Child protection reports: Key issues arising for public health nurses

Abstract
Similar to other countries, there have been a number of high profile reports into past and recent cases of child abuse and neglect in Ireland. The most recent of these reports in Ireland have been the Monageer Inquiry, the Ryan Report, the Roscommon Child Care Case and the Report of the Independent Child Death Review Group. An analysis of these reports highlights the critical role played by public health nurses with troubled families. It also makes explicit key issues that consistently emerge as problematic in terms of professional practice. This paper summarises the main findings of these reports as they relate to the public health nursing service and identifies key themes emerging along with recommendations arising. The emerging themes relate to assessment, early intervention, record keeping, communication and inter-disciplinary working, and, the role of public health nursing management.

Key words
Child Protection Reports, Public Health Nurses, Interventions, Outcomes

Background
The Public Health Nursing Service in Ireland is a generalist one with multiple client groups and incorporating clinical, health promotion and managerial elements. The service to families with children is similar to that of Health Visiting in the United Kingdom (UK) where the focus is predominantly on prevention, early identification of problems arising and the implementation of appropriate interventions (Hanafin 2008). Understandably, some of this work takes place with children in need of protection. Public Health Nurses (PHNs) work under the auspices of the Health Services Executive (HSE) which provides health and social services to the population of Ireland and which had, until June 2013, sole responsibility for all child protection issues. This has recently changed with the formation of a new Child and Family Agency that now has overall responsibility for child welfare and protection services. The Public Health Nursing Service, however, will remain under the auspices of the HSE.
The development of a new Agency is one of a number of changes to take place in child protection services in Ireland in recent years (Taskforce on the Child and Family Support Agency, 2012). These developments are presented in strategic and policy documents (HSE, 2007; Department of Children and Youth Affairs (DCYA), 2011; Health Information & Quality Authority (HIQA), 2012) and in detailed action plans (Office of the Minister for Children and Youth Affairs (OMCYA), 2009). Building on these developments, the recent Programme for Government (Government of Ireland, 2011) undertook to fundamentally reform the delivery of child protection services and, in addition to the creation of the Child and Family Agency, a national referendum took place in 2012. This resulted in the incorporation of a new Article in the Irish constitution which recognises and affirms "the natural and imprescriptible rights " of all children. Legislation is currently being drafted to introduce mandatory reporting of child abuse and neglect.

Many of these developments have taken place in response to reports written on failures to protect children and the most notable of these reports are:

a) Monageer Inquiry (Brosnan, 2008)
b) Roscommon Child Care Case (Inquiry Team to the HSE (HSE), 2010)

This paper identifies the main findings from these reports of relevance to public health nurses working with families. The findings are focused on assessment, early intervention, communication and inter-disciplinary working, record keeping and the role of public health nursing management. Key learning points for public health nursing emerging from these reports are presented and recommendations of relevance to the organisation and practice of PHN with families are outlined. A short summary of each report with key issues arising is now presented.

**The Monageer Inquiry**
An Inquiry took place into the circumstances leading to, and surrounding, the deaths of two children (aged three and four years) and both their parents, in a small village called Monageer, Co Wexford in April 2007. The report of the Inquiry found that
immediately prior to their deaths, the parents had made arrangements for the funerals of the whole family with a local undertaker. The alarm was raised by the undertaker and, over the course of a week-end, attempts were made by the local Clergy and Police to intervene with the family. Despite these attempts all four died. It is believed that the father killed both children and their mother before taking his own life. Both parents were registered as blind and Ciara, the mother, was considered to have some intellectual disability challenges. Both children had serious visual impairment and were developmentally delayed. Brosnan (2008) documented a number of interactions between the family and the Public Health Nursing service over a number of years in a chronology of events, and included a number of unsuccessful attempts at contact between the PHN and family. Although the Inquiry concluded that the deaths could not have been anticipated by the HSE, they nevertheless identified a number of issues of relevance to the PHN service.

**Key issues arising**

*Early identification and referral to other services:* The inquiry team found that although the Public Health Nurses (PHNs) identified problems with the children they did not refer them to other services. The Inquiry recommended that, irrespective of whether services were available, PHNs should refer to other disciplines and services in order to ensure children are identified as requiring services as early as possible. It can also assist in planning services.

