a supervisory grade designed to relieve senior social workers from the supervision of basic grade staff; and to enable them to address broader social work management issues. The Senior Social Work post was eventually superseded by the establishment of the post of (*Professional Manager 1*) which, typically, manages two or more Social Work Team Leaders.

2.2.4 Also in the mid-1990s the post of (*Professional Manager 2*) was created in response to one of the recommendations of the Kelly Fitzgerald report (1996). Recognising the need for direction and leadership in the planning and delivery of services at local level, it recommended the creation of a senior professional post, in each Community Care Area to effectively discharge the functions of child welfare and protection. (*Professional Managers 2*), with the necessary experience, could be drawn from any relevant professional discipline.

2.2.5 A further organisational change in the mid-1990s was the replacement of the post of Director of Community Care and Medical Officer of Health with that of General Manager. The post was created to bring a business management approach to local service delivery that was more in keeping with the times than the original post of a medical director. This post was open to both administrative and professional grades. From its establishment all service heads reported to the General Manager, who in turn reported to a Regional Manager who was a member of the Health Board's management team.

2.2.6 The part of Roscommon where the services under investigation are located is very rural. As such, staff groups must, by necessity undertake a considerable amount of travel. Members of staff were often isolated from other immediate colleagues or line managers. While this is not unique to Roscommon, or to services involved in this particular family, it is a feature of health and social service provision in rural Ireland that has an impact on service provision.

2.3 Resource Allocation

2.3.1 The publication of the report into the Kilkenny Incest Investigation (1993) brought fresh public and political awareness of child welfare and protection. Coinciding, as it did, with the dawning era of the 'Celtic Tiger', significant new investment began to be made into a child care system that had been static for years. Sections of the Child Care Act 1991 were commenced and, with their new resources, health boards began to expand staffing levels and services.

2.3.2 It has been described to us that an implicit policy within the Western Health Board was to divide new monies on a 3:2:1 basis to Galway, Mayo and Roscommon respectively, having regard to the population differential between the three counties. (*Professional Manager 2*) told us that in practice this was not evidenced in the distribution of resources. In 1999 he wrote to General Manager 1 saying that, even applying 'the 3:2:1 rule', Roscommon's allocation for that year had a shortfall of £24,500. (*Professional Manager 2*) further explained that service development priorities were identified through the service planning process and that a business case would be made for these.

Through written and oral submissions made, there are examples of proposals being made from heads of discipline and child care management for resources to meet particular needs that were specifically identified; but where these proposals were unsuccessful in securing funding. This includes one proposal in particular that was aimed at targeting serious neglect cases in County Roscommon.

At interview with the Inquiry Team General Manager 1 advised that they "constantly looked for extra resources".

2.3.3 Yet, throughout the period 2000 – 2004 there is evidence of additional resources going into County Roscommon, as the following table indicates:

Table 2: Child Care allocation 2000 – 2004

Year	Pay	Non pay	Total (£)	New posts
2000	126.85	184.25	311.10	5.8
2001	234.00	241.50	475.50	7.0
2002	00.0	224.00	224.00	0.0
2003	70.00	0.00	70.00	1.0
2004	00.0	222.0	222.0	0.0
Total	430.85	871.75	1,302.60	13.8

Source: HSE West submission

2.3.4 Thus it can be seen that over a four year period the County was allocated an additional £1,302.6m, or € 1.653m, resulting in almost 14 additional posts as well as some non-pay developments. Successive first-line managers described service planning processes where needs were identified and bids were made for additional funding to meet those needs, but there remained a sense among staff that Roscommon did not fare as well as Galway and Mayo.

2.3.5 Regardless of what discrepancies might apply to the distribution of resources and the overall capacity of the child care service to meet the population as a whole, the Inquiry Team is satisfied that, in this particular case, resources, 'per se, were not an issue. In fact, as is elaborated upon later, a plethora of services were involved in this family over a period of years. One caveat is, however, the difficulty in recruiting staff which did have an impact at critical points in the lifetime of this case. In addition, the Inquiry Team was advised that on two occasions known to the Inquiry, that is in 2000 and in late 2002, there were other serious child protection concerns in areas of Roscommon that required a good deal of attention from social workers. At both of those times there were staff shortages.

CHAPTER 3: History of Health Board/Health Services Executive involvement with the A family

3.1 This chapter outlines the history of the involvement of the Western Health Board, and other services, between 1989 and 2004. As a history encompasses more than just a chronology of events, the Inquiry Team has taken an analytical approach to the totality of actions and proceedings; commenting on the effect of some events and on the effect of other events not having occurred. Therefore, when such opinion is proffered by the Inquiry Team, this is clearly indicated in the text.

3.2 Period 1: 1989 to 1995

The A family was known to the Western Health Board from 1989. At that time the family lived with the maternal grandmother whose health was poor and as a consequence a home help service was provided.

The Public Health Nursing Service became involved with the family following the birth of their first child. A concerned neighbour contacted the Public Health Nurse (PHN1) expressing concern about the extent of the parents' alcohol consumption; and alcohol being given to the baby. PHN 1 visited and found the baby pale and irritable. She reported the concern expressed by the neighbour to the Superintendent Public Health Nurse (SPHN). PHN 1 advised the Inquiry Team that she was checking regularly on the family and continued to do so. A relative, who was also concerned about the care of the new baby, made a referral to the social work services. This relative was specifically concerned in relation to a severe and untreated nappy rash. As this social work file is missing it is not possible to determine what action, if any, was taken.

In 1990, further to a telephone call from Mr A, PHN 1 attended at the home as Mrs A had just given birth there. The nurse called the family GP who arranged a hospital admission. She advised the Inquiry Team that Mrs A explained to her some days later that she had drunk eleven vodkas the evening before the birth and had not realised that she was in labour. The PHN advised the Inquiry that she told Mrs. A that it was a lot of drink.

The Inquiry Team notes that the attendance at the home is on the PHN record but that the alcohol consumption is not referred to in that file note. There is no record of a formal follow up to that incident in terms of a discussion with the social work office or with a Superintendent PHN.

3.2.1 Home Management Advisory Service

In 1991 PHN1 wrote to the Acting Director of Public Health Nursing recommending that the family receive the support of the Home Management Advisory Service. This service has been available in Galway, Mayo and Roscommon since 1978. The purpose of this service is to help families with budgeting, nutrition and healthy living. The service prioritises families referred by social workers. It is a home visiting service provided by qualified home economics teachers. As such, they are not trained to work with families where there are complex social issues. There is no information on the Home Management files available to the Inquiry to say whether or not the family was visited in 1991 by that service.

In 1993 the PHN record shows that a complaint was received from a member of the public alleging that the children were being neglected. PHN 1 saw the two children and referred them to the GP. This GP (GP1) provided a service to the family from the birth of the eldest child until mid 2003. Much of his frequent contact with the family was in their home.

The Home Management Advisory Services has a record of a referral to that service in 1994 by a Social Worker to provide help with rent arrears. The electricity supply had also been disconnected. Home Management Advisor 1 who worked with this family from 1994 to 1995 and then again from 1997 to 2004 advised the Inquiry that Mrs. A spent a great deal of money on alcohol at times. She further said the condition of the house started to significantly deteriorate again around 2001. In relation to how she viewed the work with the family she said *"I suppose I was hopeful; rather than optimistic"*.

An undated note, which appears to be from 1994, indicates that the service did commence work with the family at that point. The entry on the Home Management Advisory Services file records that there were arrears in rent and in payments to the Electricity Supply Board and that a significant amount of the family income was being spent on alcohol. Arrangements were put in place for weekly payments for rent and electricity, but these payments were not continued.

The Inquiry Team notes that these payments were renegotiated on several occasions up to 2004 but that the payments were repeatedly discontinued by the parents.

PHN 1 continued to visit to monitor the health and well-being of the growing number of children. The other Western Health Board service involved with the A family in the period up to 1996 was Speech and Language. During 1994 and 1995 one child was referred for Speech and Language Therapy and was brought to appointments on four out of fifteen possible occasions. Again, a second child referred in 1995, was not taken to appointments regularly and was discharged after one year. He was referred to the Speech and Language Service again by a locum Public Health Nurse in 1996.

3.3 Period 2: 1996 to July 2000

From 1996 onwards concerns were consistently recorded in the Western Health Board (WHB) files in relation to this family. A new social work case file was opened in April 1996 when Mrs A sought help in relation to an eviction notice served because of mounting rent arrears.

By 1996 there were four children in the family including a newborn baby. Both parents were unemployed. The PHN records for the period show ongoing issues re hygiene of new baby noting "Mother advised re hygiene".

Also in 1996 Social Worker 1 was allocated this case. She had recently taken up a position in the WHB and worked with this family until February 1999. She had some practice experience in another Health Board area. Social Worker 1 advised the Inquiry that, on taking up her appointment, she found a cabinet full of case files (approx 100). She worked part-time on a week-on/week-off basis and had very little contact with the social worker who covered the other half of her post. She advised the Inquiry that she had a very heavy case load.

Social Worker 1 received support and supervision from the Acting Senior Social Worker who had come to the area recently as a Social Work Team Leader. The previous Senior Social Worker had been off ill for some months and died in 1997 (RIP). The Acting Senior Social Worker had social work responsibility for all of County Roscommon and, during his period in that acting position, the Team Leader post was left vacant.

3.3.1 Home Visit

Social Worker 1 visited the family in May 1996 and described the family home as "very stark, cold and bleak". Her file note records that the home conditions were very poor and that refuse had built up directly outside the house causing an infestation of flies in the kitchen. She initiated a series of contacts, largely by phone, with colleagues in the WHB who were involved with the family. This included the Public Health Nurse, the Home Management Advisor and, in addition, relevant officials from the County Council. In follow-up visits Social Worker 1 records that Mrs A had poor homemaking skills and that the level of alcohol being consumed by both parents was problematic. The files record that both parents were reminded of their duty to provide a clean environment for the children and of concerns the WHB had about the extent of their drinking. The parents denied that they had an alcohol problem. The Home Management Advisor 2, who worked with the family in 1996, described them to the Inquiry as being at the "*more severe end of concerns*".

Steps were taken by the WHB to remove the refuse from around the house; and attempts were made to get the family to start making regular rent payments. During the months May 1996 to November 1996 concerns were expressed to Social Worker 1. This was done anonymously, by letter from a member of the public; and in a telephone call by a Community Welfare Officer regarding the well-being of the children.

3.3.2 First Case Conference, 19th November 1996

A Case Conference, chaired by the (*Acting Professional Manager 2*), was held on this family in November 1996. The family were not at this meeting. The school was not represented. The Case Conference was attended by WHB staff directly involved with the family, except for the Speech and Language Department. This was the first of eleven case conferences and a number of case reviews held on this family between November 1996 and October 2004, when all of the children were taken into the care of the HSE.

In addition, during this time, the family was discussed at Core Group (later called the Child Protection Management Team) on at least six occasions based on the records available. Core Group was an initiative taken by the WHB in Roscommon whereby line managers, from different disciplines, would come together with operational staff to discuss individual cases. Based on the information presented at the meeting, Core Group would also make determinations on whether or not abuse had occurred and would categorise the nature of the abuse that had occurred. Abuse was subsequently confirmed with regard to some or all of the children five times by the core group.

The report provided by Social Worker 1 to the Case Conference states that “the house and environment constitutes a situation of neglect...I feel the children are suffering as a result of their (parents) bad management”. This social work report also notes that Home Management Advisor 2 (HMA2), who had worked with the family for the past year, “finds it difficult to initiate change”. Other significant issues raised were an uncertainty that the children were being adequately fed, concern that both parents were drinking to excess; and that the family money was being spent on alcohol rather than food. The report submitted by locum PHN2 is very clear in its assessment that “the house is in a deplorable condition and is deteriorating despite promises to clean the place up”. On the other hand, the children were said to be well cared for and the baby was attending the family GP because of dermatitis.

The minutes of this Case conference record that the parents were to agree to the following:

- The need for a home help with an extensive input gradually reducing
- That weekly shopping be supervised to make sure essential food is bought
- WHB would supply basic items i.e. beds and floor covering in order to maintain a healthy environment for the children
- A cooker to be provided by Vincent de Paul Society
- County Council to supply paint and the parents are to paint the home
- The issue of drinking was to be confronted with the couple
- Senior staff from Social Work and the Public Health Nursing Service to visit to ensure family aware of how the Health Board viewed the situation.

The Inquiry Team notes that those minutes also record that the parents were to be informed that an application for a Supervision Order “may be considered an option for the WHB”.

The records show that Senior Public Health Nurse 1 (SPHN1) and Acting Senior Social Worker 1 visited the family following the case conference. In his meeting with the Inquiry Team, Acting Senior Social Worker 1 could not remember the visit, or how he found the family, or conditions in the home. The SPHN1 did remember the home and did not recall anything unusual or anything that would cause her huge concern. The record of the visit, completed by SPHN 1, is in bullet point form and reads: “carpet in sitting-room dirty...home help may be required until house has been cleaned up”. The record says that the plan, as agreed by the case conference, was discussed with the parents.

Social Worker 1 recorded that the family agreed to the plan and, over the next few months, the house was painted and floor covering was provided for the kitchen where conditions were particularly poor. These improvements were initiated and led by WHB staff.

In December 1996 Home Management Advisor 2 recorded that the parents were resisting spending money on food shopping and were purchasing significant amounts of alcohol when they were brought shopping by her.

The Inquiry Team notes that this was just a few weeks following the first Case Conference.

Home Management Advisor 2, who was leaving her post, wrote to Social Worker 1 with an update of her work and an assessment of the family situation. She identified the provision of food and warmth as key for the family and drew attention to the ongoing hygiene issues. The disposal of refuse was also highlighted. Her assessment was that the family “needed to be supervised closely”.

3.3.3 Further Concerns

In February 1997 locum PHN 2 again wrote to the Senior Public Health Nurse outlining her concerns following a home visit in response to a written request by SPHN1 for a report for the upcoming review. The locum PHN 2 wrote that she found no food prepared for the children coming in from school, the baby’s clothing was soiled and dermatitis was evident on the baby’s head and neck. No shopping had been completed with the Home Management Advisor 3 (HMA3) on the previous day as “money would not stretch that far”. Social Worker 1 visited that month and noted that while the home was fairly clean and tidy, rubbish disposal continued to be a problem. She discussed the situation with locum PHN 2 and they concluded that home support (home help) was the best way to monitor the welfare of the children. The records show that it was difficult to recruit a home help locally at that time.

3.3.4 First Case Review

In March 1997 a Case Review was held as a follow up to the Case Conference of November 1996. Records are not complete for this review but a handwritten note on the files of the Public Health Nursing Service shows that the rent arrears had increased, no effort had been made to continue payments; and no home help service was put in place as Mr A would not agree to it. Difficulties with domestic sewage and a broken washing machine were also noted.

(*Professional Manager 2*), in his interview with the Inquiry, stated that improvements were noted by Social Worker 1; and that she did not seek a follow up review from that meeting. Mr and Mrs A again promised to pay the rent regularly, as no payments had been made up to that point in 1997; and to cooperate with weekly shopping. They were praised for painting the house.

The Inquiry Team notes that the file records do not show any reference to the welfare of the children, the misuse of alcohol or the hygiene issues previously referred to.

The Speech and Language Department of the WHB was involved through 1997 and cooperation with the service was very sporadic.

By May 1997, the next recorded home visit by Social Worker 1, the house was described as “a bit dirty with flies in the kitchen”. A skip was again organised for rubbish and rent arrears were still increasing. The next social work visit was in July 1997 when an out of hours visit was carried out at 6.30 pm. Social Worker 1 noted that the parents were surprised to see her and that the children presented as cleaner than in the past. Rent arrears were discussed and parents again agreed to pay the rent. The record of the Public Health Nurse dated 31st of July 1997 states Mrs A “smokes and drinks”.

For the period July 1997 to October 1997 there is general agreement among those working with the family that the situation had improved; but that the rent arrears continued to be problematic. It is recorded that the children looked well and were doing well at school. There were now five children in the family.

The Inquiry Team notes that there are no social work records on file for the period October 1997 to January 1998. It is not clear if any social work visits were made to the family during that period.

The Home Management records show that when the Home Management Advisor 3 visited in January 1998 to do the shopping, as agreed, there was no one at home. In early February 1998 shopping was completed; but the record shows that a significant amount of money was spent on alcohol on that day. The parents were not available to go shopping on any other agreed days in February 1998. This was despite the agreements made with the family, at the Case Conference in November 1996 and at the Case Review held in March 1997 that adequate food would be purchased to meet the nutritional needs of the children. These concerns were communicated to Social Worker 1.

3.3.5 New Concerns

Two new concerns also emerged in February 1998. The first one related to a fire-setting incident by one child and the second to a child (*too young*) being sent to the town, approximately one and a half miles away, to collect shopping (including alcohol). These concerns were discussed at the Core Group where it was agreed that Social Worker 1 should visit. The home visit concentrated on the fire setting episode.

The Inquiry Team notes that the issue of adequate food being purchased was not addressed at this time.

At a follow up home visit, in early March 1998, the issue of the young child struggling to carry bags, which included alcohol, was addressed. Mr A is described as being reluctant to desist from this practice and he had to be reminded that the main shopping was supposed to be done when the Home Management service called. PHN 1 records that she too challenged the parents on this. They agreed they sent the children for “messages” but insisted no alcohol was purchased.

The County Council again confirmed that no rent was being paid and, in early April 1998, Home Management Advisor 3 reported to Social Worker 1 that she had “grave concerns about the children”. Examples given included the baby not being appropriately dressed when out with parents, baby being cold, and that Mrs. A was going straight to the pub after dropping home the food purchased with Home Management Advisor 3.

Social Worker 1 recorded that she was unable to follow up with another home visit due to her workload. She visited the school to discuss the fire incident and the teacher spoke to her concerning the ongoing hygiene issues: “there have always been problems with hygiene”. Social Worker 1 recorded that a Case Review was now required. In April 1998 Mrs A was not home to go shopping with the Home Management Service, the wheelie bin was gone and rubbish was again accumulating. In addition, a record of a conversation between PHN 1 and the Social Worker 1 shows that PHN 1 was concerned that the baby was being fed watered down cow’s milk rather than baby formula.

3.3.6 Second Case Review, July 1998

A Case Review was due to be held in May but Mr and Mrs A did not attend. It was therefore cancelled and finally took place on July 2nd 1998. There are no available typed notes of this Case Review; but there is a handwritten note on the social work file. Mrs. A was pregnant with her sixth child. Mr A did not attend this meeting. Three WHB staff members involved with the family attended: PHN 1, Social Worker 1 and a Community Welfare Officer. There was no one there from the Home Management Advisory Service although it was that service that had expressed grave concerns in April 1998. Locum Home Management Advisor 3 had left and the regular Home Management Advisor 1 was on maternity leave.

This Case Review dealt with the issues that had arisen since the case was last discussed i.e. rent arrears, older children carrying heavy bags of shopping from the town, the need to give formula milk rather than watered down cow's milk to the baby, the need for psychology service referral following the fire lighting incident and the need for a clean up outside the home. Concern was expressed concerning a blockage in drains adjacent to the house and it was agreed to contact the Environmental Health Officer. Again Mrs A agreed to cooperate and to have the Home Help Service work with her as she felt she would be less able to cope with six children. The Inquiry Team did not find a record of a request to the Home Help Department to follow this up.

A Senior Social Worker (SSW2) was appointed on the 29th June 1998 with overall responsibility for child welfare and protection in social work practice in Roscommon. Senior Social Worker 2, who was appointed (*Professional Manager 1*) during 2001, remained in Roscommon until December 2001. In her interview, Senior Social Worker 2 advised the Inquiry that she, as Senior or (*Professional Manager 1*), would not routinely attend case conferences. She explained that, the Social Work Team Leader had day to day management of the case. She would hear of individual cases through the Core Group system or through regular (usually monthly) supervision. She also said she would meet the Social Work Team Leaders unofficially much more frequently than monthly.

3.3.7 Ongoing Concerns

In August 1998 the Home Management Service was visiting again as the worker was back from maternity leave. Home Management Advisor 1 queried whether the baby was being fed baby formula, the wheelie bin was missing again; and rubbish was in evidence around the house. These were the concerns considered in the July 1998 review. Social Worker 1 also visited in August and covered the practical areas concerning rent arrears, drains and the purchase of a new cooker.

