REVIEW OF CHILD ABUSE PROCEDURES IN THE EASTERN HEALTH BOARD

June 1994.

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TABLE OF CONTENTS:

SECTION A: BACKGROUND AND INCIDENCE

1. INTRODUCTION:

1.1 Following the publication of the Kilkenny Incest Investigation Report in May 1993, Mr. John Doyle, Programme Manager, Community Care requested that I review the child abuse procedures within the Eastern Health Board region.

The objectives of the review were:

i) to ascertain how child abuse cases are investigated in the ten community care areas,

ii) to make recommendations in relation to the standardisation of procedures within the Eastern Health Board, where appropriate,

iii) to disseminate information among the community care area teams.

1.2 A questionnaire was prepared and sent to each community care area. The questionnaire covered the following key areas:

(i) Referral system.

(ii) Child Abuse Notification Systems.

(iii) Investigation Process.

(iv) Child Sexual Abuse Referrals and liaison with the Sexual Abuse Assessment Units.

(v) Liaison systems with the gardai, General Practitioners, Psychiatric Services (Adult & Child), Schools (Primary & Secondary) and other relevant local agencies.

(vi) Case conferences.

(vii) Long-term management of cases of child abuse.

(viii) Child Abuse Registers.

2. CHILD ABUSE - STATISTICAL INFORMATION:

2.1 Each Social Work Manager submits statistical information in relation to child abuse referrals for the annual report of each community care area. In addition, the Department of Health has gathered statistical information for the entire country on child abuse referrals since 1982. The latest data available at national level, is for the year 1991. In that year 3,856 reports of alleged abuse were recorded.

2.2 There has been a considerable increase in the number of child abuse referrals to the Eastern Health Board since 1982 - See Table A.

Between 1982 and 1992 there has been a 602% increase in referrals of child abuse in Eastern Health Board region. Between the years 1982 and 1989, there was a 798% increase in referrals. There was a decrease in the number of referrals in 1990 and 1991 but the numbers increased again in 1992.

In relation to child sexual abuse, the percentage increase is more significant. Between 1983 and 1992 there was a 2814% increase in the number of referrals in relation to child sexual abuse.

2.3 According to McKeown, Gilligan et al, the increase in referrals of child sexual abuse cases was greater in the Eastern Health Board region than for the entire country in the period 1984-1989 in Ireland. Child sexual abuse referrals in Ireland increased by 1311% and they increased by 2,121% in Eastern Health Board region (1).

2.4 In reviewing this statistical data, it must be borne in mind that there is no uniform and agreed system of data collection and recording.

SECTION B: REVIEW OF CURENT CHILD ABUSE PROCEDURES IN EASTERN HEALTH BOARD

1. REFERRAL SYSTEM:

1.1 Areas examined under this section were:

i) Mode of referral.

ii) Source of referral.

iii) Anonymous referral.

iv) Initial response to referrals.

1.2 In all the Community Care Areas (CCAs) referrals are accepted by telephone, in person or in writing. All the Community Care Areas favour personal contact with members of the public who refer cases. Professional staff and agencies are expected, in general, to send written referrals (often as follow-up, to referral by telephone).

1.3 The sources of referrals are varied in all the areas. These include public health nurses, families and relatives, self-referrals, general practitioners, school and nurseries. In the majority of the Community Care Areas, self referrals and referrals from neighbours/relatives account for a high proportion. Another significant referral source is public health nurses. Referrals, overall, from general practitioners are considered to be relatively few, but tend to be more frequent in Community Care Areas 9 and 10.

1.4 The response to anonymous referrals varies. All areas strongly encourage the complainant to identify themselves and indicate clearly that the investigation could be hindered otherwise. The nature of the information determines the response from that Community Care team.

2. CHILD ABUSE NOTIFICATION SYSTEMS:

2.1 All the Community Care Areas designate referrals according to the categories specified in the Department of Health Child Abuse Guidelines 1987 i.e. physical abuse, sexual abuse, emotional abuse and severe neglect. Two Community Care Areas have prepared working definitions for these four categories, and a number of other areas are actively working on this issue.

2.2 The notification system varies from each community care area. In some areas there is no formal notification form - cases are notified by memorandum/letter. In other areas, there is a separate form for the social workers and for the public health nurses. The Director of Community Care & Medical Officer of Health and Social Work Managers are notified in all areas; the Supt. Public Health Nurse is notified in most areas. A number of Community Care Areas have devised their own notification form.

3. INVESTIGATION PROCESS:

3.1 In all the Community Care Areas, Social Workers play the key role in investigating cases of child abuse. In many cases, it is clearly identified as the responsibility of the social worker. A multidisciplinary approach is favoured, but in reality this appears to extend to the social worker and public health nurse working together when there are children under six years of age in the family.

If another agency is already involved with the family, it is often considered more appropriate that the agency would conduct the

investigation, while overall responsibility would be retained by Community Care. The reaction of agencies varies considerably, and their reluctance to become involved in many cases is viewed as detrimental to the investigation process and the welfare of the child and family.

3.2 There is considerable variation between the Community Care Areas in relation to the completion of medical examinations in cases of suspected physical abuse. See Table B.

Factors which contribute to this pattern include parental choice, the availability of Area Medical Officers, the nature of the injuries. In some cases following an initial medical examination by the Area Medical Officer the case will be referred to the hospital for further examination.

3.3 In all the areas, the sexual abuse assessment units arrange medical examination in cases of sexual abuse in the vast majority of cases, and this is the preferred choice of all the areas. Arrangements may have to be made with the Casualty Department of Children's Hospital in emergencies.

3.4 In cases involving failure of thrive/possible developmental delay the public health nurse and area medical officer have a key role in the investigation and management.

(d) The availability of services for sixteen and seventeen year olds in view of the implementation of the Child Care Act 1991. The units do not accept referrals from those aged sixteen plus.

(e) The accessibility of the St. Louise's Unit for families in Community Care Area 9 and 10.