*Following up when vulnerable families move address:* Similar to cases elsewhere, this family had moved home several times. The Inquiry team recommended that where new addresses are not identified, this should be brought to the attention of line managers. The Inquiry team also recommended that protocols for the transfer of records when a family moves be in place and be strictly adhered to.

*Records:* The report raised some questions about the professional records submitted to them. They recommended that records kept by all health professionals should be both accurate and contemporaneous and, at a minimum, should include all contacts, consultations and any actions taken. All records, the Inquiry team noted, should be dated and signed.
Communication: The Inquiry Team also identified problems regarding the level of communication between specialists in hospitals and those working with the family in the community. The inquiry recommended there should be a minimum of a yearly update provided to the family's General Practitioner and to the local Director of Public Health Nursing where a specialist is seeing the family on an on-going basis.

Management: While not singling out any individual service, the report highlighted the requirement for absolute clarity in respect of the roles and responsibilities of each service. They recommended the Head of each discipline be responsible for the management and professional practice of their team and audits should be undertaken in this regard.

Roscommon child care case
The purpose of this Inquiry was to examine the management of a family of six children living Roscommon (an area in the west of Ireland) where the mother was sentenced, in 2009, to seven years in prison following her conviction for incest, neglect and ill treatment and where the father was sentenced in 2010 to 14 years in prison for rape and sexual assault. The Inquiry was established by the HSE and reported in 2010.

Findings
The Inquiry Team concluded that the six children of "A family" were denied their most basic needs for security, food, warmth, clothing and the loving care of their parents. They were neglected and emotionally abused by their parents until their removal from the home in 2003 and 2004. Some of the children suffered severe physical abuse and some were also sexually abused. Both parents, particularly the father, appeared to be cooperative but managed to successfully resist the efforts of professionals to work in a meaningful way with the children. The parents were both heavily dependent on alcohol and family income was used to support these addictions rather than support and benefit the children. The Inquiry Team concluded that serious concerns should have been identified years earlier than they were.

Key issues identified by the Inquiry
The Inquiry team noted that in this case, resources, per se were not an issue. They found, however, that despite the good intentions of the staff involved, there was a
failure to identify the extent and severity of the neglect and abuse and there was an absence of meaningful engagement with the children. Several inter-related factors were identified as having contributed to the failure of the services to protect the children including:

- an over-valuing of the use of family support work in situations where child protection should have been an over-riding concern
- a failure to listen to the voice of the children
- ineffective assessment processes
- ineffective interdisciplinary 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.

**Issues of particular relevance to the work of PHNs**

*Roles and responsibilities:* Similar to the findings from the Monageer Inquiry, this Inquiry Team drew attention to the need for clarity on the roles of each member of staff and they recommended that each person visiting the home should be clear on the outcomes established for each child in the family.

*Assessment:* The Inquiry Team were of the view that a basic element in professional training is the capacity to undertake a fundamental assessment and they reported this did not happen with this family. They listed a number of areas that should be assessed on each interaction including observing hygiene, warmth, provision of food and clothing for each child as well as more general observations on their individual well-being. The Inquiry Team also recommended that an assessment should gather and assemble the family history, the status and condition of each family member and the home conditions at a given point in time. One area of particular concern to the Inquiry Team was a failure by professionals to recognise classic indicators of insecure, disorganised attachment.

*Voice of the child:* The report noted that while it is important to take account of the views of parents, it is equally, and sometimes more important, to listen to knowledgeable others including children themselves.
Interventions: The report of the Inquiry found that adequate planning and interventions to achieve a desired outcome did not take place and that further, there was no evaluation or review.

Records: The final area related to the records held specifically by PHNs and in this case, the Inquiry Team wrote that their records were too brief and lacked significant detail.