In early September the Area Medical Officer (AMO) visited the home in response to concern by PHN 1 that the baby was not being stimulated; and had poor trunk control. A neighbour advised the AMO that she was concerned the parents were drinking heavily. The AMO saw the child and described hygiene as "poor". The AMO wrote to Senior Social Worker 2 suggesting that the Social Work Department might put in more support.

Social Worker 1 visited in November 1998 following the birth of last child and recorded there were no problems. Later that day, another neighbour spoke to the Social Work Department alleging that the children were out in very cold weather with very little clothing. Social Worker 1 discussed this matter with her Social Work Team Leader. She records that she was advised it could be left until she was next on the duty roster, which would be in ten days time. The Inquiry Team did not find a record to show this matter was pursued in December 1998. There is a file record indicating that there was another consultation with her Social Work Team Leader two days later, where it was agreed that there should be a home visit before Christmas.

During 1998 the Speech and Language Department continued to offer appointments for two of the children, but there was no response to these offers.

The Inquiry Team notes that speech and language issues do not appear to have been known to the Social Worker and do not feature in Case Conferences discussions at that time.

On January 8th 1999, some six weeks after the November 1998 report, Social Worker 1 visited the family who made the report. This family outlined what they had seen: the children not being properly clothed and, specifically, that an older child was pushing the buggy past their house while the baby was “freezing”. They had observed this in November 1998. They also told Social Worker 1, that they heard from others, that Mrs A was involved in (*inappropriate behaviour*) and that the children were in cars with her when she was travelling to and from this activity.

The Inquiry Team notes that there is no record of a visit being made to the A family to discuss the serious issues raised in the visit outlined above.

On February 4th 1999 Social Worker 1 visited the family and saw the children outside in “harsh weather”. There was no fireguard in front of the fire and the toddler was crawling out the front door. The Social Worker did advise Mrs A that the children needed coats and that the young child should not be crawling out the front door. The provision of a Home Help was again raised but, on this occasion, Mrs A said she was managing well because Mr A was usually home and she found this helpful. In a telephone conversation with the PHN, Social Worker 1 discussed issues of the children being out without coats, the carry cot being in a dangerous position on the coffee table, and no fireguard in place in a home with three children under three years old. The social work file records that the PHN 1 expressed a view that things were safer when Mr A was at home as Mrs A “does not always have a sense of the dangers”. Both the PHN 1 and Home Management Advisor 1 agreed to reinforce the need for safety in the care of the children.

The regular Home Management Advisor 1, in a telephone conversation, told Social Worker 1 she felt things had generally improved since she recommenced work with the family. The specific evidence provided was that Mrs A cooperated with shopping more regularly and that less money was being spent on alcohol during the weekly shopping trips.

A closing summary by Social Worker 1, in February 1999, notes that Mr and Mrs A had a “possible problem with drink”, that there was a history of neglect and that the new Social Worker should liaise with Home Management Advisor 1 and PHN 1. She describes social work visits as a preventative strategy that worked reasonably well and that the family should be visited monthly. It is recorded that the family had no problems with visits from a Social Worker.

In her testimony to the Inquiry Social Worker 1 expressed the view that this was a family support case. Her assessment given to the Inquiry was that “*They (Family A) engaged but they didn't really*”.

The Inquiry Team notes that, during 1998 and early 1999, there were a growing number of concerns being brought to the attention of the WHB. These concerns could have triggered a Case Conference to consider if the lack of progress on issues, set out in the first Case Conference held in November 1996, would warrant an application for a Supervision Order; as evidence was mounting that Mr and Mrs A were not cooperating in a meaningful way with the Western Health Board. The Inquiry team also notes that Social Worker 1 visited infrequently and that this was not adequate in light of the ongoing serious concerns.

3.3.8 New Social Worker

Between February 1999 and May 1999 no Social Worker was allocated to family A. The Social Work Team Leader post for this area was vacant for the first five months of 1999. In May 1999 this family was allocated to Social Worker 2 who was supervised by the newly appointed Social Work Team Leader 2, both of whom were new to this case.

Social Worker 2 qualified in 1997 and had almost two years experience in another Health Board area. She worked with the family until July 2000 when she left the WHB. Social Worker 2 also referred to the cabinet full of files which required to be sorted through and decisions made in respect of them. In her interview with the Inquiry Team Social Worker 2 said she had tried to read the files notes compiled by the previous Social Worker, but “*struggled with some of the handwriting*”. She confirmed that, at that time, there was nothing typed in the area except Case Conference reports; and these had to be faxed to another office twenty miles away for that purpose. She indicated that she had around twenty-eight cases, including nine children in the care of the WHB.

Social Worker 2 confirmed at her meeting with the Inquiry Team that the house was not clean. On her first visit to the family on May 18th 1999 she noted that the children “presented as well attached to their parents and comfortable in communicating with adults”. Mr A immediately engaged Social Worker 2 in seeking help concerning a leaking toilet and getting help from the County Council to deal with an accumulation of sewage at the back of the house. Social Worker 2 was clear that, apart from one occasion, she only saw the sitting room and never saw any other room in the home. In particular, she emphasised she had never seen the kitchen and relied on Home Management Advisor 1, who told her it was alright.

There is a note on file to say that the child, aged two years, had very little speech and might need to be referred to speech and language therapy. The speech and language record for June 1999 shows that one of the older children, who was not taken to appointments in previous years, was referred again to the service. This child is described as not having walked until two years old and was having nightmares every night by the age of six.

In June 1999 an anonymous caller telephoned the main Social Work office to say that Mr and Mrs A were in the local pub all day every Friday. They said that this had happened on other occasions and that the children were always

with them. Social Worker 2 visited the home that day and Mrs A confirmed that they were in the pub from twelve noon until five in the evening with the children, who were off school. She said she was not so drunk that she could not care for the children. At this time three of the children were under three years. She told Social Worker 2 that, the previous week, she drank so much that she blacked out and could not remember what happened. She said her children were not with her at the time. Mrs A inquired about Alcoholics Anonymous and the Social Worker gave her details of local AA meetings.

The next recorded visit by Social Worker 2 to this family was in August 1999. This was in response to a report from a neighbour who said that a child, aged around nine years, was pushing the baby on the road. Both children had little clothing on even though the morning was cold and breezy. The neighbour was concerned with the possibility of injury to the children from traffic as well as the lack of clothing. The neighbour gave her name but did not wish to be identified to the family. Six days later Social Worker 2 visited on foot of this referral. Mrs A insisted the sun was shining that day, that the baby was teething and the older child was wheeling the baby to try to calm him down. She then engaged Social Worker 2 with a request to contact the County Council regarding the toilet and drains. In October 1999 the Social Work record details a telephone call to the local school to check on the progress of the children. They were described as nice children who were brainy but not working as hard as they could. It was also said that their basic hygiene was not great.

3.3.9 New Concerns

On October 4th 1999 relatives of the children called into the Health Centre and spoke to PHN1. The relatives advised that on the previous Friday the eldest child, then ten years old, was left babysitting the five younger children ranging in age from nine years to ten months. The Public Health Nurse advised the relatives to contact the Social Work Department. The relatives phoned Social Worker 2. They identified themselves but asked that they not be identified to the family as the source of the complaint. The relatives also advised that they were concerned about the children's hygiene and nutrition. Social Worker 2 visited the home on the same day. Mrs A admitted that children were left as described, but said that the oldest child had a mobile phone with which to contact parents. Mrs A said the children were left from 9 pm until 1am in the morning.

Social Worker 2 again offered to make a referral to the Home Help Service and Mrs A said she would consider this. The family were referred to the Western Health Board's Core Group which concluded in November 1999 that all of the A children were confirmed as neglected, the oldest child was also confirmed as emotionally abused.

On the 12th of October 1999 Social Worker 2 recorded a conversation with a member of the Gardai in the local town. The name of the Garda is not recorded. The note records that the Garda said that they had no major concerns in that the parents were not seen in the pub at night but usually during the day and only now and then. He is recorded as confirming seeing children on the road and "might feel they were a bit young".

3.3.10 Second Case Conference, 23rd November 1999

This conference, chaired by (*Professional Manager 2*), was attended by all of the staff of the Western Health Board who were involved with the family. Mrs A attended but Mr A did not. The school was represented at this conference. Apologies as recorded in the minutes of the Case Conference were given by the GP and by the Superintendent Public Health Nurse. The report, provided by Social Worker 2 for the conference, outlined her assessment that hygiene and home conditions were a concern. Alcohol consumption was also identified as a problem and Social Worker 2 stated in her report: "I feel it is interfering with the care of the children" and therefore needed to be addressed. The necessity for home help was again identified.

The Inquiry Team notes that there was no further reference to the development of the children in this report.

Social Work Team Leader 2 outlined the inappropriateness of leaving the six children without a baby sitter and queried the amount of time spent in the pub. On this occasion Mrs A said it was for two and a half hours every Friday. Mrs A insisted her drinking was under control. The Case Conference minutes do not record that Social Worker 2 challenged this by referring to her conversation with Mrs A in July and October 1999, where Mrs A admitted blacking out and said both parents spent five hours drinking in the pub. The school reported that the children were very bright but not working to their full potential. Mrs A again agreed to accept a home help. The need for an extra room was identified as an issue.

(*Professional Manager 2*) pointed out to Mrs A that, while she was agreeable to make changes, these undertakings were not carried through and also made it clear to Mrs A that leaving the children without supervision in this way was neglect. Mrs A was adamant that this time there would be changes. The issue of the children going to bed at six-thirty in the evening was identified as a problem; and it was agreed that a child care worker needed to become involved with the family.

The Case Conference made the following recommendations:

- That the Health Board would support the need for an extra room,
- The Social Worker and Child Care Leader would put a plan in place to work with the children
- That the parents would ensure a suitable babysitter was there for the children if they went out.

The Inquiry Team notes that there was no recommendation on the issue of alcohol consumption and its effects on the well being of the children.

A home visit in December 1999 concentrated on providing clothes and toys to the family for Christmas.

3.3.11 Renewed concerns of relatives

On February 18th 2000 a relative, who had previously contacted both the Social Work department and the Public Health Nurse now visited the Social Work office and spoke to the Social Worker on duty. This relative provided very detailed information and the duty Social Worker recorded the concerns. These included a lack of heating in the home, no cooked food, children not getting a hot meal, a smell from the children's bedroom with piles of clothes thrown on beds, the parents drinking heavily, the children being taken to pubs frequently, Mrs A being engaged in (*inappropriate behaviour and in the manner in which she travelled there placing her children at risk*), the oldest child being made to get up early to care for the baby, and the children being sent to bed around six-thirty each day.

Social Worker 2 visited on February 22nd 2000 and put the allegations to Mrs A. who denied each point. Mr A was not present for this visit.

The Inquiry Team notes that there is no record that either these concerns, or the concerns that had led to the Case Conference, were discussed with Mr A at any point.

The children were present on this visit. The appearance of the children was described in the social work record as: "Baby face grubby, toddler face very dirty, older child's sweater very dirty. School age children in from school were well and appropriately dressed".

Later, in February 2000, a neighbour rang and identified herself. She expressed concern over the extent of the parents' drinking; and said that one of the older boys was pushing a child in the buggy with no rain cover. She said the baby was poorly dressed and that this was during a hail shower. Social Worker 2 visited three days later on foot of this concern. Both parents were present. Mrs A said the children were properly dressed although she agreed there was no cover for the buggy. The parents then involved Social Worker 2 in a discussion regarding a shed being built close to the family home by a neighbour.

In early March 2000, Mrs A contacted PHN 1 on a Saturday morning to say that an attempt had been made to abduct one of the children who had been in the town on the previous night. PHN 1 visited the home to discuss the incident, and informed her line manager by letter of the incident. The Garda, who visited to follow up this incident, contacted Social Worker 2 to say Mrs A was drinking cans of alcohol at home when he called, the children were not appropriately dressed and that Mr A was in the pub. Garda investigations into the report of the attempted abduction were inconclusive.

The incident was discussed at the Core Group on April 10th, 2000 with information provided by Social Work Team Leader 2. The group decided that this should be seen as a 'query of neglect'. In May 2000 the Core Group agreed it would remain open within the Core Group system and the 'query of neglect' categorisation remained in place.

PHN 1 referred one of the younger children for speech and language therapy but the family did not return the consent form.

3.3.12 Third Case Conference, 18th April 2000

A Case Conference, chaired by (*Professional Manager 2*), was held in April 2000 on foot of the abduction incident. This was the second Case Conference in five months. All of the Health Board personnel working with the family were present. Mr A was not present but Mrs A was in attendance. The school was not represented at this Conference. The Case Conference record shows that apologies were given by the Assistant Director of Public Health Nursing.

The report of Social Worker 2 to the Case Conference shows that the engagement of the child care worker with the parents and children, as agreed following the November 1999 Case Conference, had not commenced and was still on a waiting list. The report mentioned the phone call received from the neighbour but described it as anonymous, although the name was provided. The abduction issue, and the concerns of the investigating Garda, were also mentioned.

The Inquiry Team notes, that the concerns of the relative, who had called and visited the Social Work office in February 2000, were not alluded to in the social work report.

The report of PHN1 to the conference states that: "The... (Two older children) aged ten and eleven now need disciplining and a firm hand".

The Inquiry Team notes that it is not recorded that thought was given to the effect the lack of attention to the basic needs of the children was having on them; and the possibility that this might be contributing to their distress or behaviour.

The minutes of the meeting show that Mrs A agreed with the content of the Social Work report; but then switched to talking about issues relating to the house. The leaking toilet that had been highlighted in March 1999 was again identified as being an on-going problem. She also advised the conference of a recent incident involving one of the older children while in town in the late evening and that Mr A refused to leave the pub to take the child home. The child was teased in school the next day and Mrs A reported that the child was upset. In his interview with the Inquiry Team the Headmaster at the school said he had only recently been made aware of teasing of some of the A children by other children in the school.

(*Professional Manager 2*) pointed out that any child was open to risks if they were in town on their own. The minutes also show that Mrs A had attended three sessions of a parenting course that had recently started. Mrs A stated that, as a result of this course, she was changing her parenting style and not sending the children to bed as early as previously.

The Inquiry Team notes that this matter was first dealt with in the November 1999 Case Conference and that Mrs A had agreed then not to send the children to bed so early.

Child Care Worker (CCW1), who provided the parenting course, told the Inquiry that Mrs A was an enthusiastic participant. Mrs A told the Case Conference that the family did not need a Home Help. Despite the views of professionals to the contrary, as recorded in the files, this was not challenged.

The recommendations of this case conference were as follows:

- The GP to be asked to support the family need for an extra bedroom by writing to the County Council. The Health Board to write to the County Council. This was done by the (*Professional Manager 2*) on May 2nd2000
- Mrs A to continue attending the group parenting course
- It was noted that both younger children were still awaiting speech therapy
- The child care work to commence and concentrate on practical issues, specifically regarding an older child and to concentrate on setting boundaries
- Information on summer camps to be investigated by Social Worker 2 and passed to the parents
- Social Worker 2 to speak to Mr A. to get him to take responsibility for his children and their welfare
- An Environmental Health Officer (EHO) report to be sought on house. Referral to the EHO took place in early July
- None of the children were to be in town on their own at night.

3.3.13 Implementing decisions of Third Case Conference

Social Worker 2 visited the home on the same day as the Case Conference. Her record shows that she spoke to Mr A about not allowing the children into town on their own.

The Inquiry Team notes there is no record of the Case Conference's recommendation concerning the need for him to take responsibility for his children's welfare being discussed with him.

There is a note to say that the bathroom and the toilet were in a bad state: "Sink unclean, floor dirty, bath full of washing ". Mrs A had told the Case Conference earlier in the day that she did not require a home help service.

The children's relatives contacted the Social Work office again on the day of the Case Conference and spoke to the duty Social Worker. They provided information that the family allowance was being spent on alcohol and spoke of a request to them, the day following receipt of the family allowance, to supply briquettes as family had no fire. One of the older children was reported as having been seen walking home with a bag full of cans of alcohol.

The Social Work Team Leader 2 left the area in April 2000 and Social Work Team Leader 3 was then appointed and supervised social work practice until December 2000.

Child Care Worker 1 commenced work with the parents in late May 2000. Both parents attended the first appointment in the home. She notes: "Mrs A showed me into the sitting room". The worker recorded that both younger children were on their mother's knee and were affectionate towards her. The children were then aged almost two and three years. She noted the home conditions were "quite basic" and that the floor needed washing. The Child Care Worker described her intended plan of work to the parents and noted that neither could suggest any activities they might do with their children. This was the only session Mr A attended. In response to a query from the Inquiry Team regarding any attempts she might have made to re-engage Mr A after her first visit, CCW 1 replied that for the first session both parents engaged well with her, particularly Mr A "I was so sure he was going to engage because he was so compliant and so interested in all of that. I didn't do anything to pursue it". The next appointment was cancelled. A follow up appointment was held in June with Mrs A only. She advised Child Care Worker 1 that they were concentrating on work with the older child. Child Care Worker 1 noted that there was no evidence of any play materials or crayons for the children. The session concentrated on establishing routines around bedtime.

The next two sessions were cancelled by the parents. A session in August again concentrated on the older child and routines. The follow up session was cancelled. Child Care Worker 1, told the Inquiry Team "the house looked fairly basic – very cramped, lots of furniture, a little bit chaotic".

The Inquiry Team notes that Child Care Worker 1 appears to have accepted the parent's view that there was an improvement in the older child's behaviour. She did not see or meet with the child about what, if any, impact her work was having on the quality of the parent's interaction with him.

Child Care Worker 1 advised the Inquiry that she had intended to see the older child at a later point, but that the new plans for the care of the children meant this did not happen.

The Home Management record for the months May 2000 to July 2000 show that there was a marked deterioration from the early months of 2000 with "poor shopping" and "house very dirty" being recorded.

Social Worker 2 visited the family in mid July. Again the parents involved her in discussion concerning the County Council's shortcomings in relation to the house and the broken door of the washing machine. On this visit Social Worker 2 spoke to the older child about the abduction incident that had been reported in April and which was the subject of the previous Case Conference.

The Inquiry Team notes that this is one of the very few records of any direct discussions with any of the children in this family.

The child confirmed earlier accounts of the abduction and told Social Worker 2 that things were now fine. Social Worker 2 informed the family on that visit that she was leaving.

The Inquiry Team notes that while Social Worker 2 visited this family very promptly on foot of the many concerns raised, her records do not show that she made the parents aware that they were putting their children at risk as a result of their actions.

Social Worker 2 advised the Inquiry Team that she was not sure if she had recorded everything she did on this case. In relation to Mr. A she said “He *had a tendency to leave all the child care discussions to Mrs A – he only wanted to talk to me about what the council were not doing.* A new Social Worker was allocated the case in August 2000.

3.4 Period 3: August 2000 to December 2002

In August 2000 the same relative as before contacted PHN 1 and again expressed her concerns about the care and welfare of the children. The relative also spoke to the family General Practitioner (GP 1). GP 1 and PHN 1 discussed the family. The GP contacted the social work service and the PHN contacted her supervisor to request a Case Conference on the A family. At interview she said “*I needed the case conference to get the social workers back on, to get them to do something.*” She said she did not have a particular course of action in mind. Social Worker 3 was allocated the case in August 2000. He had first worked in Roscommon in 1996 in a different area. He was not an accredited social worker in Ireland at that time; although he was subsequently accredited in December 2001 after he had left Roscommon. Prior to doing a home visit he spoke by phone with PHN 1, Home Management Advisor 1 and the family GP.

3.4.1 Relatives interviewed

Social Worker 3 interviewed the relatives who had expressed their concerns on many occasions. This was the first time a social worker working directly with the A family had visited these relatives. The concerns previously passed on to the Western Health Board were reiterated and the conditions within each room in the house were outlined.

Additionally, Social Worker 3 was made aware that these relatives were having the children to stay with her family as much as possible at the weekends. As a result she was acutely aware of the lack of food and suitable clothing in the A Family home. The relative provided clothing (which then seemed to disappear when the children went home) and was also washing their school uniforms.

The Inquiry Team notes that this information was not available to the Western Health Board until this time. Senior Social Worker 2 confirmed in her interview with the Inquiry Team that, in general, social workers with responsibility for a family should meet with concerned relatives.