In addition, area teams expressed concern that, increasingly, due to the size of the workload, they are not in a position to investigate cases of child sexual abuse to the extent that would be appropriate. There is also a belief that the legal system accords more credibility to reports from the specialised units.

5. LIAISON WITH GARDAI:

5.1 There is considerable variation in practice and views on this between community care areas and within community care teams. Some factors and trends can be extracted from the discussions with the teams. These include:

(a) Almost all confirmed cases involving child sexual abuse are notified to the gardai. In many instances this is done by St. Louise's and St. Clare's Unit. Some areas notify the gardai of suspected cases of child sexual abuse, where the index of suspicion is high.

(b) Reports of physical abuse are rarely notified to the gardai, and it appears that if notification takes place it is only in cases which have been confirmed.

(c) A community care area may have to work with a number of different garda divisions. In four community care areas, gardai have been designated in all or some of the divisions within those areas.

6.3 Four community care areas automatically ask general practitioners to attend case conferences. In all other areas, there are frequently or sometimes asked to attend. Their attendance rate at case conferences is quite low - other commitments e.g. surgery hours - are seen as the main hindrance to their attendance at case conferences. The expense that could be involved was also mentioned.

6.4 In general, general practitioners are viewed as an important source of information and a potentially valuable co-worker in cases of child abuse.

7. LIAISON WITH PSYCHIATRIC SERVICES - ADULT AND CHILD:

7.1 The perceived extent of notification to community care varies between the adult psychiatric services and the child psychiatric services and between community care areas. Many areas reported that notifications have increased in number from the psychiatric services, but a number of respondents queried whether all cases are notified as per the Child Abuse Guidelines; this was raised, in particular, in relation to the adult psychiatric services and their possible involvement with perpetrators.

7.2 Again, there is a considerably variation in the extent to which joint-working between the psychiatric and community care services is a feature in the management of cases. Joint working occurrs more frequently if the psychiatric services are run directly by the Eastern Health Board. Factors which facilitate this include the presence of Eastern Health Board social workers in these services and regular liaison meetings. Serious concerns were raised in relation to the difficulties associated with joint working with the child psychiatric services in a number of community care areas.

7.3 A number of general issues were raised by the community care teams. These include:

(i) Delays in obtaining forensic assessments.

(ii) The absence of services for adolescents.

(iii) Therapy vs. child sexual abuse investigation.

(iv) Accessibility and availability of child psychiatric services.

(v) The overall lack of services for troubled children and their families and the impact of this on personnel in both services, and the children/families.

9. CONTACT/LIAISON WITH OTHER KEY RELEVANT AGENCIES:

9.1 All the areas have contact with local agencies. There is a wide range of agencies involved, both statutory, and non-statutory. Issues raised by the Community Care Areas in relation to such contact were:

(i) Importance of regular meetings but the time and resources involved, in such meetings.

(ii) The need for agreed procedures between the agencies and Eastern Health Board in relation to the notification and intervention in child abuse cases.

(iii) Contact with locally based services was easier to develop and maintain.

(iv) Some agencies provide services for the entire Eastern Health Board region and liaison is more difficult to achieve e.g. CARI.

10. CASE CONFERENCES:

10.1 In six Community Care Areas, case conferences are convened by Directors of Community Care & Medical Officers of Health or Senior Area Medical Officers. In three community care areas, the case conferences are convened by the social work manager and in one area by the child abuse review group. In all areas, the social workers play a key role in initiating the process, and areas respond with flexibility to such requests. The frequency of case conferences varies from three/four per month to twelve per month.

10.2 Generally case conferences are convened following initial investigation of the case. However if there are serious and urgent child protection issues, a case conference could be convened at the initial stage.

10.6 Participation by gardai, teachers, general practitioners is covered under the relevant sections. The extent of parental participation varies - in some areas, parents do not attend; in other areas, parents attend for part of the case conference and in some instances parents attend the entire case conference. Generally voluntary workers are not invited to attend, but their concerns/comments will have been ascertained beforehand.

10.7 All areas strive to achieve a consensus at the case conference. However, all areas view that ultimate responsibility for the decision-making in relation to child protection rests with community care.

10.8 All the community care areas view case conferences as an opportunity to clarify the tasks and who is responsible. Some areas expressed concern about the concept of keyworker and there was a distinct preference for appointing "Link person/liaison person".

10.9 The rooms in which case conferences are held vary considerably ranging from totally inadequate to good. The absence of reception/waiting room facilities was noted in all areas.

11. LONG-TERM MANAGEMENT/OUTCOME OF CASES:

11.1 A high proportion of cases of child abuse require ongoing treatment and management. Community care teams, and in particular the social workers, are involved in this work, which can be difficult and time consuming. It was stated that this aspect of the work is not given due recognition and emphasis, and that to date, resources have focused primarily on the investigation of cases of child abuse.

11.2 All community care areas avail of a range of services for the victims, families and perpetrators. All areas reported a severe shortage of appropriate services. Treatment needs are identified, but often cannot be implemented due to the lack of resources. Waiting lists for services such as child guidance can be up to six months. Services are viewed as disjointed, fragmented and often inaccessible.

Community care teams favour the provision of a range of locally based, integrated services which would include child guidance, family centres, nurseries, neighbourhood youth projects.

Services for perpetrators are limited. The Northside Treatment Project for male adolescent perpetrators, the forensic services in Central Mental Hospital/Usher's Island and Psychology Service in Baggot Street (Fred Lowe, Senior Psychologist) appear to be the main services available for perpetrators.

11.3 Although no precise statistics were readily available in relation to the number of cases which would result in civil proceedings, it was felt that the percentage was quite low. Neglect rather than any other cause

13. CHILD ABUSE REVIEW GROUP:

13.1 In seven community care areas, there are regular meetings of the child abuse review group. The membership consists of Director of Community Care, Social Work Managers, Senior Area Medical Officer and Supt. Public Health Nurse. In general the meetings are held on a monthly basis. In six of those areas, the focus would be on individual cases, based on notifications received during the last month and reviews of particular cases. Policy issues could also be raised. In one area the primary focus is on policy issues. One community care area plans to establish a child abuse review group. In two community care areas, the Director of Community Care (or Senior Area Medical Officer) and Social Work Manager meet regularly to review cases.