Report of the Commission to Inquire into Child Abuse
The Report of the Commission to Inquire into Child Abuse, commonly known as the Ryan Report, was published in 2009, following a 10-year inquiry into the lives and challenges faced by children who were placed by the Irish State in residential institutions run by religious orders. The Report contains harrowing accounts of the lives of these children and details incidences of abuse of all types – physical, sexual, neglect and emotional. Following its publication an implementation plan, with almost 100 actions, titled the Ryan Report Implementation Plan, was published. These actions have been central in shaping current policy and strategy in the area of child protection.

Ryan Report Implementation Plan
This Plan takes account of a wide range of services provided to children at risk (of neglect and abuse, and of offending behaviour) living in the community, children in the care of the State and those who have been detained through Youth Justice Services. The Implementation Plan uses the Hardiker Model of children's services as a framework for categorising services (Hardiker and Baker, 1995) and this four-level framework positions services provided by public health nurses at level 1 (preventive services) and level 2 (early intervention and support). The third level refers to specialist services and the highest (level 4) to out of home care.

Within the implementation plan there are explicit references to the PHN service including a short vignette illustrating the potential role of the PHN. Other references to the public health nursing service relate to the entitlement of all children to certain services including child development checks. The authors of this implementation plan highlight the important role played by PHNs in identifying children who suffer
from chronic neglect and they noted, that these children often have unmet medical and developmental needs.

**Key issues for PHNs in this report**

*Prevention and early intervention:* The implementation plan reiterates the importance of prevention and early intervention services in order to avoid situations reaching crisis point and, having positioned the Public Health Nursing service at level 1 and 2 of the Hardiker Model, it is clear this service has a pivotal role to play.

*Leadership and accountability:* The plan drew attention to the need for leadership and accountability in child protection services and noted that it is the responsibility of senior managers to:

- set standards for staff
- check if these standards are being met and
- deal effectively with instances where deficits are identified

*Equity of service provision:* The plan identifies high levels of difference in the allocation of professional staff, particularly Social Workers, across the country. This difference is also clear across Public Health Nursing services. There is an explicit recommendation about the need to ensure that those areas with the highest levels of need get the appropriate level of services.

*Staff retention and quality:* The plan acknowledges that front-line workers need knowledge and skills as well as personal attributes of resilience, courage and capacity to work in intense and conflicted situations. In recognition of that it noted that training, supervision and ongoing skills development should reflect the reality of front-line workers environment.

*Inter-agency and inter-professional working:* Several problems were identified in respect of interagency, inter-professional and interdepartmental working and it was recommended that professionals who have regular routine contact with children, in particular PHNs and teachers, should be supported in working together at an organisational and systemic level.
Corporate risk assessment and strategy: Recommendations were made for the development and implementation of a corporate risk strategy which would clearly articulate the areas of risk and the corporate response to preventing this risk arising.

Report of the Independent Child Death Review Group

This report presents the details of 196 children who died over the period 2000-10, from both of natural and unnatural causes. The children in the report were those who were in the care of the state at the time of their death, young adults who were in aftercare and other children who were not in care but were known to the HSE through the child protection services. The majority of these children died from unnatural causes (57%; n = 121) including accidents, suicide and unlawful killings.

The ICDRG reported that the problems faced by a number of these children began early in life and the Review Group particularly noted the adverse consequences posed by parental alcohol misuse. They found many of the children had been exposed from an early age to poor parenting, neglect, abuse and psychological trauma. Other issues that were emerged across a number of cases included mental illness, domestic violence and bereavement, all of which public health nurses may be in a unique position to identify at an early stage.

Common themes arising across many of these individual cases were identified and these included:

• Poor risk assessment
• Poor co-ordination between services
• Poor flows of information
• Limited access to specialist assessment and therapeutic services
• Limited interagency work for children and families with complex needs
• A lack of early intervention and family support services responding proportionately to the needs of children at risk and families in crisis.

The ICDRG identified indicators of good practice including, among others, good assessment; consistent care, good record keeping, regulations followed, staff and foster carers supported, interagency cooperation and follow up after the child's death. A summary of the common issues arising across all reports is presented in Table 1.