3.4.2 Action Taken

Social Worker 3 visited the family the next day. Mrs A at home but Mr A was not present. Social Worker 3 was given access to all the rooms. At interview he stated that *“going around the place, it was just squalor. It was just horrible...there was just filth everywhere, no proper bedding...the smell was overpowering”*. Social Worker 3 informed Mrs A that allegations had been made to the Western Health Board concerning the care of the children, the children being left unsupervised, high alcohol consumption by both parents and that she was engaged in *(inappropriate behaviour)*. He told her that the conditions he observed appeared to indicate neglect and that he would visit again in three days.

Three days later he visited the home again and he saw some improvement. Both parents were present and he repeated the concerns regarding the care of the children. The response from Mr A was not positive. He is described as minimising the problems, accepting no responsibility for the rent arrears and being hostile to the Social Worker. Mrs A became quite emotional and left the room while this visit was underway. Before leaving, Social Worker 3 informed the parents that the Western Health Board involvement would continue until all concerns about the children were addressed.

Social Worker 3 secured funding to provide a skip to clear the accumulated rubbish, established links with all the relevant personnel, sought assistance from the Home Help department and referred the younger children for speech and language therapy. He also visited the local school and was advised that there were ongoing concerns about hygiene and clothing. It was also mentioned to him that one of the children had been teased and bullied with negative comments about his mother and that steps had been taken to stop this bullying within the school.

The Inquiry Team notes the different descriptions given about the conditions in the house. The previous social worker, Social Worker 2, had visited over a fifteen month period, Child Care Worker 1 had been in the home in August 2000 and Home Management Advisor 1 had visited on three occasions in August. The Public Health Nurse had visited the home on eight occasions in 1999. None of those professionals appear to have registered appropriate concerns in respect of the conditions the children were experiencing on a day-to-day basis or by the likely impact of the conditions on their welfare. Other professionals had also visited the home over the preceding years and seem to have considered the level of hygiene in the home acceptable.

In her interview with the Inquiry Team, Mrs A spoke of how the parents orchestrated the visits of various professionals by confining them to the living room as much as possible. This strategy seems to have worked effectively until Social Worker 3 visited and insisted on inspecting the house.

3.4.3 Involvement of Home Help Service

The Home Help service commenced work with the family in mid September 2000. Two Home Helps provided the service between them. They worked

alternative weeks calling two days each week to the home. The service to be provided, according to Home Help 1 at interview, was to: “*supervise Mrs A to teach her how to bath the children and generally give her some idea of how to keep the house clean and to check the bedrooms, check the bed linen. Check they had linen on the bed, check they were washing*”, she said “*they weren’t used to baths so the little ones had an issue with it in the beginning*”. There was no plan to include Mr A, who was unemployed at this time, in any of this work. Home Help 1, on questioning at interview about teaching Mrs. A cooking, said “I would have cooked meals with her and showed her how to make various things.”

The Inquiry Team notes that they did not consider imparting these skills to Mr A.

Social Worker 3 met with Mrs A on September 4th and discussed the allegations of (*inappropriate behaviour*) with her. The following day an office interview was held with Mr A. He was un-cooperative, appeared to take no responsibility for the situation and rejected any suggestion that the children were not looked after properly. Social Worker 3 told Mr A that nothing had improved over the four years of Western Health Board involvement and that things had possibly deteriorated.

3.4.4 Fourth Case Conference, 19th September 2000 - Plan for Shared Parenting with Relatives

A Case Conference, chaired by (*Professional Manager 2*), was held on the 19th September 2000 attended by all of the key personnel of the WHB who were working with the family. The school was not represented at this conference and apologies were received from the GP and the Assistant Director of Public Health Nursing. Initially Mr A did not come to the conference: his wife said he had flu. (*Professional Manager 2*) arranged to have him collected as he considered it critical that both parents were present.

The detailed minutes of the conference indicate that there was a full and open discussion about the issues in respect of the home conditions, the children’s hygiene and the parents’ drinking.

The Inquiry Team notes that this was a very robust Case Conference in that the parents were not allowed to deflect attention from their responsibilities and failures over the past four years.

(*Professional Manager 2*) and the Social Work Team Leader 3 advised the parents that the previous pattern they displayed of agreeing to change their behaviour and then reneging on their promises could not continue. Social Worker 3 introduced the idea of formalising the shared parenting arrangement for the care of the children between the parents and the relatives. The relatives joined the Case Conference at that point. Mr A said he would agree to the shared care but he would not sign anything.

The core recommendation of this Case Conference was that a shared parenting arrangement between Mr and Mrs A and the relatives would be put in place, initially for a two month period. This plan would be detailed, with the written agreement of all parties required.

Other recommendations included:

- Child Care Worker 1 to continue with the parenting work. Both parents recommitted to do the work
- The Home Help Service to continue until the shared parenting plan commenced
- The Home Management Service to continue
- The Public Health Service to continue to visit
- The Social Worker to again reconnect the children with the Speech and Language Department. This service was not at the Case Conference.

The children were referred to Core Group because of the physical neglect of the children.

A speech and language appointment was attended by one of the younger children in October 2000, but there appears to be no further attendance until 2002. At interview the Speech and Language therapist who saw the child in October 2000 described what happened. *"The child (aged 3) came into the room with his mother ...the nappy was so saturated with urine that it was crystallised...having said that the child was very willing, very cooperative...I would have made the Social Worker aware of my concerns re scalding or nappy rash"*.

The Inquiry Team notes that this concern is not recorded on the Social Worker file and also that despite the intense discomfort (at the very least) this young child must have experienced that morning he was still trying to comply with what was required of him.

On October 10th 2000, Social Work Team Leader 3, Social Worker 3, and PHN 1 met with Mr and Mrs A to present the proposed shared parenting schedule. It was pointed out to the parents that while this proposal was voluntary the WHB would, if necessary, apply for Care Orders for all six children because of the level of concern they now had. Mr and Mrs A were advised to seek legal advice. Mr A appeared opposed to the plan and left the meeting, leaving Mrs A to discuss the details. However, at a subsequent meeting between the relatives and the parents, some changes to the proposed plan were agreed and accepted by all parties.

A letter from a firm of solicitors representing Mr and Mrs A was received by the WHB on October 24th 2000. The letter outlined that the parents' participation in the shared parenting plan was on a voluntary basis and that they accepted the amended plan. This letter also acknowledged that Mrs A was alcohol dependent and was taking steps to address this and that both parents also committed to reduce the weekly amount they were spending on alcohol.

3.4.5 High Court Injunction

On October 25th 2000, Mrs A came to the WHB offices and served Social Worker 3 with an ex-parte Order obtained in the High Court. Mrs A was the applicant, having provided a written affidavit to the Court. Her affidavit asserted that the shared parenting agreement was being imposed on her and that her children were adequately cared for by herself and her husband. She asserted: *"I say that I and my husband as a married couple have inalienable and imprescriptible rights over our children and I ask this honourable Court for an Order entitling us to keep our children together"*.

This Order () restrained the Western Health Board from removing any of the children from the custody of Mrs A until further order of the High Court. Legal advice was sought for the first time in relation to this family. The Law Agent who was engaged by the WHB advised Senior Social Worker 2, in a letter dated Autumn 2000, that before the WHB took any action to remove the children, whether by voluntary or other means, "It would be advisable to get the present order removed to avoid any doubt".

The impact of this Order on the approach of the social work service, and the WHB, was very significant. Senior Social Worker 2 told the Inquiry: *"The High Court disabled us from acting, it disabled us from acting on our responsibilities under The Child Care Act"* At interview (*Professional Manager 2*) said: *"It was highly unusual and a bolt out of the blue for us."*

Senior Social Worker 2, in her interview with the Inquiry Team, confirmed that she had not come across such an injunction previously. She also confirmed that this order was not notified up the line in the WHB *"Practice issues that required a decision...that would either be my decision or the (Professional Manager's 2) decision"*. The Law Agent, referring to this Order told the Inquiry Team, *"It was quite broad. Again I haven't seen a precedent for an order in that phraseology in child care matters but it was quite broad in that it referred to custody. It didn't say you can't go for an order under the Child Care Act, it didn't say you can't make them a ward of court, it didn't say anything specific except we couldn't remove them into the custody."*

On further questioning he said *"I think the element of family was highlighted in that affidavit (the one provided by Mrs A) and I would have thought it was probably out of constitutional concerns for the protection of the family."*

3.4.6 Fifth Case Conference, Autumn 2000

An Emergency Case Conference, chaired by (*Professional Manager 2*), was held a few days later to decide what actions the WHB would now need to take. The Case Conference was attended by Social Work Team Leader 3, Social Worker 3, a locum PHN, and the Home Help Organiser. The relatives of the family attended. The parents were invited but did not attend. The minutes of the Case Conference record that apologies were received from the Assistant Director of Public Health Nursing and Child Care Worker 1.

A member of the Garda Siochana, who also attended, informed the Case Conference that he had received a telephone call from a woman (Ms B) who identified herself as a representative of the family. Ms B told the Garda that anyone who attended the conference would be in breach of the High Court Order. She said she was a teacher and that the A Family had stayed with her the night before they attended before the High Court.

In her interview with the Inquiry Team Mrs A was clear that the family was receiving help from a group that had some local representatives and had been involved in assisting the family with the High Court action "*They got together with me and persuaded me differently*". She further advised that, before some WHB meetings and Case Conferences, they had a consultation with a local person from this group. In answer to a question as to whether or not this intervention had helped the children, Mrs A replied "*No I should have kept to the plan (shared parenting)*".

The minutes of the Conference record that the relatives told the meeting they were threatened by Mr A not to attend the Case Conference. Mrs A had advised them that they (the parents) did not mind their having the children at the week-ends as that arrangement meant that Mr and Mrs A would not lose any social welfare money.

During the Case Conference it was recorded that Mr A asked the relative to drop the children off at the pub on the way to the meeting. During the Case Conference the relatives took a call from Mrs A to ask if they would babysit that night.

The Inquiry Team notes that this Case Conference was the first one to spend a significant time considering the effect that the family situation was having on the children. In addition, by explaining what the children had told them about their home life, the relatives brought the voice of the children into the Conference forum for the first time in a meaningful way.

The recommendations of the Case Conference were:

- All files are to be reviewed. All referrals and evidence of neglect, over the past four years, to be put together in a court report with the intention to obtain a Care Order
- If going through the High Court, there is a possibility that the children may be made Wards of the Court. This will be more difficult to revoke than a Care Order
- A further recommendation was that in the meantime the WHB was to try to maintain the same level of service to the family and that those visiting the family were to be accompanied by another person.
- The relatives were to alert the Gardai if they felt the children were at risk over the week-end
- (*Professional Manager 2*), Social Work Team Leader 3 and Social Worker 3 were to visit the home to inform the parents of the decisions of the case conference.

The Inquiry Team notes that the record of this Case Conference does not show that the meeting considered or discussed an immediate application to the High Court to apply to vacate, vary or clarify the ex-parte injunction.

The three named professionals attempted to visit the family to discuss the recommendations but Mr A refused them entry saying “see you in the High Court”.

In their interviews with the Inquiry Team, (*Professional Manager 2*), Social Work Team Leader 3 and Senior Social Worker 2 agreed with the course of action proposed by Social Worker 3 to the Case Conference in September 2000(shared parenting) and at the Emergency Case Conference (application for Care Orders) in Autumn 2000.

The Inquiry Team is not clear why Wardship proceedings were mooted in respect of the children. At interview (*Professional Manager 2*) said “*I think I introduced that into the discussion because I had this maybe misinformed notion that when it went into the High Court arena that it was on a different arena to the District Court and to the Child Care Act.*”

A note prepared, by the Law Agent following a consultation meeting on November 7th 2000 between the Law Agent, accompanied by Counsel and the WHB Social Work Staff outlined the following plans:

- Reports to be obtained from the range of services and professionals involved with the family over the years
- Care Plans to be prepared for the children; this was based on the shared understanding that the children would be placed with their relatives who would require larger accommodation to care for the children. The relatives were prepared to move house.

The file note concludes: “The Health Board in this matter are, therefore, to come back with various reports as requested. It is only at that stage that we can consider an Application and the nature of that Application, i.e. whether it would be to discharge the High Court Order and go separately in the District Court for a Child Care Order or whether we would make an Application to have the children made Wards of Court. A District Court Order would probably take more time and might not be as easy to implement as a High Court Order and in any event it is before the High Court and it may be as well to just leave it there.”

The Law Agent advised the Inquiry Team that every option open to the High Court would have to be explored and that Wardship was possibly one of those options.

3.4.7 Further Meetings

A meeting was held on November 1st 2000 between Social Worker 3, Social Work Team Leader 3 and Senior Social Worker 2. It was agreed that a larger house be sought for the relatives to enable them to foster all the children, once the legal situation was clarified.

Letters were sent to services and professionals, as agreed at the November 7th meeting, stating that the WHB was applying to the High Court to have the ex-parte injunction lifted and applying for Wardship Orders in respect of the six children. The letter was co-signed by (*Professional Manager 2*) and Senior Social Worker 2.

The Inquiry Team notes that no timescale for this action to be completed was identified in the letters.

Over the next period replies and reports were received from these professionals. PHN 1's report stated that she had known the family since the birth of the first child in 1989; and listed three occasions when she had received reports concerning the children. She wrote "Mrs A availed of child health developmental appointments as issued...speech and language therapy services and physiotherapy services." The final comment was: "in my view the A family have required intensive ongoing support from the Western Health Board services in the caring of their children to date".

GP1's report stated: "I have always found that both parents have been solicitous towards the health of their children. I have always found them (the children) to be adequately clothed and clean and appeared well nourished." The report from the Home Help Service, which had started work with the family in September 2000, indicated that they were unable to access the home to provide the service on eight occasions in September and October 2000. The Speech and Language Department outlined that one child had a moderate-severe speech and language delay with a recommendation that intensive intervention was absolutely necessary. Another child, whose earlier appointments were missed, was assessed as requiring intervention which, if provided earlier, would have been of greater benefit.

Social Worker 3 understood that he was not allowed to carry out routine home visits and he did not attempt to visit during this time. He maintained contact with the services that were allowed to visit. These were the Home Help Service (although not at the agreed frequency), the Home Management Advisor and the Public Health Nursing service. This service visited on one occasion between August 2000 and May 2001.

3.4.8 Relatives remain concerned

Early in November 2000 a local man advised Social Worker 3 that Mrs A had been very drunk on the previous night in the company of two of the older children. At the end of November 2000, the relatives called the Gardai as the six children were being babysat at night by a thirteen year old child.

Social Worker 3 sought advice from Social Work Team Leader 3, who in turn sought legal advice on what the WHB could do. On the 1st of December 2000, Social Worker 3 visited the home with the Gardai to inform Mrs A that she was placing her children at risk, both in relation to her alcohol consumption and her baby sitting arrangements.

Throughout 2000 Home Management Advisor 1 continued to offer the family a service but there was poor co-operation from the family. The supervision of the family shopping was a key task in the WHB efforts to ensure that the children received an adequate diet. There were just two months when the weekly family shopping took place each week. In March, April, May and October the family shopping was successfully carried out twice each month. In November 2000 it took place once. The record states: "poor shopping...a lot of drink around." In December 2000 shopping took place on three occasions.

A meeting in early December 2000, six weeks after the Emergency Case Conference, was attended by the Senior Social Worker 2, Social Work Team Leader 3 and Social Worker 3 and the relatives. Locating a suitable house was an ongoing issue. All avenues were being explored with little success. The decision of the meeting was to leave care proceedings until after Christmas "for the children's sake" as noted in the Social Workers' record of the meeting. It was explained to the Inquiry Team that the relatives had undertaken to report any concerns that might arise during the Christmas period to the WHB or the Gardai.

The Inquiry Team notes that from Autumn 2000, following the granting of the High Court Order, Mr and Mrs A were less co-operative with the WHB personnel and that the WHB staff were unsure how to proceed when new concerns arose. This is evidenced by the hesitancy in following up a complaint without first seeking legal advice that the six children were left in the care of a thirteen year old child.

The minutes of the Core Group Meeting in January 2001 record: "It is the accommodation for the children that is holding up the process of going back to the High Court re Wardship of the children." At interview Social Worker 3 stated that "I felt the issue of housing was a complete red herring". "A big problem for me was the idea that you wouldn't take a child into care because there wasn't a foster placement."

Meetings were held with the Housing Officer of the County Council on the issue of housing for the relatives as part of developing care plans for the children.

3.4.9 New Allegations

In February 2001 there was a further allegation that Mrs A was very drunk while in charge of one of the older children at 10pm at night. A report was made to the WHB by a paediatrician in a general hospital outlining three admissions for the youngest child between November 1999 and May 2000 with gastroenteritis and similar complaints. The letter from the paediatrician stated the hospital had not been informed of any concerns regarding neglect.

In early March 2001, Social Worker 3 discussed this case with Social Work Team Leader 3. His records indicate that he was very frustrated that the case was being allowed to drift, despite reports and evidence of child neglect. Two days later he recorded a meeting with Senior Social Worker 2 where his records describe his view that there was a lack of urgency in addressing the

welfare of the children. He asserted that there was a “management vacuum” around this matter. During his interview with the Inquiry Team he said: *“The senior people, I just felt that they just didn’t seem to get the urgency of this...I think they were inherently good people. I think they were trying to do the right thing, but they had a believing mentality. They wanted to believe all the time that this family were capable of turning it around...I came from a different place. I just didn’t believe a word of it.”*

The senior staff, in their meetings with the Inquiry, were adamant that there was no management vacuum. Social Work Team Leader 3 said: *“SW3 came to me and he was very frustrated, he was hearing referrals....As far as I was concerned there were three pieces that we were working on. We had to pull the evidence together for this case and we had to build a support structure for these children once they were in care and we had to tease out a local strategy. We would have loved to have gone in there in the morning and taken those children into care but you can’t do that. We had one shot at this and we felt we had to do whatever had to be done “.*

The opinion of (*Professional Manager 2*), Senior Social Worker 2 and Social Work Team Leader 3 was that the WHB had to have suitable housing available to allow the relatives to care for the children before they reverted to the High Court. This would strengthen the WHB’s case at the High Court as it would show that a plan was in place for the on-going care of the children.

Later, in March 2001, there were also reports about continuous infections of head lice, despite the attempts of WHB staff to treat the problem. Social Worker 3 wrote to the parents regarding this and invited them to a meeting on March 27th 2001. Mr and Mrs A did not attend the proposed meeting but phoned the office wishing to discuss the allegations. Social Worker 3 referred those two children to the Core Group on March 15th 2001.

Social Worker 3 wrote again on the 10th 2001 May and invited them to contact the office to make an appointment. In this letter a number of allegations were listed, including the younger child having received a head injury in the home caused by hot oil, all children being infested with head lice, Mrs A being observed in a public place having intimate relations with an unidentified person, and Mrs A having been observed visiting a local man for similar purposes, (*and in the manner in which she travelled there placed her children at risk*).

On May 17th 2001 Mr A replied to the social work letter. Mr A described the allegations as “a blatant attempt at character assassination”. He denied all the allegations and said if they continued they would have “no choice but to bring you to court on the grounds of slander”. The letter also suggested that Social Worker 3 identify the people who had made the allegations. The parents would be prepared to meet with Social Worker 3 and these people in a neutral venue.

The Inquiry Team notes that there is no record of a Case Review or Case Conference to discuss how the WHB would respond to allegations concerning the care of the children in light of the fact that they believed the Social Work staff of the WHB could not now routinely visit the home as a result of the reaction of Mr and Mrs A following the High Court injunction.

In April 2001 suitable private accommodation was secured to allow the relatives to care for the children. A fostering assessment was subsequently completed and the relatives were approved by the local Fostering Committee.

In early May 2001 the relatives wrote to (*Professional Manager 2*) expressing their concerns about the children and saying that they would like some answers as to the direction of the case. The (*Professional Manager 2*) replied to the letter. The relatives had continued to take the children some weekends, despite the break down in the plan for them to share the care of the children with Mr and Mrs A.

During this period the group that had supported the family in the High Court was providing certain supports to the family. Social Worker 3 had strong views in respect of the influence exercised by this group. He suggested at interview that these were powerful people and that this was a factor in the approach of the WHB.

3.4.10 Return to the High Court, Summer 2001

The Law Agent, having received all the necessary reports on the 26th of March 2001, sought Counsel's opinion on whether or not there were grounds to go back to the High Court. This opinion was provided on the 14th May 2001. It stated that there were "ample grounds at this stage for vacating the Order". It also stated that "no application should be made to the District Court until such time as the High Court Order has been vacated". Counsel further advised that the application be moved before the High Court at the first possible opportunity. Seven months had passed since the original High Court Injunction was granted.