13.2 The areas view such a forum as valuable. Lists of cases are circulated beforehand and the meetings facilitate the exchange of information among and between disciplines. Some areas favour widening the group membership to include, for example, gardai and child guidance, to discuss policy issues at specified, perhaps three monthly meetings.

14. CHILD ABUSE STATISTICS : DATA COLLECTION AND RECORDING:

14.1 In seven community care areas, the Social Work Manager is responsible for collecting and submitting the annual child abuse statistics for both the Department of Health and Eastern Health Board. In the other three areas, the Director of Community Care/Senior Area Medical Officer and Social Work Manager jointly collect the data. Respondents referred to the lack of uniformity in data collection and recording between community care areas. The variation in the format between Department of Health and Eastern Health Board is deemed to

15.1.5 The health and safety implications for workers in this area.

15.1.6 The need for supervision and support of staff.

15.1.7 The lack of preventative and family support services.

15.2 Notwithstanding the volume of work, areas have introduced developments in practice, prepared local area protocols, initiated research and conducted training programmes. There are no systems to facilitate the sharing of these skills and knowledge and maximum value is not realised across the Eastern Health Board.

15.3 The Department of Health child abuse guidelines are circulated, generally, to new staff by the relevant head of discipline. There are no formalised systems in place for the circulation of the guidelines to outside agencies e.g. hospitals, general practitioners, schools.

SECTION C: DISCUSSION AND RECOMMENDATIONS

The Department of Health issued the current Child Abuse Guidelines in 1987. Since then, our awareness, knowledge and skills in working in this area have increased. This review describes how services have developed in reality during the last seven years. All the community care areas have developed their practice in line with the Child Abuse Guidelines; however each area has also developed its own style and mode of operation. Flexibility and responsiveness to local circumstances are necessary and inevitable. However this review has highlighted the need for (1) standardisation on a number of issues, (2) the prepartion of a protocol on the investigation and management of child abuse cases within Eastern Health Board which would provide more comprehensive information and guidleines for Eastern Health Board personnel and relevant agencies within the region. Procedures, per se, do not guarantee good practice and many practitioners in the field would be reluctant to work in a system which totally relied on detailed procedures and check-lists, to the virtual exclusion of clinical judgement and skills development. A number of the community care areas have proposed local protocols for team members, or are in the process of preparing these, (this work was "put on hold" in anticipation of this report), as it is evident that further guidance for personnel is required.

A number of specific recommendation arise from this review.

1. <u>REFERRAL SYSTEM:</u>

1.1 The response to anonymous complaints varies, to some extent, between community care areas. The Child Abuse Guidelines state that all reports of child abuse (including anonymous calls) should be investigated (3.1 Guidelines). The distress that a malicious complaint

Physical abuse: physical injury to a child, including deliberate poisoning, where there is definite knowledge or a reasonable suspicion, that the injury was inflicted or knowingly not prevented.

Sexual abuse: the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles.

Emotional abuse: the severe adverse effects on the behaviour and emotional development of a child caused by persistent or severe emotional ill-treatment or rejection. All abuse involves some emotional ill-treatment - this category should be used where it is the main or sole form of abuse.

Neglect: the persistent or severe neglect of a child (for example, by exposure to any kind of danger, including cold and starvation) which results in serious impairment of the child's health or development, including non-organic failure to thrive" (2).

It is recommended that these definitions, or amended, if appropriate, should be adopted by the Eastern Health Board.

2.4 A number of respondents mentioned ongoing concerns about certain vulnerable families and whether these should be included, as a category of child abuse. "Working Together" includes a category called grave concern i.e. children whose situations do not currently fit the above categories, (physical, sexual, emotional, neglect) but where social and medical assessments indicate that they are at significant risk of abuse. These could include situations where another child in the household has been harmed or the household contains a known abuser. (3)

family is known to the public health nurse. Generally the area medical officer becomes involved in the investigation upon a specific request from the social worker or public health nurse.

3.3 The guidelines advise that the worker concerned should report and consult with their supervisor and/or Director of Community Care. This is often not feasible for social workers, who may be faced with an urgent serious situation, which requires an immediate response.

3.4 Problems also arise when another agency is working with the family, but will not actively participate in the investigation of the alleged abuse.

3.5 Inter-professional and inter-agency co-operation and collaboration have been identified as key factors in effective child protection systems. Such collaboration enables sevices to be delivered to families in an integrated manner, increases understanding of the nature of the problem and provides group support. There is also a general consensus that working together is difficult and not easily achieved. Issues that mulitate against effective co-working include different professional perspectives, different agency priorities, the relative status and perceived power of the parties, and the absence of resources to facilitate collaborative work.

3.6 **It is recommended that the following initiatives be adopted to ensure comprehensive investigation and assessment of child abuse referrals:**

(a) Written guidelines on the assessment of risk, family functioning, family supports, etc. Particular attention should

5.3 From the review, it is clear that there is no overall agreed policy in relation to the notification of cases by either the Eastern Health Board or the garda authorities. Some unease and ambivalence was also expressed about the involvement of gardai, although contact between both agencies has increased. The Child Sexual Abuse Assessment Units notify the gardai directly of confirmed cases of sexual abuse.

5.4 Discussions have been ongoing for sometime between the Department of Health and the Garda Siochana in relation to the preparation of a procedure for the notification of <u>suspected</u> cases of child abuse between Health Boards and Gardai. Such a procedure is being piloted in a number of health boards at present; within Eastern Health Board Community Care Areas 2 and 8 are involved. The Minister has indicated that it is intended to introduce an agreed notification system by the end of 1994.