Table 1: Common issues arising across individual reports
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<tr>
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<th>The Monageer Inquiry</th>
<th>Roscommon Childcare Case</th>
<th>The Ryan Report and implementation plan</th>
<th>ICDRG</th>
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<td>Referral and access to services</td>
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<td>Record Keeping and information</td>
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<td>Coordination and communication</td>
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<td>Clear roles and responsibilities for individual professionals with a clear plan for interventions</td>
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<td>Voice of the child and others</td>
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<td>Management systems, leadership and accountability</td>
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**Discussion and conclusions**

Ireland is not unique in the publication of reports on failures of the statutory services to protect children and the Munro Report (Munroe, 2011) in the UK, for example, highlights many of the same issues presented in this paper. In Ireland, and elsewhere, when these reports are published, there is often a strong focus on the role of social workers to the exclusion of other professionals. As this review has demonstrated, however, the PHN service often plays a critical role with these families. This role must be clearly articulated, made explicit and developed in line with best practice in order to ensure children are protected.

Many reports presented here draw attention to carrying out comprehensive assessments, developing a clear plan of action and implementing appropriate interventions. A recognition of the indicators of poor attachment, taking account of the voice of children, listening to knowledgeable relatives or others, and intervening when difficulties are identified were all highlighted. This work must be supported,
however, and the Ryan Report Implementation Plan, in acknowledgement of the complexity of engaging with troubled families, clearly recommended that front-line workers, including PHNs, need to be supported in their basic and on-going knowledge and skills through training and supervision. While social workers are required to take part in supervision, however, this professional support is still not in place for PHNs. This raises issues for the service in terms of compliance with good practices and highlights the need for Continuous Professional Development (CPD). Legislation is currently being prepared to mandate nurses to undertake CPD and it is important that areas outlined in this review are included in this.

The findings from each of the reports point to the importance of early intervention when problems are identified and this was particularly the case in the IRDG report where many of the critical factors, including, mental health issues, alcohol and drug use, domestic violence and neglect had been there from an early stage in the child's life. Referral to other services was highlighted in the Monageer Inquiry even in situations where adequate or comprehensive services are known not to be in place. Referrals in such cases can be helpful in articulating the role and responsibilities of each professional involved with the family and allows each service, including the PHN service, to determine and be explicit about what it brings and cannot bring to the protection of children. A need for clarity around roles and responsibilities also emerged in the Roscommon case, where it was reported that despite many professionals entering the home, there were not clear outcomes established for each child in the family.

Concerns about PHN records were raised in both the Monageer Report and also the Roscommon Report and criticisms were made of the adequacy, contemporaneous nature and accuracy of these records. A failure to adhere to the protocols regarding the transfer of records when a family moves was considered a key issue in the Monageer Inquiry and the findings demonstrate the importance of ensuring that all children, but particularly those considered to have developmental or other challenges, are followed up when they move areas. The introduction by HIQA of national standards for the protection and welfare of children deals with this issue and provides excellent guidance on record keeping. These standards may be challenging
for busy service providers to meet, but the consequences of not meeting them are too grave to ignore.

A final issue raised here relates to the role of management in terms of providing leadership and managing risks so that front line workers are equipped to deal with troubled families. This includes ensuring supports are in place for on-going training and education, that workloads are equitably distributed, that nationally agreed records are in place, and, that communication and referral processes are clearly articulated. In essence, the role of management is to make it not just possible, but easy, for PHNs to do the right thing. Many important developments, including the utilisation of the Family Assessment Framework (O’Dwyer, 2012), can provide leadership in this area but these must be matched with appropriate resources. It is crucial that this is done so that the devastating consequences for children, families and indeed PHNs working on the front line are minimised.

Key points

1. This paper presents an analysis of recent child protection reports in Ireland as they relate to PHNs
2. The findings draw attention to the central role played by PHNs in child protection cases
3. Areas consistently emerging as problematic include: appropriate and comprehensive assessment, early intervention, record keeping, communication and multi-disciplinary working and the role of public health nursing management.
4. Key areas to be addressed at a system level including, access to supervision, continuous professional development, equitable workloads, nationally agreed records, and standardised communication and referral processes
5. This analysis clearly demonstrates a need for public health nursing leadership and accountability the area of child protection so that PHNs working in difficult and complex situations with troubled families can provide a professional and safe service.

References