The High Court hearing was in Summer, 2001. The application to the High Court was to vacate the Order made by the President in Autumn 2000; and seeking an Order pursuant to the provisions of the Child Care Act 1991 Section 18 to place the children in the care of the Western Health Board.

Mr A did not attend the High Court hearing. Mrs A was accompanied by Ms B. Mrs A's affidavit stated that she and her husband were caring adequately for their children and that the reason for her application to the High Court was that the parents were being coerced into signing away their children. She also noted that it was now seven months since the original Order was granted and that Social Worker 3 could have come into court at any point, with only twelve hours notice, "if there was urgency."

Her affidavit alluded to the fact that the relatives were continuing to have the children at week-ends. She said they did not have any parenting experience and that the children would be damaged psychologically if there was a shared parenting arrangement.

The Inquiry Team notes that, while Mrs A was not legally represented in the High Court, her affidavit appeared to have the benefit of professional input in its drafting.

Social Worker 3 also provided an affidavit outlining the concerns of the WHB and others in relation to the care of the six children until the High Court injunction in Autumn 2000.

The Inquiry Team notes that it did not detail the concerns and allegations that had arisen since Autumn 2000.

The note of the Law Agent in relation to the High Court in Summer 2001 outlines what occurred: "The Judge indicated that what he felt would be appropriate would be to vary the order to facilitate a District Court Order. It would not be a vacate of the order in the full sense but would allow the Health Board to get orders of the District Court which would take the place of his order if granted... Having considered the matter... () advised Mrs A that it would be best to co-operate with the Western Health Board and not be confrontational. () directed that the order would be varied to restrain the Western Health Board from removing the children otherwise than in accordance with an order of the District Court and without prejudice to the right of the Health Board to apply to the District Court under the Child Care Act". A handwritten note of the Law Agent states that "the judge complimented her (Mrs A) on the condition of the children" (some of the A children accompanied Mrs A in the High Court). See Appendix 6.

From the submissions by Senior Social Worker 2 and Social Work Team Leader 3, it is clear that they understood that the High Court Judge had considered the case for a Care Order. They understood that the Judge had concluded that a Care Order should not be granted based on the information before the Court. This they understood would mean that an application for a Care Order to the District Court would be unlikely to succeed.

The Inquiry Team notes that the District Court has original jurisdiction regarding the Child Care Act 1991. On application by the WHB () the High Court varied his original order so as to acknowledge that the WHB could apply to the District Court under the Child Care Act 1991. It seems that the understanding of Senior Social Worker 2 and Social Work Team Leader 3 of the effect of the Order when varied was mistaken insofar as that understanding was to the effect that the WHB could no longer apply to the District Court for a Care Order or that the Order of the High Court had a direct and negative bearing on the likely success of such an application.

Social Worker 3 left Roscommon shortly after that High Court Case. He told the Inquiry "I simply couldn't carry on". (*Professional Manager 2*), in his interview, said "my perception was that we had given this our best shot in the affidavit outlining all the concerns...My assumption was that a Judge would read this information and have some opinion on it."

The Inquiry Team notes that there should have been a much more immediate approach to the High Court to vary or have vacated the ex-parte Order. The WHB had agreed, based on the concerns expressed at the Case Conference held on September 19th 2000 and repeated at the Emergency Case Conference in Autumn 2000 that the welfare of these six children would be best served by removing them from the daily care of their parents. The Inquiry Team also notes that the various issues notified to the WHB regarding the care of the children in the seven months before the matter was heard in the High Court were not fully investigated due to hesitancy on the part of the WHB about how to respond following the High Court injunction and the lack of clarity on the exact extent of the injunction.

This matter was discussed with various witnesses to the Inquiry. (*Professional Manager 2*) and Social Work Team Leader 3 took the view that it was the time it took to collect and collate the necessary information from the various professionals involved with the family and, in particular, the delay in obtaining a house big enough to accommodate the children with the relatives, despite strenuous efforts to find such accommodation, which impeded progress.

Senior Social Worker 2 told the Inquiry that as well as needing to get the Order vacated the WHB also wanted to get Care Orders under the 1991 Child Care Act and stated: "If we had decided to just go back to get the injunction vacated we would have done that immediately...In doing both together we needed to have a number of things in place...we knew that by taking the action to the High Court as vacating the order with [an application for] the care orders that it was going to take us a long time.". Senior Social Worker 2 also spoke of the need to get the relatives assessed and approved as foster parents, the need for a bigger house and the need for care plans for the children to be developed. The Law Agent was unable to say precisely why seven months had passed before this matter was heard before the High Court, but stated: "I have no telephone calls, I have no letters". He had no notes of conversations with the relevant social work staff seeking to expedite the matter.

3.4.11 Revision of plan for children

In early June 2001, (*Professional Manager 2*), Senior Social Worker 2, Social Work Team Leader 3 met and decided to revise plans regarding an application for a Care Order. The note of this meeting is unsigned but it outlines that "the parents have limited capacity to change/implement changes in children's situation". The WHB's approach would now be to put services in place to meet needs identified by professionals taking a needs-based approach to the children's welfare. The plan, therefore, was to apply for a Supervision Order for one year. Detailed plans were to be set out for each of the children and sent to relevant professionals seeking their input. It was

understood initially that the application for the Supervision Order would not be contested by Mr and Mrs A.

The Inquiry Team notes that no Case Conference or Case Review was called to sanction this change in direction. Senior Social Worker 2 spoke of the planning meeting that approved the change in plan and also told the Inquiry: “the case conference should be the main forum in which the direction is changed, that is what should happen”.

Later in June 2001, a meeting was held attended by Mr and Mrs A together with Senior Social Worker 2 and Social Work Team Leader 3 at which a new social worker, Social Worker 4, was introduced to Mr and Mrs A. Mr and Mrs A were advised that the Health Board had decided not to proceed with the applications for Care Orders and instead apply for Supervision Orders under Section 19 (1) of the Child Care Act 1991. The note of the meeting records that Mr and Mrs A were accompanied by a “friend of the family”. Mr A said he was opposed to any Court Order and asked that the WHB give them another chance “to put changes in place”. Both parents agreed to Social Worker 4 visiting.

Social Work Team Leader 3 sent the Law Agent a copy of a detailed paper which included a plan for an assessment of the children’s physical, emotional, educational and housing needs: “Following this the WHB will provide family support services such as Home Management, Home Help, Family Support Services, Child Care Worker Service, Psychology Service, Social Work Service, as required to ensure the identified needs are addressed adequately”.

The Inquiry Team notes that there is no evidence that these plans were ever activated and that all the services referred to (except Family Support Services) were already involved with the family.

The view now taken by the WHB was that the family was prepared to work with the agency and it is recorded that both the Home Help service and the Home Management Advisory service had no issues at that time. There was also the support being offered by “a right wing organisation and that had contributed to some improvement in the children’s circumstances” according to Social Work Team Leader 3 at interview with the Inquiry.

PHN 1 also commented at interview on the support provided by this group and said: “in 2000 when they took out the Injunction when they came back from Dublin and he bought a new car, a station wagon and he set up his own painting business and things were going very well. They were going all right up to 2002 and they would take a holiday maybe twice a year.” (Professional Manager 2) also advised the Inquiry of the support from this group of which he said “the support they seem to be accepting from other people that they weren’t accepting from the Health Board.... A car was produced, Mr A was house painting. We had heard of holidays”.

The Inquiry Team notes that no meeting appears to have been held with this outside group to consider how the support they were providing fitted into the WHB plan for these children.

One of the Home Helps who worked with the family throughout this period said *“they needed someone from 9.30 in the morning to 5.30 in the evening 5 days a week and you might get somewhere.”* She referred to the constant issue of making some progress but never being able to sustain it.

Social Work Team Leader 3 records that Ms B who accompanied Mrs A to the High Court contacted the office of the Law Agent prior to the scheduled District Court hearing. She requested that the Supervision Order hearing be held in public and sought details of the meeting where the decision to revoke the plans for a Care Order had been made. The Law Agent advised the Inquiry that he did not speak to Ms B who was claiming to represent the family. Ms B also wrote to the then Minister for Children asking that she write to the Western Health Board telling them to stop persecuting the family. The Minister responded that the Department had enquiries made of the Western Health Board on behalf of Ms B and further advised that it would be inappropriate to comment on an individual case. The letter from the Minister concluded that the Board (WHB) has assured the Department that applications for Supervision Orders were only made where necessary for the provision of services in the best interests of children

3.4.12 First Application for Supervision Order, 20th July 2001

On July 20th 2001 an application was made to the District Court for Supervision Orders in respect of the six children. Mrs A was in attendance and was accompanied by Ms B. They sought to have the hearing adjourned and, in consultation with Social Worker 4, who was getting access to the house, a hearing in early September was agreed.

Mrs A and Ms B wanted access to the home confined to this social worker. The District Judge said that Social Worker 4 would be the main person visiting the home but that he could bring in others if he deemed it necessary.

This worker, who is no longer employed by the Health Services Executive, did not attend for interview despite repeated requests from the Inquiry Team.

The Inquiry Team notes that there are very few records on the file from Social Worker 4 and the notes that are there are largely disorganised and unsigned.

The Law Agent, in communicating the agreement to the adjournment, queried the preparedness of the WHB to apply for the Supervision Order in that *“the social work report contains a lot of hearsay and reported allegations from unspecified individuals”*. He posed a number of questions about the allegations going back to March 1998.

The Inquiry Team notes that this Court report is very similar to the Court report prepared by Social Worker 3 for the High Court. It might be expected that these areas would have been addressed in the seven months taken to prepare the application to lift the original High Court Injunction.

Senior Social Worker 2 told the Inquiry *“You can have chronic neglect occurring, you can have harmful effects on children but translating those into hard evidence for court is a very different thing. My experience of neglect is certainly most of evidence that stands up in court is medical evidence, failure to thrive, educational evidence in terms of lack of school attendance, that kind of thing.”* Referring to the WHB policy of applying to the Courts for Orders under the Child Care Act, 1991, she said: *“While there was tons of concerns in terms of hard evidence, for a neglect case in court there wasn’t confidence that we had (the evidence)...there are very few neglect cases that win Court Orders.”*

3.4.13 Preparation for second Court Hearing

In mid August 2001, a meeting with the Law Agent was held, attended by Social Work Team Leader 3, Public Health Nurse 1, Home Management Advisor 1 and a Senior Home Help Organiser. The Social Work record of this meeting states: *“slight improvements in that the home help was getting access more frequently”*. However, Home Management Advisor 1 reported that Mrs A advised her that a friend was now helping with the shopping so the services of the home management service were no longer needed.

A file note of this meeting prepared by the Law Agent states: *“I asked the WHB to look at the case again and bring all their information together. While I would not like to see us responding to pressure from an outside group such as that run by Ms B it would appear that we are getting access to the premises and that has been the only reason why we have sought this Supervision Order. If that is happening and there is hope that it will continue to happen then it might be best to leave it the way things are because it would not be helpful to have all the various personnel giving evidence in Court against the A family. That might only ruin the relationship that exists and defeat the purpose of the whole exercise”*.

Senior Social Worker 2, in her meeting with the Inquiry, stated: *“Supervision Orders are not about access it is about cooperation in a sense. I would have been happier to actually go and hear the Supervision Orders but in the absence of that I suppose once it was adjourned with a right to go back that was okay.”*

(Professional Manager 1) told the Inquiry “A Supervision Order is really used when a family does not cooperate...I don’t think having the Supervision Order would have made any difference to that cooperation...At no stage were they not doing what we were asking them to do”.

The Law Agent, in his interview with the Inquiry Team, was clear as to his role *“I did not say to the HSE do not go with the Supervision Order. I was instructed to bring an application, I brought an application and we went to Court...In a Court Case we have to anticipate what may come from the respondents or what may come from the judge and we have got to be able to respond. It is a matter for the Health Board to decide what they want to do and I bring the application and we argue the application”*.

(*Professional Manager 2*) received a letter, dated August 10th 2001 from Ms B describing how workers from her organisation would help the family and indicating that she had local workers involved. She asked that the Western Health Board withdraw all of their workers for six months to “allow the children forget the threat of removal.”

A further WHB meeting was held on August 31st 2001 to “assess what situation is now and if this could be improved by a Court order”. There is a handwritten unsigned note on the social work file of this meeting. It was attended by the WHB personnel going into the family home, together with (*Professional Manager 2*) and Social Work Team Leader 3. Concerns raised at this meeting included signs that Mrs A was continuing to drink but was drinking less than previously, the Home Management Advisor was not always getting receipts for rent payments as agreed, three of the children were described as lacking in self-esteem, being fearful and emotional; and, in particular, one child was noted as having difficulties in allowing Home Helps to carry out bathing. This child had recently been to the GP with abdominal pains and Mrs A had told GP 1 the child was insecure and clingy because of the Health Board plans to place the children with the relatives nine months previously.

The positives noted by the Home Helps were that Mrs A was cooking for the children, the head lice problem had been resolved and hygiene had improved. The file note is unclear but appears to suggest that a child care worker would become involved with the children regarding their emotional needs; and the possibility of doing a ‘Stay Safe’ programme is mentioned. It notes that two of the children were allowed to visit a family in the Dublin area whose identity was unknown to the parents.

There is a typed note titled ‘Proposal for the Adjournment of Supervision Order’ dated Sept 2001 and signed by Social Worker 4. It said that, as a result of the progress being made, the WHB would consider seeking an adjournment of the application for a Supervision Order for a period of six months; subject to conditions and that the services in place should continue i.e. Social Work, Home Help, Home Management and the Public Health Nurse.

The services of a Child Care Worker and a Family Support worker to help with homework were to be introduced. It also stated that the situation would be reviewed on a monthly basis to ensure that the family continued to work positively with the professionals and to discuss any issues which might arise. Six different professionals would now be visiting the family; social work, public health, home help, home management service, child care and the family support.

In September 2001 the application for the Supervision Order was adjourned to March 5th 2002. The Law Agent’s note states: “I made it clear to Mr A that these terms and conditions (as listed above) of any Order which would be made by the Court but in some cases represented what was presently being

done and in other cases what it was hoped to achieve with their consent". Mr and Mrs A were accompanied in Court by Ms B and other supporters. The matter was adjourned for six months with the consent of both parties and the Law Agent asked the Judge "to include a provision for either party to apply on 7 days notice".

The Inquiry Team notes that this is the last reference on file to the involvement of the outside group with the family.

3.4.14 Period of the Court Adjournment; September 2001 to March 2002

Social Worker 4 visited the family in late October 2001 and noted that the outside of the house was littered with household rubbish and toys. He further noted that the inside of the house was untidy. Mr A said that the refuse had not been collected due to the expense. Social Worker 4 wrote to the family on November 6th to say he would be calling with Child Care Worker 2 as agreed. Social Worker 4 had referred one of the children to the child care service in relation to the child being insecure and traumatised by the possibility that the children would be placed in a shared parenting arrangement with the relatives.

In early November 2001, the younger child was seen for a speech and language appointment. The report of the assessment says that Mrs A was confused as she described the child's speech as very good but the therapist found his speech incomprehensible in the clinical setting. The child was not taken to the next appointment.

On November 19th 2001, there is an unsigned summary of the main points presented to the Core Group. It outlined that the child care work had started, that there were no problems in school, that the children presented clean and well dressed and that there was good co-operation from both parents. It states that Social Work services continued to work with the family and gave three dates of home visits, 23rd and 30th October and 13th of November.

The Inquiry Team notes that there is no record of these visits on the Social Work file. Following this, the Core Group decided to cease its involvement with this case.

Child Care Worker 2 called to meet the family in November 2001. On this visit the parents made an allegation that one of their children had been sexually abused by a person outside the home. This was subsequently investigated and found to be entirely without foundation.

The Inquiry Team notes that this allegation had the immediate effect of ensuring that Child Care Worker 2 could not work with the child until the matter was investigated.

This new allegation was referred to the Core Group on November 20th 2001.

3.4.15 Period of Employment of Social Worker 4

Social Worker 4 started work in Roscommon in June 2001. He was not an accredited social worker in Ireland and had no significant previous experience of child protection work. Senior Social Worker 2 who was involved (along with the *(Professional Manager 2)*) in his recruitment told the Inquiry that it was impossible to recruit and retain social workers in Roscommon at that time *and* it has been confirmed to the Inquiry Team that there were difficulties in recruiting social workers in many areas of Ireland at this time.

During his period of employment in Roscommon, Social Worker 4 had long periods of sick leave and there is only one hand written record of a home visit from July 2001 to December 2001. There is also a note of some telephone calls to and from the parents and of a visit from Mrs. A to the office.

At interview with the Inquiry Team the challenges this staff member presented were outlined by his supervisors. Social Worker 4 had two direct supervisors during this period. He was initially supervised by Social Work Team Leader 3 from his appointment in June 2001. Social Work Team Leader 3, in her interview, said: *"I would have had to put a lot of support work around supporting him in writing reports...I managed [SW4] for two to three months in total during that time as a new social worker I felt he needed mentoring and support. I put a lot of work into that court report for the initial application for a Supervision Order) as a training exercise on the one hand for him and as a document that had to be good for the courts to succeed."*

Social Work Team Leader 3 went on maternity leave in September 2001 and the supervision of Social Worker 4 became unclear. Senior Social Worker 2, told the Inquiry, said that he would have been supervised by the other Social Work Team Leader in the County or by whoever was available during the months (October 2001 to December 2001) when no Social Work Team Leader was appointed in this office. Senior Social Worker 2 left the office in December 2001. A new *(Professional Manager 1)* was appointed in January 2002 initially as an *(Acting Professional Manager1)* and then as *(Professional Manager 1)* from July 2003. She had previously worked in the area as Social Work Team Leader 2 from November 1999 until April 2000. A new Social Work Team Leader (Social Work Team Leader 4) was appointed in January 2002.

The supervision of Social Worker 4 then passed to Social Work Team Leader 4, who was new and inexperienced in that role. In his interview Social Work Team Leader 4 said in relation to Social Worker 4: *"He had the case from June 2000...I would have assumed that he had a good grasp...there was a lot of sick leave in 2002. There was quite a lot of absenteeism. I instructed him to see family A every couple of weeks. I would have been aware there were difficulties in relation to note keeping and it is something I would have raised with SW4 in June 2002. I brought it to the attention of the (Professional Manager 1). During 2002 I was still based in another office twenty miles away. He went on sick leave on a month to month basis in November 2002. I then had his case load and the caseload of another worker who left until April 2003. In early 2004 following his resignation from WHB I went to his home and took back whatever was available, diaries etc."*

(Professional Manager 1) told the Inquiry Team: “ Social Work Team Leader 4 would have come to me fairly quickly, he had some issues around attendance, performance...[SW4] himself spoke to me in June 2002...he wanted to flag he was feeling that he was being put under pressure...and that he was extremely stressed. I talked through these issues with him but I would also have spoken to him about our expectations of him as a Social Worker. I had a number of meetings with him and one with Social Work Team Leader 4 and Social Worker 4. Social Worker 4 went on sick leave in November 2002 before the next scheduled meeting.”

(Professional Manager 2) said:” I knew attendance was a problem; sick leave was becoming quite a problem. Later I was unsure about the quality of the work, whether regular visits were actually taking place or not and if they were what the quality of them were. Social Work Team Leader 4 tried to support him but that support wasn’t always appreciated”.

3.4.16 Sixth Case Conference, 18th February 2002

Social Worker 4 requested a Child Protection Case Conference in order to determine if progress had been made and to decide if a further adjournment of the Supervision Order should be requested. It was chaired by *(Professional Manager 2)*.

Attendance at this Case Conference included the WHB staff working with the family together with senior managers from the public health nursing department, the home help department and the Area Medical Officer. With the exception of *(Professional Manager 2)*, and Home Management Advisor 1, none of the key workers present at this Case Conference were involved when the decision to seek a Care Order was made in August 2000. Mr and Mrs A were also in attendance. The school was not represented at the Case Conference and the GP gave his apologies.

A report prepared by locum PHN 2 for the Case Conference notes that she called to carry out a three year developmental test on one of the younger children whose development was noted as normal. It is recorded that this child was not toilet trained and was having speech therapy. The report from Social Worker 4 stated: “Mr and Mrs A are co-operating fully with the department. They have made great efforts to ensure an adequate level of hygiene and safety in and around the home. There has been steady progress with this family and they continue to work well with the professionals involved. There is a definite commitment to making improvements and providing a secure and loving home for the children. There are no concerns presently identified that would compromise the welfare of the children.”