5.5 **In the meantime, it is recommended that each Community Care Area should have discussions with their relevant chief superintendents. Experience has shown that where a number of gardai have been designated as contact persons there is a greater degree of understanding and co-operation. This should be set up for each Community Care Area.**

5.6 However, a formal notification system will not automatically lead to good working relationships - "there must first be mutual recognition, understanding and acceptance of each other's roles". (4) Local meetings and opportunities for joint training will enhance the co-operation between health board personnel and the gardai.

7. PSYCHIATRIC SERVICES:

7.1 Contact and involvement with the psychiatric services varies between community care areas. Factors, that influence the extent of agency collaboration include adult vs. child psychiatric services, Eastern Health Board vs. other agencies. Issues that have arisen concern the reporting of cases of child abuse to community care and the involvement of the child psychiatric services in the investigation and management of child abuse cases.

7.2 **It is recommended, that consultations take place at senior management level between the Community Care Programme and the Special Hospital Care Programme to address these issues, initially. Further meetings can then be arranged at area level once agreement has been reached on policies which will guarantee effective working relationships.**

8. SCHOOLS:

8.1 From the review, it is apparent that there is a greater degree of contact between Community Care Area personnel and primary school teachers. Apart from the direct contact in relation to a specific case, the opportunities for meeting as a result of school medical examinations and the Child Abuse Prevention Programme have enhanced the working relationships. The employment of Home School Liaison Teachers in some areas has facilitated communication also. All are in agreement that teachers are a most valuable source of support and information.

have had a significant effect on the way a case was handled, but was not held at all, or was ineffective for one reason or another". (6)

10.2 **It is recommended that a policy document be prepared in relation to all aspects of case conferences. This should include:**

(a) reasons for calling/not calling a case conference.

(b) the organisation of case conferences.

(c) the chairing of case conferences.

(d) the availability of written reports.

(e) minute taking.

(f) attendance and participation at case conferences.

(g) decision-making process.

(h) preparation of case plan amd review.

10.3 **Effective case conferences will require additional resources e.g. waiting rooms, case conference rooms, secretarial supports and training.**

11. LONG-TERM MANAGEMENT OF CASES:

11.1 The Child Abuse Guidelines refer briefly to the long-term management of cases (4.18). It was frequently expressed while completing the review, that the provision of services for the management of child abuse services is inadequate and fragmented.

11.2 In the study on child sexual abuse cases in Eastern Health Board conducted by McKeown, Gilligan et al in 1988, it is reported that further intervention for the child was recommended in 65% of all cases (641 cases) and in 84% of confirmed abuse cases (432 cases).

12.4 Child Abuse Registers are seen to fulfill the following functions:

(a) to provide information about children already known or suspected to have been abused.

(b) to aid diagnosis of a sequence of repeated injuries/events which might otherwise not be identified as a pattern of abuse.

(c) to promote co-ordination and communication.

(d) to provide a format for regular monitoring/reviewing of cases.

(e) to provide statistical data for planning purposes.

12.5 Many questions have arisen about their operation and effectiveness. For example should parental names be recorded rather than the child's name as family composition can change; should the names of perpetrators be recorded? Research conducted on the use of child abuse registers in UK has highlighted wide variation in registration criteria, civil liberties concerns, issues of reliability and accuracy.

12.6 The establishment of formal child abuse registers was not favoured by the respondents. All acknowledged the need to centralise information, especially in working with transient families.

12.7 **It is recommended that procedures be agreed in relation to the maintenance of lists in the Community Care Areas. The computerisation of social work records is planned (pilot to commence in Community Care Area 9 later this year). It is recommended that child abuse registers should not be set up until the Social Work Information System (SWIS) is reviewed, as that system could fulfill many if not all the function of a child abuse register.**

SECTION D: ACTION PLAN

1.1 Four key areas should be now addressed:

1.1.1 The prepartion of a protocol for Eastern Health Board staff which will outline the philosophy and principles of the child protection services and will encompass the recommendations referred to in Section C.

1.1.2 The introduction of a comprehensive training programme for all staff within the Eastern Health Board working in the area of child abuse and the promotion of joint training schemes with General Practitioners, Gardai, Psychiatric Services and Schools. A number of Eastern Health Board personnel have completed the Advanced Diploma in Child Protection. The training programme should utilise the knowledge/skills obtained from this course.

There are a number of relevant and highly regarded publications and journals on the subject of child abuse. These should be available in each Community Care Area.

1.1.3 The provision of consultation and supervision for all those working in child abuse. The professional literature and inquiry reports emphasise the importance of supervision for all practitioners in child protection. The task is complex, is frought with emotion and stress. Critical analysis and objective judgement is essential. This can be provided through regular and professional supervision. "Searching but

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8. McKeown, Kieran; Gilligan, Robbie; op cit. p.p. xxxix and 151/2.

9. Kilkenny Incest Investigation op cit. p.99.

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APPENDIX A

July 1993.

CHILD ABUSE PROCEDURES - A REVIEW
Eastern Health Board

It is intended that the review will cover the operation of the Department of Health Child Abuse Guidelines 1987 in each Community Care Area and any other relevant local protocols/procedures. Due to time and work constraints it is not feasible to examine the actual management and processing of individual cases.

Information is sought from each Community Care Area on the following:

1. *Referral System:*
   - (i) Mode of referral.
   - (ii) Source of referral.
   - (iii) Policy regarding anonymous referrals.
   - (iv) How decisions are taken on the appropriate response to the referral.

2. *Child Abuse Notification Systems:*
   - (i) Definitions of child abuse.
   - (ii) Notification system/forms, e.g. who completes such forms; to whom are they submitted.

3. *Investigation Process:*
   - (i) How is it initiated?
   - (ii) Who investigates child abuse cases, in general?
   - (iii) In cases of physical abuse, who completes the medical examination of the child?
   - (iv) In cases of sexual abuse, who completes the medical examination of the child?

4. *Referrals to child sexual abuse units - St. Louises/St. Claires:*
   - (i) Who makes the referral?
   - (ii) When are such referrals made?
   - (iii) Length of waiting list/provision for emergency appointments.
   - (iv) Any other comments about contact/liaison with these units.

5. *Contact with Gardai:*
   - (i) When and how are referrals made by your area to the local gardai?
   - (ii) Response of Gardai - e.g. designation of selected Gardai for such cases.
   - (iii) Procedures/systems for joint - working in cases of child abuse.
   - (iv) When and how are referrals made by Gardai to the Director of Community Care.
   - (v) Any other comments about contact with Gardai.

14. *Department of Health Child Abuse Statistics.*
    (i) Who prepares/submits annual child abuse statistics?
    (ii) How figures are collated for Department of Health returns i.e. who is included?
    (iii) Any comments about these.
    (iv) Child Abuse Statistics 1992.

15. *General Issues:*
    (i) Training in child abuse.
    (ii) Local area protocols in child abuse.
    (iii) Circulation of child abuse guidelines (Department of Health).
    (iv) Research projects in your area.
    (v) Developments in practice.
    (vi) Key ongoing difficulties in relation to the management of child abuse cases.

Brid Clarke.
27th July, 1993.

APPENDIX B

Child Abuse Input Document

Name of Child : _____ Address : _____

Date of Birth/Age : _____ _____

Date of CA notification : _____ _____

Abuse category code(s) (1) : ____ ____ ____ ____

Referred by : _____ Ref. Address : _____

Relationship of referrer (2): _____ _____

Referrers Phone : _____ _____

Family Composition

Father : _____ Date of Birth : _____ Occupation (3) : ____ MS(4) : ___

Mother : _____ Date of Birth : _____ Occupation (3) : ____ MS(4) : ___

Other Family Members

			(5)				(5)
Name: _____	Sex: __	DOB: _____	Type: ___	Name: _____	Sex: __	DOB: _____	Type: ___
Name: _____	Sex: __	DOB: _____	Type: ___	Name: _____	Sex: __	DOB: _____	Type: ___
Name: _____	Sex: __	DOB: _____	Type: ___	Name: _____	Sex: __	DOB: _____	Type: ___

Other Personnel Involved

Teacher/School : _____ Hospital(s) : _____ Gardai : _____

PHN : _____ S.W. : _____ GP : _____

Other : _____

Referral Reason : _____

Action Taken : _____ Date : _____

Signed :	Title :	Date :

Previous Notification : Y ☐ N ☐ Date of case conference : _____ Date gardai notified : _____

Date DCC notified : _____ Care no. if in care as a result of abuse : _____

Outcome of investigation code (6) : _____ Date of Outcome : _____ Criminal Proceedings : Y ☐ N ☐

Civil Proceedings code(s) (7) : _____ _____ _____ Closed : Y ☐ N ☐ Date Closed : _____

Final Outcome : _____

Signed :	Title :	Date :

CA no. :	Referral no.:	Member no. :

Code Tables

1. Abuse Category

1=Neglect
2=Physical Abuse
3=Sexual Abuse - Intra Familial
4=Sexual Abuse - Extra Familial
5=Emotional Abuse

2. Relationship of referrer (CA)

1=Mother;
2=Father;
3=Putative Father;
4=Son;
5=Daughter
6=Guardian;
7=Adult;
8=Sibling;
9=Half Sibling;
10=Aunt;
11=Uncle;
12=Mat. Grandmother
13=Mat. Grandfather;
14=Pat. Grandmother;
15=Pat. Grandfather;
16=Co-Habitee;
17=PHN;
18=GP;
19= Teacher;
20= Other Care Worker

3. Occupation

1=Professional
2=Trade
3=Manual
4=Farmer
5=Army
6=Unemployed
7=Unknown
8=Other

4. MS - Marital Status

1=Single
2=Married
3=Widow
4=Widower
5=Separated
6=Divorced
7=Other

5. Type

1=Mother;
2=Father;
3=Putative Father;
4=Son;
5=Daughter
6=Guardian;
7=Adult;
8=Sibling;
9=Half Sibling;
10=Aunt;
11=Uncle;
12=Mat. Grandmother;
13=Mat. Grandfather;
14=Pat. Grandmother;
15=Pat. Grandfather;
16=Boyfriend of sibling;
17=Girlfriend of sibling;
18=Co-Habitee;
19=Child adopted out

6. Outcome of Investigation

1=Confirmed
2=Unconfirmed - Case closed
3=Unconfirmed - Still under investigation
4=Unfounded

7. Civil proceedings Type

1=POS
2=FPO
3=Ward
4=Custody
5=Protection Order
6=Barring Order
7=Guardianship
8=Custody & Abduction Act
9=Other

6. *General Practitioners:*
   (i) Notification of cases by General Practitioners.
   (ii) Notification of cases to General Practitioners.
   (iii) The extent of involvement of General Practitioner's in child abuse cases.

7. *Psychiatric Services - Adult and Child:*
   (i) Notification of cases by the psychiatric services to the Director of Community Care.
   (ii) Joint working - Community Care and Psychiatric Services.
   (iii) Comments about contact with psychiatric services.

8. *Schools - Primary and Secondary Level:*
   (i) Notification of cases by schools.
   (ii) Impact of "Stay Safe" Programmes.
   (iii) Contact with schools - comments.

9. *Contact/Liaison with other relevant key agencies in your area:*
   (i) Details of any specific arrangements/agreements.

10. *Case Conferences:*
   (i) Who convenes case conferences?
   (ii) When and why are these convened?
   (iii) Format of case conferences e.g. chairing, secretary, agenda, attendance, prior circulation of reports, etc.
   (iv) Decision - making process.
   (v) Nomination of key worker.
   (vii) Facilities for case conferences e.g. meeting room, waiting area, etc.

11. *Long Term Management/Outcome of Cases:*
   (i) Community Care involvement in long term management of cases.
   (ii) Availablity of services - for victim, families, perpetrator.
   (iii) Legal proceedings.
   In 1992 what % of reported cases of child abuse resulted in civil proceedings under the child care or family law provisions?
   In 1992 what % of reported cases of child abuse resulted in criminal proceedings?