Home Help 1 reported that the children were well cared for, that good meals were provided and that the problem of the head lice was being sorted out.

The Inquiry Team notes that there is no record that the concerns, expressed at the meeting of August 2001, were discussed. The parents were congratulated on their work and cooperation.

The recommendations from the Case Conference were as follows:

- The application for supervision order be withdrawn
- The family continues to work with the professionals involved
- Child care work to recommence following investigation interviews (in relation to allegation of sexual abuse made in November 2001 by parents)
- Social Work to support need for extension to the family home
- The children continue to attend developmental clinics
- The Case to be reviewed in 6 months.

Social Work Team Leader 4 was new to this case. He said: *“What I picked up at that Case Conference across the board was that the A family had improved, that they were co-operating with the WHB”*

This case was scheduled to come back before the District Court on March 19th and the Law Agent was instructed to strike out the application. At interview the Law Agent said *“if there is an agreement in relation as to what is to be done the Health Board will work with agreement rather than a court order.”*

(Professional Manager 1) advised the Inquiry as follows; *“I don’t believe until the sexual abuse came up we would have got orders at that time on those children”*.

The allegation of child sexual abuse (CSA) made in November 2001 was finally followed up with referral to the Department of Psychology on March 4th 2002. The psychology service completed its work on March 15th 2002 and concluded that CSA had not occurred. The Psychologist advised the Inquiry Team that she saw the children with Social Worker 4. The usual practice would be that one of the interviewers would speak to the children while the other team member would record the interview. On this occasion the Psychologist conducted the interview but did not receive any notes of the meeting.

The Inquiry Team notes that there is no record of this interview on the WHB files. On the 25th March 2002 the Core Group were notified that the CSA allegation was without foundation by Social Worker 4 and the Core Group then ended its involvement.

The Speech and Language Department notified the Social Work Department that the appointments offered to the family in 2002 were not being kept. Appointments were not kept in April 2002, in July 2002, in October 2002 and in November and December 2002. Social Worker 4 was advised of these failed appointments which formed part of the recommendations of the February Case Conference.

3.4.17 New Developments

In April 2002, Child Care Worker 2 wrote to Social Worker 4 advising him that one of the older children had been sent to hospital in Dublin. Child Care Worker 2 sought an update on the investigation of the child sexual abuse allegation made in November 2001 as she was waiting to commence work with the children. Finally, in May, Social Worker 4 advised her that she could re-engage with the family. When she arrived for the first home visit, arranged by letter, no one was at home. Subsequently only two out of five agreed appointments were kept by the parents.

Home Management Advisor 1 recorded that in January, February and March 2002 shopping took place just once each month instead of the agreed four times per month. In April, it occurred twice and on one of these days Home Management Advisor 1 did some cooking with Mrs A. In early May cooking was again planned but Mrs A refused to cooperate.

On May 28th 2002, Home Management Advisor 1 arrived to find the family had a new car. According to her records it was purchased on a Hire Purchase plan. The repayments were €400 per month, which was to come from the Child Benefit payment to the family.

In June 2002, Home Management Advisor 1 helped Mrs A to change around the bedrooms. In July 2002 she was informed that the parents were doing their own shopping and the service was not required. Home Management Advisor 1 visited in August 2002 in relation to speech therapy appointments, again in September 2002 and October 2002 and then in December 2002 with a food hamper.

The Inquiry Team notes that co-operation by the parents was not maintained to an acceptable level once the application for a Supervision Order was withdrawn.

3.4.18 Seventh Case Conference, 17th September 2002

The Case Conference, chaired by (*Professional Manager 2*), was attended by the Social Worker 4, (*Professional Manager 1*), Home Help 1 and Home Management Advisor 1 and by Mr and Mrs A. The school was not represented at the Conference. There were apologies from the GP, the PHN, the Child Care Worker and the Social Work Team Leader. The minutes recorded positive progress. Home Management Advisor 1 reported that the family were currently managing their finances and doing their own shopping.

The Inquiry Team notes that it is not recorded that the Conference was informed that € 400 per month was being spent on the new car.

The report from one of the schools, according to Social Worker 4, who said he had spoken to the Principal, was positive. His report further stated that one of the younger children had not had an appointment for speech therapy.

The Inquiry Team notes that there was no mention of the three failed appointments for another family member.

The report from Child Care Worker 2 stated that she was attempting to carry out an assessment on the children referred to her earlier. Her report catalogues the missed appointments since she had re-engaged with the family in June. Some of these failed appointments happened because the family were on holidays; and on other occasions there was no one home.

The minutes of the Case Conference show that Home Help Worker 1 also commented on the great improvement with the family, highlighting the nourishing meals provided by Mrs A. She did say she had some worries in relation to one of the older children, whom she described as a thin, quiet child who could benefit from a tonic. She also said that the child had a problem with head lice. Mr A told the conference he had started his own business as a painter and that the family had extra income.

The recommendations of the Case Conference were:

- The family will continue to work with and engage with the professionals involved
- Child Care Worker 2 will continue to assess the children
- The family will continue to attend all medical and developmental appointments
- Case to be reviewed in 6 months or sooner if there are concerns.

The Inquiry Team notes that there are no file records of any visits by Social Worker 4 to the family home from January 2002 to September 2002, when he told the Case Conference the family was making great progress. There is also no record of social work home visits to this family for the remainder of 2002, or for the first three months of 2003. Social Worker 4 had long periods of sick leave and the Inquiry was informed that there were other staff vacancies during this period. There was also no mention of the outside organisation which, the Inquiry was informed, was being relied on as part of the total family support package to this family.

Child Care Worker 2 visited this home on November 15th 2002. She described the home as follows “the floor in the kitchen was extremely dirty and looked as if it hadn’t been washed in a very long time...the duvet covers were old and worn (children’s bedroom) the floor was dirty and sticky and like the kitchen floor it hadn’t been washed in a very long time”. She was unable to carry out any work that day as there were other children present in the household.

3.5 Period 4: January 2003 to November 2004

In March 2003 a local hospital wrote to the WHB regarding one of the older children who had been admitted following a history of neck stiffness. The child was referred to a Dublin hospital for an EEG. In August 2003, that hospital concluded that the child's symptoms including what were described to the hospital staff by Mrs A as "seizures" were psychosomatic and referred the matter to the child guidance service. However, in September 2003, when Social Worker 5 (who was by then working with the family) made a joint home visit with a (*Professional Manager 1*) from the child guidance service, Mr A told them the child had not experienced any further seizures, was doing very well at school, had plenty of friends and did not need the service. Mrs A later confirmed this.

3.5.1 Eighth Case Conference, 7th March 2003

This Case Conference, chaired by (*Professional Manager 2*), was a planned follow-up from the previous Case Conference in September 2002. There was a small attendance at this meeting. Present were the Home Help Organiser and Home Help 1, PHN 1, Social Work Team Leader 4 and Mr and Mrs A. The schools were not represented at this Case Conference. Apologies were made by the GP, the Social Worker, the Child Care Worker and the Home Management Advisor.

The minutes of the Conference note that Social Worker 4 was on sick leave and that Social Work Team Leader 4 was in regular contact with the family.

The Inquiry Team notes that there are no records of this contact on the file.

The minutes of the Conference also record that Mr A told the Conference he was continuing to work as a painter, that the family had extra money as a result; that they had been on holiday three times in 2002 and once in 2003. He also reported that the children were all doing well, that the older children in particular were doing well in secondary school and never missed a day. He also informed the Conference that an extension to the house, promised by the County Council, seemed to have stalled. Mrs. A said all appointments for the children, except speech and language, had been kept. Home Help 2 said her service was continuing to go to the house twice a week and that this was working well.

The family's washing machine was broken and they were seeking help from the Community Welfare Officer to replace it. Meanwhile the home help service was helping to get the washing done.

The following recommendations were made:

- Social Work Team Leader 4 to contact the county council re the house extension
- Social Work Team Leader 4 to provide assistance re the Community Welfare Officer
- Home Help to continue
- Social work to continue contact with family
- Child Care Worker 2 to re-establish work with children when work load allows
- Parents to continue to engage with the services.

In April 2003 Social Worker 5 took over as the new social worker for the family as Social Worker 4 had not returned to work. Social Worker 5 had eighteen months social work experience in another Health Board area.

The plan, as recorded based on the recommendations of the Case Conference of March 7th 2003, was to provide support to the family and “to visit monthly and contact home help and schools”. The social worker records that the home helps were reported to be “happy with the current situation” and the Principal of the National School described attendance as “quite good” but said that the children’s hygiene was poor.

In May 2003 the mother was admitted to a regional hospital following a seizure. Also around this time the family changed their G.P. The social worker described all the family as being “in good form” following a home visit. In June the family’s rent arrears stood at €3000 and the County Council was again considering issuing a notice to quit.

The social work file records that in May 2003 the secondary school had informed Social Worker 5 that both children in that school had missed a significant number of days in school. The school had also said they appear a “little unkempt and dishevelled at times”.

Child Care Worker 2 recommenced work with the two children, which had been disrupted in late 2002. A home visit, which she arranged for July 24th, was cancelled by Mrs. A. Also in July 2003 Home Management Advisor 1 visited to invite the children on a holiday, organised for local children, but the parents declined the invitation. Child Care Worker 2 visited again on July 30th 2003 to find the child with whom she was due to work with was unwell. This child had a previous admission to hospital with tummy pains and is the same child, referred to by Home Help 1 at the Case Conference in September 2002, as quiet and thin and about whom the parents had made a false allegation of child sexual abuse in November 2001.

Mrs A told Child Care Worker 2 that the child had been seen in the hospital but did not explain the reason for this. On July 31st 2003, Social Worker 5 received a call from the Social Worker in a local hospital. She said that the same child had been referred by the family’s new GP, with a query of sexual abuse, following a presentation to him of bleeding and abdominal pain. The local hospital referred the child on to a regional hospital for a more specialist examination.

That examination by a hospital consultant concluded there was no cause for concern and a letter was sent to Social Worker 5 confirming this. Social Worker 5 advised (*Professional Manager 1*) of this development.

Approximately two weeks later, on August 11th 2003, Social Worker 5 spoke with the mother regarding the query of CSA. Social Worker 5 also saw and spoke with the child. Mrs A indicated that she had already been advised of the outcome by GP 2.

The Inquiry Team notes there is no record of any liaison between the social worker and GP 2 over the CSA query.

At interview GP 2 had no recollection of the event, but he did identify his letter of referral to the local hospital when presented with it.

The Child Sexual Abuse referral was discussed at the Child Protection Management Team and the outcome recorded as non-abuse.

Child Care Worker 2 visited the family on August 21st 2003 and Mr and Mrs A told her they now had no concerns “about this child’s emotional or physical well-being.” On August 29th, 2003 after consultation with Child Care Worker 1 (now the Child Care Worker Team Leader), the case was closed to the child care service with “the parents’ agreement”.

The Inquiry Team notes that, in effect, Child Care Worker 2 had been unable to work with the children as planned.

In her statement to the Inquiry Team, Child Care Worker 2 stated: “*On all visits with the family the house appeared dirty and unhygienic but I was aware that social workers allocated this case were addressing these ongoing concerns with Mr and Mrs A.*”

The Inquiry Team notes that, by the time Child Care Worker 2 finished this work with the family, two home helps had been visiting the family for more than two years, a number of Case Conferences in 2002 and 2003 had been told that the family was making good progress, and that the issue of hygiene did not arise in a significant way at these conferences.

The question of rent arrears for the family was back on the social work agenda and arrangements were put in place for the family to repay €300 per month. However, the August payment was not made. A note on the social work file for October 1st 2003, records that the Principal of the National School had ongoing concerns about head lice infection and on 2nd of October Mrs A advised Social Worker 5 she was treating the infection.

3.5.2 Ninth Case Conference, 25th November 2003

There were just four people at this Case Conference chaired by Social Work Team Leader 4 - Social Worker 5, Home Management Advisor 1 and Mr A. Apologies as recorded on the record of the Case Conference were given by

the (*Professional Manager 2*), the Assistant Director Public Health Nurse, the original GP (not now GP for the family), the Child Care Worker and the Home Help Organiser. Neither of the schools attended by the children were represented at the Case Conference.

Social Worker 5 prepared a very short report for this Case Conference. It outlined that Mrs A was working part-time with a local cleaning company, but that she had been unwell and was unable to attend the Case Conference.

The Inquiry Team notes that the Social Work report made no reference to the hospitalisation of either of the two children since the last Case Conference.(see 3.5 and 3.5.1) Neither did it make reference to the concern of the National School Principal regarding lice infestation.

A note by Home Help 1 to the conference states: “the children are in good general form, clean, well-fed and happy”. This note does mention the admission to hospital of one of the children but states: “is well now”. The minutes of the meeting note that speech and language appointments for the younger children were missed and Social Work Team Leader 4 pointed out that these were important appointments. Mr A agreed to keep them in future.

The finances of the family were also discussed at this case conference. Mr A said he was on a back-to-work scheme and, after much discussion, it is reported that he agreed to re-engage with Home Management Advisor 1. She had maintained some contact with the family although they had told her she was no longer needed in July 2002. The task for Home Management Advisor 1 was to work out a budget to ensure their rent arrears, ESB, grocery shopping would be addressed.

The Inquiry Team notes that these are the same items that were on the list for the home management service from their involvement in 1994.

The need for an extension to the house was again raised. Information was provided that the County Council would not undertake this work until there was evidence of commitment to clearing the arrears. Mr A agreed to make payments. Mr A further advised the Conference that the children were all doing well at school and in particular that the two children in secondary school were doing very well.

The Inquiry Team notes that the information provided by the Secondary school in May 2003 was not provided to the Case Conference, nor was it put to Mr A.

The recommendations were:

- Parents to co-operate with Home Management Advisor 1 on budgeting issues
- Home Management Advisor 1 to talk with County Council re rent arrears agreement
- Parents to set up a direct debit to ensure rent is paid
- Social Worker 5 to write to County Council re house extension

- Social Worker 5 to contact Speech and Language Department re appointment for younger children and parents to keep appointments
- Home help to continue visiting family at same level
- Social Worker to continue to monitor
- Next case conference set for 30.3.04.

Following the Case Conference, Home Management Advisor 1 visited regarding the rent arrears and made arrangements to have payments deducted at source. On December 3rd 2003, Social Worker 5 found the mother and children at home and invited the children to join a Christmas outing. The Social Worker visited on two other occasions throughout December 2003 but found no one at home.

Throughout 2003 the speech and language department staff offered five appointments for the two younger children and two of these appointments were kept.

3.5.3 Mounting Concerns

In January 2004 the same child who was previously hospitalised with a kidney infection was admitted to hospital. (This is the child where query CSA was considered in July 2003) The hospital social worker advised Social Worker 5 that this child had had two recent admissions due to abdominal pain. The hospital staff are recorded by Social Worker 5 as describing this child as “more withdrawn” than on previous admissions. A kidney X-ray was clear.

The child was referred to child guidance by the hospital consultant and was seen on the 22nd of April 2004. Mrs A took the child to the appointment. The child guidance record shows that Mrs A “did all the talking”. Mrs A spoke of the behaviour of this child who was very clingy and said it was because of inappropriate sexual contact by an adult in 2001 (see 3.4.14). In fact this inappropriate sexual contact had never occurred. The Child Guidance Worker was unable to get the child to talk to her that day and made another appointment. Follow-up appointments for this child offered by the service in May and June 2004 were not attended.

Home Management Advisor 1 visited the family again in January 2004 to discuss rent arrears. Social Worker 5 called to the home on four occasions in late January 2004 and February 2004 but there was no reply. At a home visit in early March 2004 Mrs A and the four younger children were at home. Social Worker 5 described the children as being chatty and in good form. Mrs A did advise the social worker that, when the parents went out, they left the five younger children in the care of the eldest member of the family. In February 2004 the County Council confirmed the rent arrears still stood at €3000. The family went on holiday in April 2004. Later that month, the County Council expressed concern at the untidiness of the home. The family sought help from the Community Welfare Officer to replace the washing machine and the dryer.

3.5.4 Tenth Case Conference, 2nd June 2004

Early in May 2004 the parents visited Home Help 1 to say that *(one of the children had talked about behaviour of a sexual nature)*. The Home Help insisted that they inform the social worker and ensured they did so. This child, and another sibling, were seen by GP 2 who advised that there was no obvious sign of trauma on examination but that poor hygiene was evident.

The Case Conference on June 2nd 2004 chaired by *(Professional Manager 2)* was attended by the Social Work Team Leader 4, Social Worker 5, Home Management Advisor 1, Deputy Home Help Organiser and Mr and Mrs A. Apologies were received from the Assistant Director of Public Health Nursing and the Home Help Organiser. The schools attended by the children were not represented. The initial part of the conference concentrated on practical issues. The County Council had advised that only two payments of rent were made in 2004 despite agreements and, once again, Mr A agreed to pay the rent regularly. The Home Help department reported that the installation of a shower meant that hygiene had greatly improved. The children were said by Mr A to have very good school attendance. Once again, the parents said they would keep all appointments for the children.

The Conference then considered the alleged inappropriate sexual behaviour and discussed the next steps that would be taken. The parents spoke of their concern and actions they were taking to ensure there would be no further occurrence. The recommendations were:

- Parents to contact the County Council solicitor re rent arrears agreement
- Home help to continue
- Appropriate interviews to be conducted to follow up on allegations.

The appropriate interviews were conducted and therapy was commenced. *(The behaviour of a sexual nature talked about by one of the children)* was subsequently confirmed by the Child Protection Management Team (previously Core Group) meeting held on June 28th 2004.

3.5.5 Eleventh Case Conference, 27th July 2004

The purpose of this conference, chaired by *(Professional Manager 1)* (in her capacity as *(Acting Professional Manager 2)*) was to follow up on concerns about the *(behaviour of a sexual nature talked about by one of the children)*. In the intervening period one of the children requested that they be received into the care of the WHB and this was agreed. The case conference was attended by the staff working with the family and by both parents who informed the conference they were going on holiday the next day. Apologies were received from two representatives of Child Guidance Service, Public Health Nurse and the Child Care Worker. The schools were not at this Case Conference.

Recommendations were:

- The Home Help to continue to support the family
- The child who had requested to be admitted to care was to remain in placement
- Child Care Worker 2 to become involved again in working with the children at home
- Mr and Mrs A to continue to be vigilant and protect the children
- Rent to continue to be paid.

3.5.6 Further Developments

On August 18th, 2004, Social Worker 5 recorded that the child who had told of the *(behaviour of a sexual nature talked about earlier)* was again admitted to hospital with stomach pains. Social Worker 5 spoke to a hospital doctor who attributed this to stress.

On August 30th, 2004 a Child Protection Management Team (CPMT) meeting was held in relation to a second sibling *(who also spoke of similar behaviour)*. This was confirmed by the meeting.

Also in August 2004 the child in care expressed concern over the babysitting arrangements for the children remaining at home and disclosed that they had not been properly supervised for many years while Mr A and Mrs A went out to the pub at night on a very frequent and repeated basis. The lack of food in the home on occasions, the ill fitting clothing provided for them and the heavy burden placed on the older siblings to care for the younger children were clearly outlined. Concern for the safety of the children still in the home was emphasised. From early in the care placement this child expressed a wish not to return home. It was clear that the child was frightened to say so directly to Mr and Mrs A who were insisting that the child return home. Although reassured by placement staff that it would not be permitted against the child's wishes and best interests, the previous intervention by the High Court when relatives wanted to care for the children was referenced by the child who felt Mr and Mrs A might be able to get another such Order. The staff were also informed that Mr and Mrs A were telling the child not to talk to staff of the WHB. The fact that Mr and Mrs A had drink taken when they attended for access meetings was also noted and both parents were advised this was not appropriate.

Child Care Worker 2 commenced work with some of the children still living at home as agreed by the case conference. Four appointments were made for the children before they were taken into the care of the WHB but, despite the expressed concern of the parents over what had happened in the home, two of these appointments were cancelled by them. The work continued when the children came into the care of the WHB.

In September 2004, allegations were made by one of the children concerning physical and sexual assault by Mr A and subsequently a statement was provided to the Gardai to this effect. (On March 5th 2010 Mr A was sentenced to 14 years imprisonment following his conviction on forty-seven counts of rape and sexual assault in the Central Criminal Court in relation to these offences).