12. *Child Abuse Registers:*
   (i) Status/Designation of "Register".
   (ii) Who is responsible for the maintenance of the "Register:.
   (iii) What procedures govern the recording of data; the disclosure of information; the removal of data from the "Register".

13. *Child Abuse Review Group:*
   (i) Is there a child abuse review group in your area?
   (ii) Composition of child abuse review group; purpose of group; schedule of meetings, etc.

ACKNOWLEDGEMENTS:

I wish to thank all the people I met in the Community Care Areas for their co-operation, information and valuable time. Their knowledge, experience and expertise is incorporated in this report.

A special word of appreciation to Carmel McLoughlin who had the unenviable task of deciphering my writing and typing this report.

supported supervision is vital to achieving the necessary degree of objectivity in case management and also to the maintenance of staff morale in such difficult work". (10)

1.1.4 The Child Abuse Guidelines have been in operation for seven years. This review is the first overview of the operation of the guidelines in the Eastern Health Board. Individual Community Care Areas have and are reviewing their procedures and practices. Ongoing evaluation of guidelines and protocols is necessary. Research on methods of intervention and management should also initiated.

Brid Clarke,
Head Social Worker.

June 1994.

13. CHILD ABUSE REVIEW GROUP:

13.1 It is recommended that a child abuse review group consisting of Director of Community Care/Medical Officer of Health, (or deputy) Social Work Managers and Supt. Public Health Nurse be established in each Community Care Area. This review group should meet on a monthly basis to review cases notified in the previous month, cases requiring follow-up or attention and policy issues.

14. CHILD ABUSE STATISTICS:

14.1 It is recommended that a uniform system of data collection and recording be introduced for Eastern Health Board Community Care annual reports. Discussions should also take place with Department of Health regarding the national system of data collection on child abuse.

15. GENERAL ISSUES:

15.1 It is recommended that arrangements are put in place to ensure that the Child Abuse Guidelines are circulated on a regular basis to the agencies listed in Section 8 of the Guidelines. A monitoring system should be introduced to ensure that the guidelines have been made available to all key personnel and agencies.

Intervention were not carried out in 27% of cases - of these, the lack of services was the stated reason in 12% of cases. (7)

11.3 Social workers are most frequently and intensively involved in the long-term management of child abuse cases. Public health nurses are also involved in families with young children.

11.4 This review did not focus on the long-term management and outcome of cases. Each Community Care Area has identified deficits in service provision. Current service developments may address some of the short fall in service. **It is recommended each Community Care Area prepare a report on service needs in relation to the long-term management and treatment of child abuse cases. Research should also be initiated on the outcome and effectiveness of interventions.**

12. CHILD ABUSE REGISTERS:

12.1 The Child Abuse Guidelines refer to the recording of information on child abuse cases and the maintenance of lists of suspected and confirmed cases of child abuse. (5.1 Guidelines).

12.2 The Report on the Kilkenny Incest Investiagion recommended that computerised child abuse registers be set up in each Community Care Area. (8)

12.3 The Law Reform Commission Report on Child Sexual Abuse stated that certain safeguards should be incorporated into any system of listing. They include - defined system of classification; disclosure of information about entries to parents/guardians; system for removal of names and regular reviews of the data recorded. (9)

8.2 Contact with second level schools is less frequent, and is more likely to involve the guidance counsellor rather than individual teachers.

8.3 Although the Department of Education issued guidelines dealing with allegations or suspicions of child abuse to primary schools in 1991 and to second level schools in 1992 these were not distributed officially to the Community Care Areas, and have not been seen in many access.

8.4 It is recommended that:

(a) the Department of Education Guidelines be made available in each Community Care area.

(b) Ongoing contact and liaison between local schools and community care area personnel be promoted. Ideally, if resouces permitted, the assignment of a social worker to schools would be a positive and beneficial development.

9. LIAISON WITH LOCAL KEY AGENCIES:

9.1 **It is recommended that local Community Care Areas commence discussions with key agencies in relation to child abuse, with a view to agreeing joint protocols.**

10. CASE CONFERENCE:

10.1 The Child Abuse Guidelines emphasise the importance of case conferences in the management of child abuse (see sections 3.3 and 4.17). The Report on Kilkenny Incest Investigation states that the "case conference has a pivotol role as a method of interdisciplinary contact, analysis and decision-making" (5). The D.H.S.S. Summary of Inquiry Reports states, "All the inquiry reports either implicitly or more often explicitly highlight critical occasions when a case conference could

6. GENERAL PRACTITIONERS:

6.1 The role of general practitioners is outlined in Section 4.12 of the Child Abuse Guidelines. It is also expected that general practitioners would be kept informed of developments in their cases by Director of Community Care/Medical Officer of Health.

6.2 From the review, it is clear that the level of contact and active involvement of General Practitioner varies. All the community care areas indicated that General Practitioners could be valuable members of the multidisciplinary team. However their employment as private contractors, outside the community care team has limited the development of their role in the management of child abuse.

6.3 It is recommended that:

(a) **contact should be made with the family's general practitioner (where known) in cases of suspected and confirmed child abuse.**

(b) **General practitioners should be invited to attend case conferences and the minutes should be sent to them if they are unable to attend.**

(c) **Joint open/training days should be arranged in each Community Care Area for general practitioners. The Irish College of General Practitioners is a valuable forum for such contact.**

focus on the assessment of families who can be in a state of "turbulence"/frequent crisis. (There are numous relevant publications available for guidance).

(b) **Multi-disciplinary meetings within Eastern Health Board community care teams and inter-agency meetings to clarify roles and responsibilities in relation to child abuse.**

(c) **Joint training on child abuse.**

4. <u>LIAISON WITH ST. LOUISE'S/ST. CLAIRE'S UNITS:</u>

4.1 The review highlights a number of issues concerning the liaison between the Eastern Health Board and the Sexual Abuse Assessment Units. **The availability of sexual abuse assessment services for sixteen and seventeen year olds requires immediate attention.**

5. <u>GARDAI:</u>

5.1 The Child Abuse Guidelines refer to the child care and possible legal/criminal implications of cases of child abuse and close co-operation between health boards and gardai is recommended. (Section 3.2 Guidelines). The Guidelines, in relation to child sexual abuse, state that "where there are reasonable grounds for suspecting child sexual abuse, the Director of Community Care/Medical Officer of Health should report the matter to the gardai" (6.2.1).

5.2 The Kilkenny Incest Investigation Report recommends that all allegations of child abuse should be notified to the Garda Superintendent by the Director of Community Care/Medical Officer of Health. (3)

Other agencies use the category "at risk" or "potential abuse". **A more specific definition would be required to avoid over-usage if such a category is included.**

2.5 All the community care areas have devised their own notification form and in some areas, different forms are used by the social workers and public health nurses.

2.6 **It is recommended that a standardised child abuse notification form be introduced for the Eastern Health Board which would be completed by whoever, within the Eastern Health Board, received the referral.** The carbon form should be printed in quadruplicate - the original for the staff member completing the form, a copy to the Director of Community Care, Head/Senior Social Worker and Supt. Public Health Nurse.

2.7 **It is recommended that the attached form, which has been used in one community care area and has now been adapted for the proposed social work information system be introducted.** (See Appendix B).

3. <u>INVESTIGATION PROCESS:</u>

3.1 Sections 4.1 to 4.11 of the Child Abuse Guidelines outline the action to be taken by a social worker and/or public health nurse following a referral of a child abuse case.

3.2 Personnel in the community care areas follow broadly the guidelines. In practice, social workers are mainly responsible for the investigation of child abuse cases; such investigations may be completed with the public health nurse if there are children aged six or under and the

can cause to a family was emphasised; yet undoubtedly some anonymous complaints can be genuine and serious.

1.2 **It is recommended that specific guidelines be drawn up in relation to the investigation of anonymous complaints.** (These would be included in the recommended protocol for Eastern Health Board - see section D). These guidelines would cover:

(a) appropriate methods of investigation, depending on the nature of the complaint.

(b) written procedures to deal with cases of persistent (but unfounded) anonymous complaints about a family e.g. when and how it is decided that such complaints will not, in future, be investigated.

(c) clear system of recording the outcome of the investigation.

2. CHILD ABUSE NOTIFICATION SYSTEMS:

2.1 Although all the community care areas categorise child abuse as physical, sexual, emotional and neglect, the absence of definitions leads to a wide variation in the notification of child abuse within each community care area and between each area.

2.2 Definitions of child abuse cannot be precise and absolute and are inevitably subject to subjectivity and cultural norms. Borderline cases will always arise. Investigation of a child abuse case can have very serious and far-reaching implications for a child and family. Written, working definitions of abuse contribute to the creation of an objective and accountable system of investigation.

2.3 DHSS guideline "Working Together" defines child abuse as follows:

be unhelpful and confusing. More feedback and analysis of the data would be viewed positively.

14.2 Trends in cases of child abuse vary annually and between community care areas. Some have seen an increase in cases of child sexual abuse; others have noted an increase in cases of neglect and physical abuse. There is a perception that emotional abuse is under-reported.

15. GENERAL ISSUES:

15.1 This section was included to give respondents an opportunity to highlight service developments and particular issues not covered elsewhere. A summary of the key points is as follows:

15.1.1 The absence of a formalised, multidisciplinary, continuous training programme covering child abuse. Subjects which should be covered include familiarisation with guidelines/protocols, interviewing skills, assessment skills, treatment skills, report writing, chairing case conferences. Interagency training especially with gardai, teachers and general practitioners is also favoured.

15.1.2 The availability of relevant publications and literature on child abuse in each community care area headquarters.

15.1.3 The increase in the number and complexity of child abuse cases, without a corresponding increase in resources.

15.1.4 The absence of facilities such as interview rooms, waiting rooms for families, case conference rooms, secretarial supports and facilities.

was the most frequent reason for care proceedings. Child sexual abuse was seen rarely as the sole cause of care proceedings. The current limitations on the use of barring orders is viewed as detrimental to the child's welfare. None of the community care areas receive regular and comprehensive data from the police in relation to criminal proceedings in child abuse cases.

12. CHILD ABUSE REGISTERS:

12.1 None of the community care areas maintain an official register of cases of child abuse. All areas have a "list/book" which contains a variable amount of information. The information is based on the data extracted from notifications of child abuse. These "lists" are maintained by the Directors of Community Care and Social Work manager or the Social Work Manager only. The relevant parties are not informed of these lists - they are viewed as part of the agency's recording system. A number of areas raised the issue of recording details of perpetrators.

12.2 None of the areas favour the establishment of formal registers of child abuse cases. The value and usefulness of such registers was queried - in particular how the maintenance of registers would assist in the protection the child. Registers were viewed as costly, and could absorb scarce resources.

All areas favour the development of a centralised, accessible, computerised data system which would facilitate the exchange of information. Such a system would be particularly useful in following up transient families. The advantages of linking with hospital and general practitioner data systems was also mentioned.

Case conferences are convened for the following reasons in all the community care areas:

(a) to share and assess information.

(b) to co-ordinate and clarify responses and roles.

(c) to facilitate planning and future intervention.

Case conferences are viewed as of being particular benefit when a number of agencies are involved.

Most community care areas do not record why a case conference is not being convened on a particular case; each area has their own criteria/guidelines for making that decision.

10.3 In some areas, the Director of Community Care or Senior Area Medical Officer chairs case conferences. In two areas, this task is shared between Director of Community Care/Senior Area Medical Officer and Social Work Manager. In one area, the majority of case conferences are chaired by a social work manager.

10.4 Minute taking is an ongoing issue in seven community care areas. Three community care areas have a designated secretary for case conferences.

10.5 All areas request that written reports are submitted prior to or at the case conference. Some outside agencies decline to submit reports beforehand, and cite confidentiality as the reason. Pressure of work and the shortage of secretarial services prevent health board staff in many instances from adhering to this policy.