On October 1st 2004 the child who had first spoken of the inappropriate sexual behaviour was again admitted to the regional hospital, following a referral from GP 2, concerning stomach pain and vomiting. The referral requested that a urine sample be checked. On October 7th 2004 a Paediatrician in the regional hospital raised concerns that a urine sample, which had been brought from home, had been contaminated. Concern was also expressed about the high number of hospital attendances with no explanation.

On the 8th of October 2004 Mr A phoned the child in care saying he was going to bring them home. The child was very upset by what they saw as a threat and the staff took them away for a few days break. Subsequent to this it was necessary for Social Worker 5 to organise supervision of access visits with the parents, as the child was afraid of Mr A's reaction to the information being provided to the WHB staff.

On October 11th 2004 the remaining five children were taken into the care of the WHB based on the information provided by the child who was already in care. The children were made the subject of an Emergency Care Order under Section 13 of the Child Care Act 1991. On October 12th Mr A was interviewed by the social worker concerning the allegations. He denied them and added that he wanted no more to do with the child who had told staff what was happening. Mr A was later interviewed by the Gardai and again denied all the allegations. Interim Care Orders under Section 17 of the Child Care Act 1991 were granted in respect of all six children on October 2004.

(Professional Manager 1) advised the Inquiry Team that the reason why the children and young people were able to speak about their experiences at home very shortly after their admission to care was because of the relationships the HSE staff had built up with them while they were still living at home, "...because of the relationships that were built with workers while the children were at home which would be an underlying ethos of how we do work...The children when they did come into care very quickly gave us details we didn't have" .

3.5.7 Twelfth Case Conference 4th November 2004

On November 4th a Case Conference was held which the parents attended together with a range of workers involved with the family. The Gardai were also represented. It was chaired by the Children's Act Services Manager (a post unique to the WHB) as *(Professional Manager 2)* was not available. Mr A adamantly opposed the WHB involving the relatives, who had previously cared for the children, in future plans for them. Mr A said he had told the five children removed from home on October 11th 2004 it was their sibling's fault they were in care and that they now wanted to have no contact with that sibling. Mr and Mrs A agreed to engage with an addiction counsellor and to undergo psychological assessment with regard to their parenting capacity.

On November 16th 2004 the Interim Care Orders were extended, with parental consent, for a further six months while these assessments were completed.

Care Orders under Section 18 of the Child Care Act 1991 were granted in respect of all six children on the 20th May 2005. In the interim Mrs A had separated from Mr A and had supported the information given by the child first admitted to care in relation to abuse in the home.

There are some further records on the WHB files that the Inquiry Team particularly noted in relation to their remit to examine the entire management of the case from a care perspective. Social Worker 5, in a report provided for a Case Conference held on 12th May 2005, wrote: "The housing conditions were deplorable. The children while living at home presented in a dirty and unkempt manner".

The Inquiry Team notes that Social Worker 5 visited this home regularly from April 2003 until the children came into care in October 2004 but did not record home conditions, or the presentation of the children, in the manner described above.

Further to the Case Conference of 4th November 2004, a Senior Clinical Psychologist and a Social Worker jointly undertook a parenting capacity assessment on Mr and Mrs A. The assessment was undertaken between December 2004 and May 2005. During this period all six children were in the care of the WHB. It was based on meetings with the parents both together and individually and on direct observation of the home.

The following description of the family home in January 2005 comes from that assessment report: "the kitchen was in very poor condition, lots of rubbish everywhere, one couldn't see the table or counters. Plates everywhere, bags of rubbish with ashes, drink cans in the bag and on the table. Kitchen floor was extremely dirty and the covering was almost non-existent." There is also a description of an amount of alcohol spread over the kitchen. The description of the bedroom matches exactly that given by Social Worker 3 in 2000 on his first visit. Two other rooms were also in very poor condition as was the bathroom.

The report of this assessment found that, despite the work of the WHB staff: "there has been very little in the way of positive change; the financial difficulties of the family continue and Mr A projected the blame for the bills on to his wife, and alleges that she was looking after the finances of the family". The report concluded that "Mrs A could not meet her children's needs if they were returned to her care, and that Mr A lacks insight into the concerns regarding the children and does not acknowledge any problems."

The Inquiry Team notes that this type of parenting assessment based on gathering information, interviewing the parents and observing the home conditions, could have occurred at a much earlier point. If it had, the WHB might have acted very differently in relation to plans for these six children.

3.5.8 Victim Impact Statements

Victim Impact Statements on four of the children were provided by the HSE following the conviction of Mrs A in 2008 under the Punishment of Incest Act, 1908. Victim Impact Statements are provided for under Section 5 of the Criminal Justice Act 1993. The HSE was entitled to submit Victim Impact Statements to the Court as the children were subject to Care Orders under Section 18 of the Child Care Act 1991.

The statements were prepared by a team consisting of an Acting Senior Clinical Psychologist, Social Work Team Leader 4 and Social Worker 6 who was then working with the children. The statements provided very full accounts of the effects on each of the children caused by the years of neglect and lack of parenting skills that were available to them. The content of these reports were widely reported in the media at that time. The description of how the children presented when they came into the care of the WHB and the description of the home conditions contained in these reports mirror the descriptions given to Social Worker 3 in August 2000 by relatives of these children. In their meeting with the Inquiry the relatives confirmed how the children lived and the lack of care and attention they received from their parents.

The Inquiry Team notes that these reports referred in detail to how the children presented when they first came into care. The following direct quotes from those reports tell the story “The child (in school for 3 years) had significant delays with expressive and receptive speech - this impacted on education and on social interaction and development ...level of age appropriate play very much lower than other children of similar age...has responded very well to secure foster care...very likely difficulties caused by emotional abuse and neglect suffered in childhood”. This child is now progressing well within the care system.

In respect of another child the impact statement says “shows symptoms of attachment disorder...shows a level of confusion and mistrust of people. Struggling in school with basic reading and mathematical concepts” Again this child is now doing very well with security and care from a foster family.

The Inquiry Team notes that the impact statements describe a chaotic household. They state that the children were not cared for in terms of being fed, having clean warm clothes that fitted them, having dry, clean, warm beds, being clean and having clean hair and also state that they lacked appropriate social skills as a result of the lack of the parenting capacity of Mr and Mrs A. The children required extra help in school to reach their potential and were subjected to teasing in school.

The Victim Impact Statements contrast sharply with the earlier reports to Case Conferences which had described the children as doing well across all aspects of their lives. Some interviewees told the Inquiry Team they saw no reason for these children to come into the care of the State before the issue of child sexual abuse arose. Other witnesses who regularly saw the children and visited their home either did not see or

failed to describe the reality of the children's lives and home conditions as outlined in the victim impact statements. The Inquiry Team notes that it is difficult to reconcile the two sets of reports and accounts presented.

CHAPTER 4: Findings

4.1 Introduction

All the workers who provided services to the family were well intentioned and concerned for the family's welfare, and made genuine efforts to improve the situation in which they lived. However, in the view of the Inquiry Team, they were, with one or two exceptions constantly diverted and deceived by the parents and were unduly optimistic about the parents' ability and willingness to care adequately for their children.

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 from the time of their birth until their admission to care in 2004. A significant contributory factor to this failure was the absence of meaningful engagement with the children directly and an over-reliance on parental accounts of their well-being.

A number of inter-related factors contributed to the failure of the services involved to respond appropriately and in time to the needs of the children. These included a local rationality, or reasoning, that over-valued the use of family support work in situations where child protection should have been an over-riding concern; ineffective assessment processes; ineffective inter-disciplinary working; faulty decision-making; weak management systems; failure to learn from previous case reviews, inadequate opportunities for training and professional development and poor knowledge of the relevant child care legislation.

4.2 The voice of the child

A particular deficit in the numerous case records is any detailed description or account of the children. Prior to their admission to care, the voice of the child is virtually silent. In exploring this during interviews with staff, a view emerged which supported a belief that to reach the children, one must first work through the parents to gain a level of trust and co-operation. Yet, a basic requirement in the delivery of child protection services is the necessity to at least see the children and, ideally, to seek their views of their situation. This is set out as a key task in *Children First, the National Guidelines for Child Protection and Welfare* (1999) and its absence in practice has been identified as a deficit in other inquiry reports (Ferguson, 2007).

The absence of the child's voice was also evident in court proceedings. This was most noticeable in the High Court injunction proceedings taken by the parents to prevent the Western Health Board from removing the children from their parents. There, for constitutional and legal reasons, the parents' right to be heard was not matched by equal consideration of the wishes or the needs

of the children. They had no independent representation or voice in these or in any subsequent proceedings.

4.3 Local Rationality

4.3.1 There was a strong and laudable ethos of family support in the HSE West (formally Western Health Board). The argument has long since been won among practitioners, managers, policy-makers and academics regarding the benefits of family support as an effective intervention. One of the core concepts of family support is intervention that is appropriate to need (DoH&C, 2003).

Yet we have found that, in this case, local rationality appeared to create a default position whereby an ill-defined family support approach was preferred over a child protection approach, even when there was a well established pattern of parental non-compliance and recidivism. Despite the fact that the parents would consistently promise co-operation and then withdraw it, key staff members displayed an extraordinary optimism in their ability to change and a belief that things would get better. For this reason the interventions provided were often not appropriate to need.

4.3.2 There was also a prevailing belief that the legal threshold of proof, required by a District Court in neglect cases, was very high and, therefore, very difficult to meet. The Inquiry Team believes that this understanding prevented an earlier application being made to the District Court for a Supervision or Care Order.

4.4 Assessment

4.4.1 A notable feature throughout the duration of the period under examination is the absence of any formal assessment of this case, particularly in relation to risk to the children. A basic element in professional training is the capacity to undertake a fundamental assessment through the gathering and assembly of a family history and other information, the status and condition of each family member, and the home conditions at a given point in time. This is followed by stages of planning, intervention to achieve a desired outcome, evaluation and review. These stages were noticeably absent in this case. Had an adequate assessment been undertaken, it would have led workers to take more decisive and appropriate actions.

4.4.2 There was one exception in 2000, when a new social worker did undertake an assessment of the case. This involved interviews with concerned relatives, interviews with the parents, an inspection of the house and, consequently, an appropriate intervention plan. That plan was for a shared parenting arrangement between relatives and Mr and Mrs A. However, following a legal intervention by the parents, it was resolved by the Health Board to try and secure a full Care Order on the children. This application was not made to the District court. The next documented formal assessment happened when the children were taken into Care in 2004.

4.4.3 There is no regional specialist Child Sexual Abuse team or unit available in the West of Ireland to build up experience and expertise in Child Sexual Abuse assessment. Consequently, when the first query of sexual abuse was raised in 2003, a multi-disciplinary assessment was not undertaken. The opinion of a medical consultant was accepted without the added benefit of a social or psychological assessment being undertaken or without an investigative interview with the child.

4.5 Neglect and Emotional Abuse

4.5.1 Workers were not sufficiently alert to indications of ongoing neglect. Such indicators included the squalor in which the children almost constantly lived, the fact that they were left alone or in the care of an under-aged sibling, made to carry home shopping bags containing alcohol, left without adequate clothing and bedding; and the hunger which they regularly experienced.

A study undertaken in one Irish health board area (Horwath & Bishop, 2001) found that, although neglect accounted for more than half of cases reported, there was still a lack of understanding among staff as to its precise meaning. Many professional respondents believed that social workers accepted lower standards of parenting than other professionals.

Closely associated with neglect is emotional abuse. It has been described as “hostile or indifferent parental behaviour which (if severe and persistent) damages a child’s self-esteem, degrades a sense of achievement, diminishes a sense of belonging, and prevents healthy and vigorous development”, (Iwaniec, 2006). These conditions abounded in this case.

4.5.2 Many reports of neglect and emotional abuse were received by the WHB/HSE over a protracted period until the children’s admission to care in 2004. In most cases, these concerns were addressed in an episodic manner. In this way the insidious, incremental and long term effects of chronic neglect went largely unnoticed and, therefore, largely unaddressed.

4.6 The views of the parents

The views and opinions of the parents were accepted largely at face value by some WHB staff engaged with the family. The parents were deft at deflecting staff from critical issues. They did this by ‘stage-managing’ home visits and case conferences, skilfully manipulating the attention of workers away from the children on to practical issues concerning the house and other material matters.

Furthermore, staff lacked the assertiveness to confront the parents appropriately when required and did not adequately challenge them regarding the effect their behaviour was having on the children. In general the Inquiry Team believes that staff did not exercise their statutory authority under the Child Care Act 1991 to protect these children at the earliest possible point.

4.7 Attachment

Many of those we interviewed described a strong bond between the parents and the children despite all their difficulties. This was manifested for example by demonstrations of overt affection in the company of parents or great excitement upon reunion with a parent and an excessive and an age-inappropriate clinging by one child to Mr A. A contrary professional view was expressed by GP2 who felt these manifestations could be viewed as abnormal. It is evident in retrospect that the professionals involved did not recognise some classic indicators of an insecure, disorganised, attachment in the children.

Children may appear to display a strong attachment to an abusing parent but, in fact, such an attachment is disorganised and insecure, as it is virtually impossible for a child to form sound attachments within a dysfunctional family. In addition, we are also satisfied that, in fact, the children were coached by the parents to give the impression to outsiders that all was well and that this was not picked up by the professionals involved.

4.8 The concerns of relatives

We found that the concerns of the relatives were not sufficiently taken on board. Repeated referrals were made since 1990 following various expressions of concern and, in most instances, these were not treated with sufficient gravity by social workers. For example, no social worker, working with the family, sat down with the relatives until Social Worker 3 did in August 2000.

At a particular critical point, the older children were being cared for by these relatives at weekends, but social workers did not know this because they were not in touch with the relatives. At that time there was clear evidence of neglect as these relatives knew what was really going on in the family. Examples at that time included persistent head lice, dirty clothes, an absence of underwear, hunger and the fact that the children would spend pocket money, provided by the relatives for treats, on non-perishable food supplies, such as cans of tuna, which they stored for sharing with their younger siblings during the week when they were all at home.

4.9 Alcohol and drug dependency

There was evidence to suggest that both parents had a considerable dependence on alcohol, upon which much of the family income was spent. This preoccupation with alcohol clearly affected their parenting capacity. It was manifested by the children often being left alone when the parents were in the pub and by the older children having to fulfil adult roles such as minding and feeding younger siblings. The purchase of alcohol was also tolerated by home management staff when the mother was brought shopping.

Notwithstanding this, it is noticeable that much of the attention regarding parental drinking was directed solely at the mother.

The birth of one of the children occurred at home following a night of binge drinking, after which the mother did not realise she was in labour. PHN 1 was alerted and attended the mother the following (Sunday) morning, even though she was not on duty. However, she did not subsequently raise this situation as a child protection concern with colleagues.

Later, one of the parents had an additional and serious dependence on prescription drugs, but this does not seem to have been appreciated by the staff involved.

4.10 Inter-disciplinary working

4.10.1 Although a plethora of services was involved with this family over the years, it is perhaps ironic that it was the wide range of services and their deployment, rather than a lack of them, which contributed to an overall failure of the service to recognize the full extent of the children's suffering. The number of services going into the home may have led to a false perception that everything possible was being done while in reality the children needed to come into the care of the State to protect them from their parent's actions.

4.10.2 Staff worked in 'silos' sharply focused on their own piece of work and in some instances without a clear understanding of the involvement and role of other professionals with the family. One example of this was the Child Care Worker carrying out parenting work in the home without being observant of the hygiene issues that were evident in the house and documented by SW3 when he first visited in August 2000 some very short time after the last visit by Child Care Worker 1. Another example relates to the provision of nourishing meals for the children - a nourishing diet was an ongoing issue for these children and all workers should have been alert to this issue and observant of it. A number of workers visited this home after the children came in from school. Some reported seeing good meals on the table at this time while others reported seeing either sandwiches or tea and biscuits. On the children's admission to care it is reported that they were not familiar with many regular foodstuffs.

4.10.3 The role of the social workers was more that of case manager than case worker. In effect they contracted in other services and often relied upon the views of those service providers, rather than using their own professional judgement which, by virtue of their qualifications, they were best equipped to make. The Inquiry Team was concerned by the lack of the application of core social work skills.

4.10.4 The provision of a home management advisory service, over the years, was not effective. This is evidenced by the fact that there was no improvement in the domestic skills of the parents as a result of the intervention, and the rent arrears grew rather than diminished over the period of involvement. This outcome was not for the want of trying on the part of

Home Management Advisor 1, who demonstrated genuine and persistent concern for the mother and children.

4.10.5 The Home Help service was designed to meet the needs of older people. As such the two Home Helps in this case were not trained to work with dysfunctional families where there were young children. As with the home management advisory service, their involvement had no lasting positive effect as parental capacity was so limited. Both Home Helps were generous as demonstrated, for example, by their supplying underwear and towels at their own expense. Home Help 1 also recognised warning signs in relation to one of the children and conveyed this concern to colleagues with more expertise in this area.

4.10.6 There was a notable absence of General Practitioners attending case conferences. While this is not in itself unusual, their absence was compounded by the fact that, while they were often invited, they never received minutes of the proceedings. As such there was a significant breach in the information chain of professionals involved in the case.

4.10.7 Similarly, other secondary services featured little in terms of joined up practice and overall interdisciplinary working. For example, while there was contact with the schools, this was intermittent and they were seldom represented at case conferences. This was also true of speech and language therapy, psychology and the hospitals. Speech and language appointments which were essential for the welfare of the children were frequently not attended until the children came into care.

4.11 Decision-making

4.11.1 Good systems were in place for making and reviewing decisions, especially case conferences, reviews and core group meetings (latterly Child Protection Management Team meetings). However, the decisions that were actually made often failed to adequately respond to the presenting facts, or were made without sufficient facts being available. There was little evidence to demonstrate that decisions taken at reviews of the case were made on the basis of a clearly articulated plan by which progress could be measured.

4.11.2 A clear pattern emerges over the years of similar decisions being repeated at different case conferences, even though the previous decisions had not yielded favourable outcomes. Repeatedly, following case conferences, there was no evidence to suggest any additional monitoring or protective intervention, such as increased home visiting or individual work with the children. Indeed sometimes the reverse occurred. On many occasions there was one home visit on the day of the Case Conference or shortly thereafter and then long periods elapsed before any further home visits occurred. As such, there was insufficient focus on the needs of the children and no clear focus on ensuring the recommendations of the Case Conference were being implemented by the parents.

4.11.3 The quality of information presented at meetings to consider the case often lacked clarity and detail. There are examples where social workers took at face value the views of others, such as the home helps, without examining the facts for themselves. These views in turn formed the basis of information presented at case conferences and reviews whereby critical decisions would be made with the flimsiest of information.

Often the use of language in reports contributed to the vagueness of decision-making. Phrases such as “all well” and “no concerns” are commonplace but are not backed up by supporting evidence or subjected to any interrogation. There is even evidence of Social Worker 4 presenting information as if it was current when it was, in fact, repeated verbatim from earlier reports without any fresh assessment or review being undertaken. The absence of case notes from this worker makes it impossible to judge from where the justification of his optimistic reports to case conferences came.

4.11.4 It is evident, both from the record and interviews conducted, that the G.Ps were not well linked in to the decision-making process. At critical points in this case, where the G.Ps had important facts or opinions, particularly in relation to specific queries of child abuse and parental addiction, there was no direct contact between them and the family social workers.

G.P2, who was the family GP when the children were received into care, was not made aware of their admission. In contrast to G.P1 who described the children as clean and appropriately dressed, G.P.2 expressed a strong opinion to the Inquiry Team about the poor physical appearance of the children, poor parental capacity, lack of hygiene and the poor condition of the house.

4.11.5 The Inquiry Team is concerned that in September 2000 the WHB identified a very high level of concern in relation to the welfare of these six children. From October 2000 to February 2002 a number of new concerns were reported to the WHB. Yet, in February 2002, a decision was taken not to apply for any Court Order to protect the children. From the end of May 2001 until February 2002 the decisions to change from an application for a Care Order to an application for a Supervision Order which was then adjourned twice and finally not pursued occurred without any formal Case Review or Case Conference being convened by the WHB.

The Case Conference in February 2002 relied to a large extent on a report from Social Worker 4 who was not accredited and was not functioning to an acceptable level of professional work standard.