(vi) Liaison with agencies providing services for the mentally handicapped.

8. LIAISON WITH SCHOOLS - PRIMARY AND SECONDARY LEVEL:

8.1 All areas reported an increase in the number of notifications from schools - typical comment "more and more appropriately". Some areas reported a certain hesitation or reluctance to report and teachers have stated that they fear litigation. Also in a few instances, teachers have requested anonymity.

8.2 It is thought that there may have been an increase in disclosures as a result of the "Stay Safe" programmes. All areas recommended that the C.A.P.P. should be evaluated. The contact between the social workers and the schools, which is part of the C.A.P.P., was seen as one of the most positive outcomes of the C.A.P.P.

8.3 All areas reported that teachers attend case conferences, and that the teachers welcome this involvement. Teachers are viewed as a "hugely important resource", a significant person to the child.

There is a greater degree of contact with schools at primary level due to visits from public health nurses and area medical officers. This contact and familiarity is absent at second level.

8.4 Some of the Community Care Areas had seen the child abuse guidelines issued by the Department of Education; these however were provided on an informal basis.

(d) Joint working between gardai and Eastern Health Board personnel is rare; some areas recalled a few instances of joint-interviewing. Gardai accompany the social workers when children are being reomoved from care when required. Gardai, increasingly, are being asked to attend case conferences and their response to such requests is seen as positive.

(e) The gardai rarely refer cases to community care.

5.2 In general, the areas reported that there is a growing degree of co-operation between the gardai and Eastern Health Board personnel and it was stated that contact is now initiated by the Eastern Health Board "sooner rather than later". The difference in the role and perception of the gardai in urban and rural areas is seen as a significant factor. Contact at local level is viewed as being crucial; however it can be difficult to contact gardai who work a shift system and do not have a co-ordinated information system. Concern was also expressed about the lack of feedback from the gardai in relation to the prosecution of cases.

6. LIAISON WITH GENERAL PRACTITIONERS

6.1 In general, general practitioners rarely refer cases of child abuse to the Eastern Health Board. In cases of child sexual abuse, general practitioners tend to refer to St. Louise's/St. Claire's more frequently than to the Director of Community Care & Medical Officer of Health.

6.2 Not all cases of child abuse are notified to the general practitioners by the Health Board. Contact is more frequently initiated by the Eastern Health Board rather than the general practitioner. The Public Health Nurses are more frequently in contact with general practitioners.

4. LIAISON WITH SEXUAL ABUSE ASSESSMENT UNITS:

St. Louise's Unit, Our Lady's Hospital, Crumlin - Southside

St. Clare's Unit, Temple Street Hospital - Northside.

4.1 If the referral to one of the above named units emanates from community care, the referral in all instances, is made by a social worker. General practitioners and families sometimes contact the units directly. All community care areas indicated that the units notify them of such referrals. All referrals are in writing.

4.2 Factors determining when the referral is made include the nature of the alleged abuse, and parental consent.

4.3 The waiting period of both units is in the region of six to eight weeks. In most instances, the units respond rapidly to emergency referrals. The waiting period can be a time of considerable stress and anxiety for the child and family. Concern was expressed about the delay in receiving reports from St. Louise's Unit.

4.4 Overall, the community care areas report a positive working relationship with the units, and all favour regular meetings with the units - at least two per annum. Issues that have arisen include;

(a) Referrals where there is an ongoing custody dispute, but there are child protection concerns also.

(b) The policy of the units in relation to the gardai.

(c) The units' policy regarding medical examination.

TABLE B - MEDICAL EXAMINATIONS IN CASES OF SUSPECTED PHYSICAL ABUSE

Community Care Area	1	2	3	4	5	6	7	8	9	10
Area Medical Officer	Most Frequently	Less Frequently	No Particular Preference	Most Frequently	Less Frequently	Rarely	Most Frequently	Most Frequently	Rarely	Rarely
General Practitioner	Rarely	Most Frequently		Less Frequently	Most Frequently	Less Frequently	Rarely	Less Frequently	Most Frequently	Most Frequently
Hospital	Rarely	Rarely		Less Frequently	Rarely	Most Frequently	Less Frequently	Less Frequently	Rarely	Rarely

In most instances, discreet enquiries are made initially within the Community Care team, and sometimes the public health nurse will call, without stating that a complaint has been received. In some instances, a direct and immediate approach to the family will be required.

All the teams referred to the difficulties in investigating anonymous complaints. Some of these have been malicious and have caused distress for the family concerned. Some of these have also been associated with cases involving custody/access disputes. One Community Care Area believes that there are legal limitations to the extent that such complaints can be followed up.

1.5 Initial Response following Receipt of Referral:

This varies depending on who receives the referral. Public health nurses discuss the referral with their supervisor (Senior/Supt. Public Health Nurse) and in most instances the case is referred to the social work team. If a social worker receives the referral, appropriate enquiries/checks are made, and ideally the social worker would consult with their supervisor (Team Leader, Senior Social Worker, Head Social Worker) and/or Director of Community Care. However, in many instances, the social worker will have to proceed with the case, without consultation. All areas emphasised the importance of proceeding with the investigation.

TABLE A - CHILD ABUSE REFERRALS IN EASTERN HEALTH BOARD 1982 - 1992

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
All Child Abuse Referrals	189	199	257	353	504	793	1,398	1,699	1,155	1,077	1,327
Child Sexual Abuse Referrals	Not Avail.	21	Est. 29	81	201	452	568	644	547	542	612

Sources: Department of Health
Eastern Health Board Annual Reports

(ix) Child Abuse Review Groups at community care level.

(x) Statistical data regarding child abuse.

(See questionnaire - Appendix A).

It was not intended that this review would examine the actual management and processing of individual cases.

1.3 Meetings were held in each community care area with the Director of Community Care & Medical Officer of Health, Supt. Public Health Nurse (and Senior Public Health Nurses in some areas) and Social Work Managers. These meetings took place between September and December 1993.