4.12 Case Conferences

4.12.1 There are also examples of case conferences where extraneous matters dominated the proceedings, rather than the risk to the children which prompted the need for the meeting in the first place. A typical and early example of this is in 1999 when a case conference discussed the parent’s drinking; but the recommendations arising from the meeting were all about

home improvements and similar matters. Again the ability of the parents to deflect attention away from substantive issues is evident.

4.12.2 In essence, the purpose of many of the case conferences was unclear. They were convened as a matter of routine; but there appeared to be a disconnect between the calling of the meeting and using it to achieve positive outcomes. Frequently the decisions and recommendations emerged were not linked to matters of primary concern, namely the needs of the children. To this extent the case conferences, in that format, were a waste of time and money. Conversely, from October 2000 to February 2002, no case conference was held and in that period there was a complete change from a plan to apply for Care orders in respect of all six children to a decision to apply for no protective order.

4.12.3 This emphasises the importance of the role of the chairperson and the need to bring clarity of purpose to the proceedings. The task is even more challenging when parents are present at meetings, as they usually were in this case, when difficult issues need to be articulated and confronted. The skill and persistence needed to keep the meeting focused, and to avoid being led down a 'blind alley', were not always evident in this case. There are as many examples in the records of the chairperson praising the parents as there are of challenging them. In fact most of the improvements made in the home, or in the welfare of the children, can be attributed to the direct work of HSE staff, not the parents.

4.13 Management

4.13.1 While (*Professional Manager 1*) attended the regular Core Group/CPMT meetings they seldom attended case conferences. The Core Group/CPMT meetings consider a number of children and families at each meeting. One example in November 1999 in relation to Family A is recorded as follows: Decision: Close to Core Group Category: Confirmed neglect and emotional abuse x 6.

The (*Professional Manager 1*) seldom attended case conferences in relation to this case. No doubt, one explanation is the sheer volume of such meetings. Yet, in this case at least, a hiatus existed where the social work manager was usually absent when decisions were being taken in relation to case management. Neither was there evidence of the (*Professional Manager 1*) reading case files, and providing direction in relation to cases, as a matter of course. Social Work Team Leaders were always newly appointed when they assumed day to day management role and responsibility for social work practice in this case. It appeared to fall to the relevant Social Work Team Leader to advise the (*Professional Manager 1*) of developments in the case rather than the (*Professional Manager 1*) adopting the management role of endorsing actions to be taken and holding staff accountable for their implementation.

The purpose of the case conference as outlined in Children First is as follows: "when decisions of a serious nature are being considered which require the

input of a number of professionals from different disciplines and agencies". The case conference provides a place for individual cases to be considered in depth and plans made and the attendance and participation of experienced senior professionals could only enhance the decisions reached and ensure that decisions are implemented.

4.13.2 (*Professional Manager 2*) had responsibilities delegated by the CEO for the overall management of child care services. This situation was unique to the Western Health Board and was taken as a proactive step to localise decision-making. However, as this case highlights, the delegation order had the unintended consequence of abdicating senior management responsibility for effective governance as no management systems were in place to quality assure the work of subordinates in this area.

(*Professional Manager 2*) had responsibility for the management of the child protection system as a whole. A more proactive approach to fulfilling this role, such as more rigorous testing of the information presented and quality assurance measures, would have contributed to better quality decision-making at the many meetings which the post holder convened and chaired.

4.13.3 In the year 2000, a system of International Organisational Standards (IOS) was introduced to the social work team. The purpose of its introduction in Roscommon was to provide standardised business processes and procedures to the social work team; thus replacing the haphazard systems that existed heretofore. These systems were designed to address business processes which are very important in setting out how a case should be managed. The Inquiry Team did not find that the ISO had a positive influence on the management or outcome of this case. In this context the Inquiry Team is concerned that the service continues to hold a Q mark for quality in child protection work as it gives the misleading impression of high practice standards when they were clearly lacking in the case under examination.

4.13.4 The files provided to this Inquiry Team were, by and large, in no particular order, usually hand written, often unsigned and, in some instances key records were missing. The social work records were of particular concern to us. The Inquiry Team was not provided with the records in relation to this case of social work management. These records in relation to their actions on this case should be on the main file that pertains to the family. As it was, considerable time and effort were required to extract the children's story from a disorganised record system that was not even in full chronological order. Going through diaries that would cover many other cases and tasks would have made the task of the Inquiry Team impossible. It has been suggested to the Inquiry Team by a number of senior HSE Managers that it was up to the Inquiry Team to request these records. There is an issue around who owns the records of Managers and where these are kept in the system. The situation was compounded by the fact that it was not until 2001 that any typing facilities were made available to social work staff. Indeed, it was only in 2009 that administrative assistance was provided to the social workers dealing with this case.

The records of the public health nursing service were so brief that they lacked significant detail. As such they do not provide an adequate record of public health nurse involvement in this case.

There were very limited records available from line managers in general, with a total absence of records from Senior/(*Professional Manager 1*). There appeared to be confusion as to what constituted personal records and what were official management records. In addition, Senior Social Worker 2 believes that her records were destroyed after her departure.

4.14 Resource Allocation

An implicit policy existed within the Western Health Board whereby resources were allocated on a so called 3:2:1 basis between Galway, Mayo and Roscommon. The intention was to distribute resources in a manner that was commensurate with the population of the three counties. Whatever the methodology, the fact remains that there were three dedicated and targeted family support services in Galway for adolescents; there is still no targeted family support service in Roscommon for families with young children where informal family support, or universal family support services, are not adequate to meet the needs of the children and families. It is a particular challenge in rural areas to provide such services where the population, and indeed the staff, is dispersed.

4.15 Staffing

4.15.1 The Inquiry Team is conscious of the fact that there was an ongoing difficulty in attracting social workers to this part of rural Roscommon. In addition, there were proportionately fewer social workers allocated by the WHB to Roscommon, compared to Galway and Mayo. As a result there were periods in the lifetime of this case where no social worker was allocated, or where the level of involvement was insufficient. In particular, there was also a period where a Social Work Team Leader, who was relatively new and inexperienced in that role, carried unallocated social work caseloads as well as undertaking his primary duty of supervising front line staff. In the context of child welfare and protection services, we found this to be an excessive burden.

4.15.2 A particularly disturbing finding has been the conscious employment of social work staff who were not accredited to work in Ireland. This occurred on two occasions. The first was in 2000 when a social worker was originally employed in this case without the necessary qualifications. He was subsequently accredited following an additional period of academic study.

Another worker was taken on in 2001 to work on this case and he remained unaccredited as a professional social worker in Ireland for the duration of his involvement. Furthermore, the individual concerned was treated as if he were professionally qualified as no safeguards were built in for him or his clients in terms of additional supervision or oversight. This situation was compounded

by the fact that there were shortcomings in this social worker's performance, in addition to long periods of sick leave. In our view this person's employment represents a corporate failure as systems ought to have been in place to ensure that such persons could not be placed on the payroll, and was in fact in breach of a directive from the Department of Health and Children (DoH & C, 1999). As it transpired, the shortcomings in this social worker's performance were noticed and responded to by immediate line management; and the case was re-allocated during the last period of sick leave.

4.15.3 Another staffing issue of concern to us was the management of job-sharing arrangements. One Team Leader, who was job-sharing, was off duty when key decisions were being made. In effect, two people were not sharing one job: there were, in fact, two separate workloads worked by separate people on a part-time basis. The result was a lack of supervisory continuity in this case.

4.16 Continuous Professional Development

4.16.1 There was little evidence to suggest a learning culture prevailed in HSE West. In particular, the learning from the Kelly Fitzgerald case (1996) in Mayo, which was within the same health board, was not incorporated in any organised way into the professional development of staff. The same was true for the West of Ireland Farmer case (1995), which occurred in the adjoining county of Sligo (see Appendix 7).

There was no evidence of any systematic attempt by management at the highest level in the WHB/HSE West to implement the salient recommendations of these reports or to involve staff working in the area in an examination of the issues that arose in those cases. The recommendations arising from these case reviews highlighted areas for improvement in dealing with neglect and child abuse cases which, had they been acted upon, may have prevented more unnecessary suffering by children, this time in County Roscommon.

4.16.2 We found little evidence of on-going training in respect of new legislative responsibilities under the Child Care Act 1991 (as amended) and as set out in relevant international law⁴. While staff were briefed, there was no systematic effort to embed Children First, the National Guidelines on Child Protection and Welfare (1999) into practice. Nor was there any evidence of professional development in relation to evolving practice or new case law. A better knowledge of national policy and the law would have benefited practitioners in this case.

4.16.3 During the time period examined by the Inquiry there was no targeted training on matters pertinent to this case, such as working with resistant clients, the effects of addiction on parenting capacity and the importance of inter-disciplinary working. At supervisory and management level there was a

⁴ As a statutory body the HSE is bound by Article 3 of the European convention on human rights to protect children from harm and ill-treatment.

lack of management development training for first and second line managers. There was also insufficient training in the provision of professional supervision, for supervisors and supervisees, which would have contributed to overall quality control, reflective practice and support for workers.

4.17 Staff Welfare

4.17.1 Clearly, the primary concern of all of us involved in this Inquiry is the effect of events on the children and young people at its centre; and what learning can be extracted to ensure service improvement into the future. While the Heads of Discipline indicated that they did what they could to promote staff welfare at that difficult time, the Inquiry Team found at a corporate level a deficit in relation to the organisation's obligations to staff in the area of health and safety.

4.17.2 Child welfare and protection services are delivered in a socio-political environment where there is a public expectation that every vulnerable child will be protected. This brings huge pressures to bear on those who undertake this challenging work. Front line staff in this case were largely left to their own devices, in poor office accommodation, with little or no administrative assistance, without a corporate recruitment and retention plan and where resources, proportionate to need, were absent.

4.17.3 Those involved in the stressful and anxious business of child welfare and protection require the ongoing support and affirmation of senior management for what they do; and their welfare and safety should be a high priority. It was not evident in this case. No formal debriefing was available to staff after the full and traumatic circumstances of the case unfolded. When the case first came to public attention, the understandable search for individual accountability was not matched by a corporate responsibility to the workforce as a whole in relation to staff health, safety and welfare; regardless of any culpability that might subsequently be attributed to any individuals.

4.18 Court Process

4.18.1 The Inquiry Team is satisfied that that there were sufficient risk indicators in this case to warrant an application being made for a Supervision Order at a much earlier point. The lack of co-operation from Mr and Mrs A was apparent as early as December 1996 (see 3.3.2) .

4.18.2 There should have been a much more immediate approach to the High Court to vary or vacate its original Order and, if that had been successful, an application to the District Court could then have been made.

4.18.3 Insufficient consideration was given to the positive potential use of a Supervision Order.

Shannon (2005) sets out the parameters of a Supervision Order thus:

"Section 19(4) allows the Court to make further provision for the monitoring of a child's welfare. This permits the Court, in particular, to require that a child who is the subject of a Supervision Order be submitted for medical or psychiatric examination, treatment or assessment at any place (hospital or clinic) as specified by the Court".

4.18.4 The nature of the relationship between Law Agent and the Western Health Board did not promote the provision of proactive legal advice. For his part, the Law Agent clearly indicated to the Inquiry that his responsibility was to take instructions.

4.18.5 The Roscommon Child Care Case attracted huge public interest and media comment. The Inquiry Team is concerned that the coverage of the case had a further detrimental effect on the well-being of the six children and young people who were the victims in this case. Section 252 (1) of Children Act, 2001 provides for the anonymity of children who are victims or witnesses in any proceedings for an offence against a child. The young people and child victims in this matter were not identified by name, but considerable information about them was put into the public domain, both through the victim impact statements and from interviews with some key players in this matter. The children and young people believe that they could be identified from the information in the public domain.

It is a criminal offence to breach this anonymity and the statutory offence is without prejudice to the common law of contempt of court. This section is very specific in the limitations on reporting and states:

Section 252._ (1) Subject to *subsection (2)*, in relation to any proceedings for an offence against a child or where a child is a witness in any such proceedings-

- (a) no report which reveals the name, address or school of the child or includes any particulars likely to lead to his or her identification, and
- (b) no picture which purports to be or include a picture of the child or which is likely to lead to his or her identification,

shall be published or included in a broadcast.

The Inquiry Team is concerned that adequate reporting reminders, or admonitions, were not given to the bona fide representatives of the press in this matter. It raises the question whether there is a need to further reconcile any difficulties that arise, in terms of the protection of the privacy of children under the Child Care Act 1991 on the one hand, and the provision of victim impact statements under the criminal justice legislation on the other. The Inquiry Team notes that Mrs Justice Catherine McGuinness, in a paper given to a conference in 2008, addressed the issue of the place in the trial process of victim impact statements and concluded: "it is necessary to reconcile the aims of the criminal justice system with the aim of assisting the victim".

4.19 Gender Issues

We are conscious that, in relation to the parents, most references in this report relate to the mother. This is because considerable focus was placed on Mrs A by the staff involved in this case without reference to Mr A who, for the most part, was unemployed and at home. This is evident, for example, in the work of the Home Management Advisors and Home Helps, who dealt almost exclusively with the mother, even when Mr A was at home when they called.

It is also evident that Mr A carefully monitored the activity of the WHB. He was there, for example, for the first visit of Child Care Worker 1, but then left matters to his wife. Similarly, he was instrumental in ensuring that Child Care Worker 2 did not complete her work with one of the children when there was the potential of a disclosure being made. He had no engagement with the home helps at any stage, leaving them and Mrs A to undertake domestic duties; but he was always present when important matters were being discussed at Case Conferences.

Following the two criminal trials, it is now known that Mr A ruled his home by exercising considerable control over each member of the household. In the same vein, he also took a controlling stance in relation to the professionals working with his family and those involved in the decision-making fora.

CHAPTER 5: Recommendations

The HSE is a statutory body and an organ of state, and as such is bound by the European Convention on Human Rights (ECHR) by virtue of the European Convention on Human Rights Act 2003. Under the ECHR the State has a positive duty to protect children from harm and ill treatment. The report of the Inquiry Team into the Roscommon Child Care Case is occurring in the context not only of this individual case but also in the broader context of that positive duty. Significant developments in the area of child care policy and practice have occurred since the WHB/HSE commenced work with this family on an ongoing basis in 1996. In particular a number of key initiatives have been taken to strengthen the voice of the child; among the more important ones are the establishment of the office of the Ombudsman for Children (2003) , the commitment of the then Taoiseach Mr Bertie Ahern (T.D.) in 2006 to hold a referendum to insert children's rights into the Irish Constitution (the recommendations of the Joint Committee on the Constitutional Amendment on Children on the wording of such an amendment is currently being considered) and the appointment of the Special Rapporteurs on Child Protection to the Oireachtas(2006).

Other significant developments include the development of Children First : National Guidelines for the Protection and Welfare of Children(1999) (the finalised revised National Guidelines are awaited at this time), the development of the National Children's Strategy (2000), the establishment of the Office of the Minister for Children and Youth Affairs(December 2005), the development of standards and the establishment of an external inspection system of services for vulnerable children HIQA(2007), the publication of a number of child abuse inquiry reports e.g. The West of Ireland Farmer Case (1998) Ferns Report (Murphy et al.,2005), Report of the Commission to Inquire into Child Abuse (Ryan Report 2009), Report into the Catholic Archdiocese of Dublin (July 2009), The Monageer Report (2009) and the publication of reports into the deaths of Child A and Child B (April 2010).

From a policy and practice perspective, the development of The Agenda for Children's Services (OMCYA, 2007) has a clear focus on achieving better outcomes for children and families and sets out seven National Service Outcomes for Children in Ireland. The Implementation Plan issued by the Office of the Minister for Children and Youth Affairs(July 2009) provides the response of the Government to the report of the Commission to Inquire into Child Abuse and this implementation plan sets the agenda for the development of practice, policies and structures to better protect children in Ireland. Children at risk of chronic neglect or harm are identified as a key group of children in need of the care and protection of the State and the Implementation Plan highlights the need for "specialist social work child protection teams to assess these children and their circumstances in the same way as they do where concerns of physical and/or sexual abuse are raised" (pg 9).

The recommendations of the Inquiry Team are made both in the context of the wider agenda for vulnerable children and families and in the context of the particular case that was the subject of this Inquiry. Many of the recommendations echo those made both by other inquiries and by other commentators who are concerned with improving the systems, services and practices that are dedicated to protecting our children and young people. The recommendations are organised into the following five key areas.

5.1 Organisational Change

The HSE is one national agency and as such needs to ensure that its child welfare and protection services are being run in a way that is consistent across the country. The HSE has put systems and personnel in place in some disciplines: for example in respect of the medical and nursing professions to ensure consistency in those disciplines and the national leads are supported by clinical leads in the regions. The Inquiry Team welcomes the recent initiative announced by the Mr Barry Andrews. T.D. Minister for Children that a national director for children and family services reporting directly to the CEO and board of the HSE would be recruited (Statement to the Dail 9th June 2010).

- ***It is recommended that the post of national director for child and family services be supported by a clinical team (professionally qualified and experienced social workers and other suitably qualified staff) to drive and support practice in child welfare and protection services and ensure that national standards are set, monitored and delivered.***

5.2 Policy Change

The failure to consult with, and to hear, the voice of the six children was a notable feature in this case. It is not within the remit of this Inquiry to recommend legislative changes, as this Inquiry is limited to making recommendations that are relevant to the work of the HSE or that can be implemented by the HSE. However as noted already, the Government has committed to holding a referendum on inserting children's rights into the Irish Constitution and to legislative change to ensure that the voice of the child is heard when courts are considering matters that affect them.

- ***It is recommended that the HSE ensure that all appropriate policies and procedures are compliant with the requirements of the United Nations Convention on the Rights of the Child for children to be heard in all matters that concern them. This should include all stages in the child welfare and protection system from the initial assessment stage where a child's welfare and protection are being considered.***

5.2.1 Victim Impact Statements

It is clear that the use of the victim impact statements was not intended to compromise the right to privacy of the six children. In this case the children who were victims of very serious offences were in the care of the State when the victim impact statements were provided. They felt very strongly that the reporting of family details made it easy to identify them.

- ***It is recommended that the HSE engage with the offices of the Director of Public Prosecutions to determine how best the identities and personal information of children involved in Child Protection Cases can be better protected, particularly where victim impact statements are supplied in relation to criminal cases. Guidance should be issued to HSE staff regarding the preparation and presentation of victim impact statements, and the rights of children in care to privacy.***

5.2.2 Quality Assuring the Child Welfare and Protection System

The importance of monitoring the quality of work across all related areas is recognised as being essential in building public confidence in Child Welfare and Protection work. It is recommended 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 County 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. It would identify best practice models for dealing with these cases and develop national standards to guide practice in these cases.***
- ***The Q-mark should be relinquished and replaced with a nationally appropriate quality assurance system that considers the practice issues as well as the technical aspects of each case.***
- ***The procedures that are in place in the HSE for the reporting up of escalating risks and cases of public importance should be reviewed to ensure they are fully understood and that they are applicable in the wide range of possible situations that arise across child welfare and protection work.***

5.2.3 Court Process

Another key issue that emerged in this case related to the use of the Child Care Act 1991 and the Court process to protect these six children. Given the complexity of child care, the constitutional and legal issues which can arise in taking decisions in this area the following recommendations are made:

- ***The HSE should take steps to ensure that specialist legal services in child care matters are available at all times.***
- ***Law agents/legal advisors should be consulted, and their views elicited, regarding any possible legal remedies at an early stage, when there are serious concerns around child welfare and protection.***
- ***The likelihood of success should not be used as a criterion for determining whether or not relevant and appropriate legal remedies should be pursued.***
- ***Where a legal matter arises in a case that is unfamiliar to personnel involved, it is recommended that a wider consultation process in undertaken within the HSE to ensure the experience of colleagues who have dealt with similar matters is considered.***

5.3 Practice

The role of front line staff is critical in ensuring children's welfare is protected. The accepted wisdom that child protection is the responsibility of everyone was not borne out in this Inquiry. Some HSE staff, as well as those from other services, saw social workers as being more responsible for protecting children. A number of recommendations are made across various domains in child welfare and protection work.

It is recommended that:

5.3.1 Staff Roles

- ***Greater clarity should be articulated on the roles of each staff member in cases where there are child protection concerns, so that everyone is clear on the exact concerns for each child and understands their role both in terms of their professional expertise but also as part of the team working together on each case. Each person visiting the home should be clear on the outcomes established for each case. Involved professionals who never/seldom attend conferences or reviews should be communicated with on an ongoing basis and it should be agreed who has responsibility for doing so.***

- ***Social workers should see and speak directly to every child where there is a concern about their welfare. It should be the responsibility of the Social Work Team Leader and the (Professional Manager 1) to ensure that this is done. Working directly with children and families are core social work tasks and their training provides them with the knowledge, skills and competencies required for this work.***
- ***Contact with children should appear on the agenda for every professional supervision meeting and form part of every report for a Case Conference. Where there is more than one child in a family, the needs, wishes and feelings of each child must be considered and reported on as well as the totality of the family situation.***

5.3.2 Assessment

Assessment in any case is an ongoing and iterative process. It should be informed by evidence and identify the strengths and challenges that each case presents. There is long-held general acceptance among practitioners that a clear assessment is a basic requirement in every case. Efforts made in the past to introduce an assessment framework have not been successful across the HSE as there are a number of models in use.

It is recommended that:

- ***A national common assessment framework be introduced without delay for all child welfare and protection cases. The framework needs to identify core components while allowing for flexibility. It is recognised that any such framework will need to be reviewed and updated as knowledge and practice develops and changes.***

5.3.3 Home Visits

In this case there were often long gaps between home visits, particularly evident following Case Conferences. Social work visits that are 4 to 6 weeks apart are not sufficient to ensure change occurs or is maintained in families where chronic neglect is the identified concern of the HSE Child Welfare and Protection Services.

It is recommended that:

- ***Where there are ongoing concerns of child neglect, as in this case, the appropriate frequency of home visits by the family Social Worker should be agreed and carried through.***
- ***All workers should be clear about the purpose of each home visit and all staff should be alert to parents or guardians constantly guiding the conversation away from the welfare of the children and on to practical issues.***

- ***Home visits should include observing hygiene, warmth, provision of food and clothing for each child in cases where these are identified as a deficit for the children involved. It should also include general observations on the well-being of each child. Those observations should be recorded by each discipline and shared with other disciplines.***
- ***Care should be taken to work with both parents and in particular workers should be proactive in seeking to engage fathers.***

5.3.4 Chronic Neglect Cases

It is recognised that these cases are often among the most difficult for personnel to work with and outcomes can be difficult to establish and measure. Families where chronic neglect is identified are often characterised by a lack of routine and consistency.

The following recommendations are made:

- ***In all child welfare and protection cases explicit outcomes should be identified in respect of each family member but particularly in respect of each child about whom there is a concern. Both short-term and long-term outcomes should be identified.***
- ***The case management plan should include how progress on each key element in these chronic neglect cases is to be measured.***
- ***Workers should be mindful of the need to consider alternative plans where the desired outcomes are not achieved. In all situations it is important that the case file records the reflective thinking, planning and consideration of outcomes that is guiding the work for the child and family.***
- ***It is further recommended that where concern is expressed, or a referral made, concerning neglect and/or emotional abuse each episode should be judged and assessed in the context of any previous concerns.***
- ***The key designated worker in chronic neglect cases should meet regularly with all personnel who are visiting the home to ensure that all are fully aware of the key concerns for the children.***

5.3.5 Concerns of relatives and others.

A consistent aspect of this case was the attempts by relatives and neighbours to highlight the plight of these children. The concerns expressed by neighbours and family members were consistent with each other and over time. The following recommendations are made:

- ***Third parties who express concerns should be interviewed as part of the assessment of the family. Full assessments require that those reporting concerns are interviewed wherever possible and their concerns investigated fully. The provision of feedback to those reporting concerns should follow the process outlined in Children First as revised.***

5.3.6 Working with parents who seek to distract workers

The parents in this family were practised in deceiving the workers who visited this home. There is a growing literature on this phenomena and it has been dealt with in recent inquiries including the Baby P (2008) and the Victoria Climbié inquiry (2008).

- ***It is recommended that the views of parents should be taken into account and checked against the facts and the views of concerned others.***
- ***It is recommended that all personnel be alert to parents and carers who consistently try to divert attention away from the primary concern with the well-being of the children.***

5.3.7 Attachment

The personnel involved with this family relied on a perceived strong attachment of the children to their parents. They did not recognise classic indicators of insecure disorganised attachment. The possibility that their belief in relation to attachment was an unsafe assumption was not queried.

It is recommended that:

- ***All staff involved in child protection and welfare work should be knowledgeable about, and alert to, attachment theory and test their assumptions in supervision.***

5.4 The Development of Services

It has long been accepted that families are the best place for children to grow and develop. The policy of Prevention and Early Intervention has been accepted as offering the best chance for children whose families require extra support to ensure they can grow and develop within a safe family environment.

The Inquiry Team makes the following recommendations:

- ***A system should be devised and implemented for the equitable distribution of HSE resources based on assessed need. This system should be agreed and communicated to relevant managers and staff.***

- ***A targeted family support service aimed at working with families with young children should be developed for this part of County Roscommon⁵. Any model introduced needs to be appropriate to a rural/town setting. It is of course acknowledged that any such service must work actively with families, communities and local services. Some elements of services already in the area could be subsumed into such a service.***
- ***There should be full involvement of the HSE Speech and Language Department in the development of support and treatment services for children and families where this is an issue for children's well-being. All systems should be organised in a way that maximises the possibility of children getting the services they require.***
- ***Within the context of the development of such a service there should be a review of the effectiveness of the Home Management Service in respect of working with families where chronic neglect is an identified issue.***
- ***A specialised Child Sexual Abuse Unit or Team should be put in place in each HSE region to build up expertise and experience in assessment and to act as a centre of excellence when frontline workers require advice. Therapeutic treatment services must also be available for children who have been sexually abused.***

5.5 Management

The role of management at all levels is recognised as a key component in the delivery of a comprehensive child welfare and protection service. Managers in the professional area of Health and Social Services are usually highly professionally qualified but may not have had the benefit of any management training. The following recommendations are made in the context of staff management, decision making, staffing, and continuous professional development.

5.5.1 Staff Management

It is recommended that:

- ***Accredited management training should be provided to all new managers who are managing front line health and social services staff.***
- ***Managers providing supervision to staff should receive training in supervision theory and practice.***

⁵ The Springboard Family Support model which is already being implemented within many areas of the HSE could be explored for its suitability

- ***Systems should be in place for supervisors to review and sign case files, and to endorse or disapprove actions being taken.***
- ***Systems should be in place for senior professional managers at local/regional level to quality assure the overall child protection and welfare system.***
- ***Management, in order to fulfil their role, needs to have available the necessary resources in terms of appropriate offices, clerical support , computers etc for every member of staff to allow the work of the department to function to an optimum level.***

5.5.2 Decision-making

Informed decision making at each point is another key element in building child welfare and protection systems that is robust and commands public respect. The Child Protection Management Team made decisions that these children were being abused and neglected. There appeared to be a disconnect between those decisions and the subsequent actions taken to protect the children.

The following recommendations are made:

- ***The HSE should ensure that, as the revised Children First Guidelines⁶ are implemented locally, all systems of decision making are well linked and provide for the decisions to be fully carried through and reviewed for effectiveness.***
- ***The chair of case conferences⁷ should be trained for, and alert to, the demands of this role. This includes interrogating the facts and opinions presented at case conferences and reviews. It also includes reviewing cases where there are numerous case conferences are held on a child/family where the same issues are repeated from case conference to case conference, with little evidence of change. The Chair should also ensure that the voice of the child is heard at all case conferences and that their welfare and safety are paramount.***
- ***The purpose of each case conference and review should be clear and where it is proposed that a course of action agreed by a case conference should be changed, the case conference group should be reconvened to agree the new course of action as soon as possible.***
- ***The record of each case conference should be clear and easily accessible with a clear record of those invited, those attending, and those providing an apology. The minutes of each case conference should be approved by the chair and contain a clear***

⁶ The Ryan Implementation Plan 2009 has committed to putting those guidelines on a statutory footing.

⁷ See appendix 6 of revised Children First.

plan, with responsibility for each task assigned and the plan for how each assigned task is to be monitored should be outlined. The review meeting should be alert when the agreed outcomes are not achieved and alternative action should be undertaken. The minutes should go to all those invited to the case conference including those unable to attend.

- *Standardised file recording and file management systems should be devised and introduced. It should be clear what records are specific to each case and the case file should be complete. The decision reached and guidance given at staff supervision in respect of individual cases should be recorded on the file.*
- *The nature of Public Health Nursing records in respect of children where there are child protection concerns should be reviewed to ensure their adequacy.*

5.5.3 Staffing

Investment in staff is of utmost importance to build up and retain expertise and experience in child welfare and protection work.

The following recommendations are made:

- *A human resource recruitment and retention plan should be developed and implemented.*
- *Systems should be in place to ensure that anyone employed in the area of child welfare and protection is accredited and is competent to undertake the work.*
- *A standardised supervision system should be implemented and sustained.*
- *Supervision of frontline staff should be no less than monthly and may need to be more frequently for new and inexperienced staff.*
- *Newly qualified workers should have a protected caseload and receive additional supervision and support.*
- *Although it is difficult to be entirely prescriptive in relation to caseload size, it is recommended that attention is paid to caseloads so that each worker can function fully and work proactively with every case for which they have responsibility.*
- *Procedures for job-sharing should be in place to ensure that such jobs are actually shared and that cover is available at all times, particularly in key management positions.*

- ***Staff welfare should be a corporate responsibility, reflected in policies and procedures that value, respect and support the individual worker.***
- ***Debriefing arrangements should be put in place as an option for all staff exposed to personal or vicarious trauma.***

5.5.4 Continuous professional development

The retention of good staff in the child welfare and protection services is greatly enhanced if there is a culture of professional development built into every discipline and agency.

It is recommended that:

- ***Learning from other case reviews, legal cases and judgements, and emerging practice initiatives should be systematically embedded into practice, through multi-disciplinary training and opportunities for professional reflection.***
- ***A training needs analysis should be periodically undertaken with staff and relevant training put in place.***
- ***Specific training should be regularly delivered on child care legislation, national strategy and policy and developing international best practice.***
- ***Other areas where training should be considered depending on assessed need could include assessment, abuse and neglect, involuntary and resistant clients, worker assertiveness and authority.***
- ***In addition in this case the following issues were also identified where additional training could have supported the work of the frontline staff: new developments and understanding of attachment theory, drug and alcohol dependency and in particular its effects on parenting and working directly with children. Particular attention should be given to report writing and the need to evidence opinions provided in reports.***
- ***Management development training for first and second line managers.***

CHAPTER 6: Conclusion

The Inquiry Team concludes that the six children of the A family were neglected and emotionally abused by their parents until their removal from the home in 2003 and 2004. Some of the children have spoken of severe physical abuse by their parents. Some of the children were also sexually abused. There is no evidence that either parent understood or sought to consistently meet their children's needs. Both parents, but particularly Mr A, successfully resisted the efforts of professionals to work in a meaningful way with the children, while appearing to be cooperative on the surface.

We have identified that while the WHB did recognise the neglect and indeed on occasions the emotional abuse of the children, it failed to follow up the decisions taken by the Core Group/Child Protection Management Team, in a way that offered the children better protection from the effects of that neglect, in a way that was lasting.


Staff utilised services to support the parents. The parents tended to agree readily to accept the support offered but the Inquiry Team did not find any evidence that any area of their parenting showed a positive consistent change over the eight year period from 1996 to 2004. The parents were both heavily dependent on alcohol and in the later years one parent had an additional dependence on prescription medication. This addiction and the use of the family income to support those addictions, rather than for the support and benefit of the children, were not fully taken on board in the planning in respect of this case.

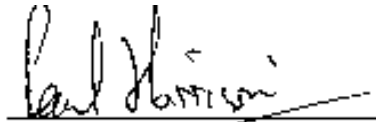
There was a belief that these parents could, with support, meet the needs of their children. There was a focus on working with the parents. Progress was made at times in the general condition of the home but that progress was initiated by WHB staff, the actual clean up was undertaken by the staff and then over time conditions again deteriorated. Until the children were taken into care there are few accounts of them as individuals on file although on one occasion in 2001 there was a proposal that their needs should be assessed and a plan put in place based on that assessment. That assessment was not undertaken. In families where ongoing and chronic neglect is occurring the services going into the family home must look at what day to day life is like for the children. We know from accounts given by the children since they came into care that this was not a home where 'good enough parenting' was available. We believe that the threshold as to what was considered "good enough parenting" was set too low for these children.

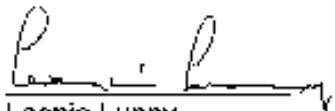
We have concluded that, had there been a better insight and understanding of the condition and the needs of the children over a protracted period of time, the hope that this family could function in a positive way would have given way to serious concerns years earlier than it did and the children offered protection.

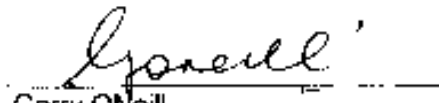
The views and opinions expressed, conclusions reached and recommendations made in this report are those of the Roscommon Inquiry

Team comprised of Norah Gibbons, Paul Harrison, Leonie Lunny and Gerry O'Neill following the completion of the process described herein. We are satisfied that we have fulfilled the terms of reference provided to us by the HSE.


Norah Gibbons


Paul Harrison


Leonie Lunny


Gerry O'Neill

Appendix 1

HSE confirms investigation to examine the events surrounding the Roscommon Childcare Case (January 24th 2009).

The HSE is to undertake a full investigation to examine the events surrounding the Roscommon Childcare Case.

The investigation team will be chaired by Director of Advocacy with Barnardos, Norah Gibbons.

The decision to initiate the investigation was made today by Laverne McGuinness, HSE National Director Primary, Continuing and Community Care after considering the initial findings of the preliminary review of the case. That review is currently being finalised.

The terms of reference for the investigation team will be:

- To examine the entire management of the case from a care perspective
- To identify any shortcomings/deficits to the care management process
- To make a report on findings and learning arising from the investigation

Appendix 2

Inquiry procedures for interviewees

Fair procedure is a key principle of this investigation.

Fair Procedures Outline

- You are not obliged to have attended before the Inquiry as the Inquiry does not have compellability of witnesses.
- You are not obliged to answer any question put to you. It will be a matter of record that the question was not answered.
- If you do not understand a question – do let us know and it will be rephrased.
- You may request a break at any time. Please let me know.
- You may choose to leave the meeting at any time and not conclude your interview. Again this will be recorded. It will not prevent the Inquiry Team from compiling its report or the making of findings based on the evidence it does hear.
- You will get a copy of the transcript of your interview if you request it.
- You will be given any portion of the draft report that applies to you and will be able to correct any factual inaccuracies.
- You can make a submission in regard to any findings that concern you. That submission may be included in the report. Reasons for exclusion could be, for example, if it was defamatory of another person.
- Proceedings of this hearing must not be disclosed to any person. Any reports furnished to you by the Inquiry either in the course of the sittings or in the course of compiling the report are strictly confidential and must not be disclosed to any person.
- Any witness may be recalled by the Inquiry – examples when recall could happen include:
 - To clarify any matter.
 - To provide an opportunity to answer any allegation made against them by another witness.
- There is a Criminal Trial outstanding. It is important to ensure that this Inquiry does not prejudice those proceedings.
- On conclusion of this interview you may submit in writing any relevant information you omitted to give us today to myself.(Chairperson of Inquiry Team)

Appendix 3

Confidentiality Agreement

I, _____ of _____ confirm that I will be accompanying _____ to an Inquiry convened by the Health Service Executive held at _____ on the _____. I confirm that I will not divulge the proceedings before the Inquiry in any way whatsoever to any person, or discuss same with any person except with _____ or members of the Inquiry Team. I confirm that I understand fully the absolute need to ensure the confidentiality of proceedings before the Inquiry Team and will do all that is in my power to ensure that this confidentiality is protected.

I understand that I will be permitted to attend the Inquiry only during the attendance of _____ and that I am not entitled or permitted to make any submission to the Inquiry or attend during the attendance of any other person aside from _____ before the Inquiry.

Appendix 4:

Text for Addressing Companion/Representative at Interview with Inquiry Team

For the record **[interviewee's name]** is accompanied today by **[companion's name.]**

I would like to address **[companion's name]** directly as to how this interview will be conducted.

[Companion's name] you are also very welcome here today.

The Inquiry accepts that you are here to accompany and support **[interviewee's name]**. The Inquiry Team will ask questions and you are not entitled to object or intervene or answer on **[his/her]** behalf. You are not here under any compulsion, this is not a court of law, and we cannot conduct the business of the Inquiry if you interrupt.

We want to get as full an account as possible and cannot function with interruptions. Therefore, you will be asked to leave should that arise.

I would also like to stress the confidential nature of this interview and that the statement submitted and the documents that may be discussed are also confidential and should not be discussed or disclosed to another person.

Appendix 5: *(Redacted protected court material)*

(Redacted protected court material)

Appendix 6:

(Redacted protected court material)

Appendix 7:

Relevant Sections from previous Inquiry Reports

KELLY FITZGERALD; Report of A Committee of Inquiry

Finding:

“...working with children who have been abused or neglected. Such cases are complex in the extreme and the children concerned typically have a very mixed relationship with their parents of which extreme loyalty and collusion are features.” **P 204**

Recommendations:

“...that the WHB review its current deployment of community care staff. In our view the public health nurse in this case was too isolated...they [PHNs] should not work on their own, particularly where that work entails at least aspects of child protection.” **P211**

“...that WHB ensure that all of its child protection staff are aware of the importance of assessment and that relevant staff receive training in the identification of abuse...” **P 219**

“...in each case the WHB develop a plan of intervention based on its assessment of the risk involved in the child. The plan must have clear objectives to be achieved within a defined timeframe.” **P219**

“Case conferences should be arranged to facilitate the implementation of planned intervention or to review its continuing appropriateness or effectiveness. In each instance the purpose of the case conference should be clear.” **P219**

“...the WHB clarify the status of legal advice given at case conferences and whether any such advice which indicates that a Court application will not be successful should be followed in every case irrespective of the views of relevant staff.” **P 220**

“...that a comprehensive training programme be developed in consultation with staff to include, inter alia,

- Assessment
- Dynamics of abusing families
- Case conference management, roles, etc.
- Corporate responsibility under the Child Care Act 1991
- Team development
- The psychology of inter-disciplinary and inter-agency collaboration
- Communication – its dynamics and processes
- Investigative techniques **P 221**

“...takes the steps necessary to ensure an adequate level of administrative support to child protection staff.” **P 222**

“...initiate a process to consider aspects of inter-disciplinary and inter-agency communication and collaboration involving staff from each discipline and agency.” **P 223**

“...investigate measures used in other employments to provide support to workers who may experience trauma in the conduct of their professional duties.” **P224**

WEST OF IRELAND FARMER CASE- Report of Review Group

Conclusions:

“The review which we have undertaken demonstrates an operational philosophy within the community care area social work department focused on a non legal interventionist approach towards child protection.

There was a stronger emphasis on the parental and familial aspects of the case presentation as compared with the protection needs of the children. Thus parental support, not child protection, was in sharp focus

With regard to the overall case management, no systematic review of relationships within the family network occurred. The focus moved from episode to episode without a holistic management approach being taken. A failure to share or link information within the system, particularly within the hospital setting also occurred. Given that there was just one hospital involved, the review group believe that this was a very significant factor in not establishing the full picture.

The totality of information held by all the professional staff was not collated and thus not translated into action to protect the children or promote their welfare.

Recommendations

Child protection practices operated within the board should conform to a standard board policy. A quality assurance programme is an essential mechanism in developing child protection services and should be a key responsibility of the proposed accountable child protection manager.

Personnel attending a case conference should as far as practicable be consistent over the duration of the board's involvement with a child or family. The designated officer for convening a case conference should have access to all previous information on contacts with the child's family especially previous case conference notes. This will require adequate secretarial and data retrieval facilities being readily available.

In convening a case conference, arrangements should be made to have a chronological record of all community and hospital contacts between the board and the child who is the subject of a case conference provided to all the participants at such a conference. Where a case conference is not called, the reasons for not doing so should be recorded and circulated to appropriate personnel.

In all cases where the board is exercising statutory responsibilities it is essential that specific monitoring arrangements are installed, managed and regularly evaluated.

Training for board staff, GP's and school teachers to enable them acquire the skills and knowledge necessary to deal appropriately with child abuse should be regularly reviewed, monitored and provided as necessary. Training in the chairing of case conferences is an example of such specific training.”

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