Report on the Inquiry into the Operation of Madonna House

DEPARTMENT
OF HEALTH
AN ROINN
SLÁINTE

May, 1996.

Report on the Inquiry into the Operation of Madonna House

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Madonna House — Background to Inquiry and Progress in Implementation of Recommendations

Appointment of Inquiry Team

1.1 In September, 1993, the then Minister for Health was informed by the Eastern Health Board that the Board, in co-operation with the Garda Síochána, was investigating allegations of sexual abuse and other misconduct made against a number of members of staff at Madonna House. Immediate action was taken to safeguard the welfare of the children who were residing in the home at that time.

1.2 The criminal investigation undertaken by the Garda Síochána subsequently resulted in a member of staff being convicted of various indecency offences and sentenced to three years' imprisonment.

1.3 In September, 1993, the Sisters of Charity, who were responsible for the operation of the home, and the Department of Health decided to appoint a team to carry out a review of the operation of Madonna House.

1.4 The following persons were appointed to the Inquiry Team:

Mr. Fred Donohoe (Chairman), former Programme Manager Community Care, Eastern Health Board,

Mr. Ger Crowley, Head Social Worker, Mid-Western Health Board,

Ms. Mary Gordon, Clinical Psychologist, North Eastern Health Board,

Dr. Mary Hynes, Director of Community Care and Medical Officer of Health, Eastern Health Board,

Sr. Mary Magdalen, Sisters of Charity.

1.5 The terms of reference of the Inquiry Team were:

"To review the operation of Madonna House in the light of allegations of misconduct made against certain members of staff"

Closure of Madonna House

1.6 On 31 May, 1994, the Sisters of Charity announced that Madonna House was to be phased out. The Eastern Health Board worked closely with the Sisters

of Charity to provide appropriate alternative accommodation for the children who were residing in the home. This process was completed in April, 1995, and Madonna House then closed.

Publication of Report

1.7 In October, 1994, a commitment was given to Dail Eireann that as much information as possible would be made available following the inquiry, consistent with protecting the identities of innocent parties and avoiding interference with ongoing legal proceedings.

Legal Advice

1.8 In March, 1995, a copy of the Report of the Inquiry Team was furnished to the Minister for Health by the Sisters of Charity. This was referred to the Office of the Attorney General for advice as to whether the Report could be published. The Office of the Attorney General advised that it could not be published in full because of the need to protect the identities of certain parties and to avoid interference with ongoing investigations and legal proceedings. The Office of the Attorney General further advised that a Barrister be commissioned to examine the report to determine what could be published without undue risk of legal complications.

1.9 The legal opinion received indicates that substantial parts of the report cannot be published without running a serious risk of committing grave contempt and defamation. A number of civil actions have been initiated against the Sisters of Charity and the Eastern Health Board by or on behalf of former residents of the home. Those actions claim damages against the defendants for assault, negligence and breach of duty. The advice indicates that it would be improper and unlawful to publish any material which prejudges issues arising for determination by the Courts in the pending proceedings.

New Garda Investigation

1.10 A new allegation of abuse of a child at Madonna House was made recently. This allegation is currently being investigated by the Garda Síochána, in co-operation with the Eastern Health Board.

Abridged Report

1.11 In accordance with the commitment given to Dail Eireann that as much as possible of the report be put into the public domain, an abridged report of the inquiry into the operation and management of Madonna House is contained in Part Two. This abridged report contains as much of the report prepared by the Inquiry Team as is legally possible to publish. Those segments of the report which, for legal reasons, cannot be published are indicated by the symbols ***. It is recognised that the deletion of those segments results in a disjointed report; however, this is unavoidable in the circumstances. Some minor modifications have

been made to the text of the abridged report in order to protect the identity of persons involved, particularly alleged victims of abuse.

Recommendations of Report

1.12 The Report of the Inquiry Team contains important recommendations for protecting the welfare of children in residential care and for improving standards in the sector generally. A number of important measures have already been taken which give effect to key recommendations of the Report and further initiatives are planned.

New Residential Care Regulations

1.13 The Child Care (Placement of Children in Residential Care) Regulations, 1995 were brought into operation with effect from 31 October, 1995. These Regulations, which were made under Part VI of the Child Care Act, 1991, govern the placement by health boards of children in their care in residential centres. They apply to residential centres operated by voluntary bodies as well as those operated by the boards themselves.

1.14 The new regulations lay down detailed requirements to be complied with by health boards in relation to the placement of children in residential care, the conduct of centres provided by boards, the supervision, visiting and review of children placed in residential centres and the removal of children from such placements, in accordance with the relevant provisions of the Child Care Act, 1991.

1.15 In particular, the new regulations require each health board to:—

- monitor standards in each residential centre in which the board has placed a child and ensure that the centre is visited from time to time by an authorised person;
- arrange for the supervision of children placed in residential centres by the board and for the children to be visited within prescribed intervals;
- arrange for the preparation of individual care plans and the periodical review of each child placed by the board in a residential centre;
- satisfy itself that adequate arrangements are in place at each residential centre to guard against the risk of injury and for the reporting and recording of accidents and injuries affecting children residing there;
- satisfy itself that procedures are in place for the prompt notification to the board of significant events affecting children placed there by the board.

1.16 The regulations are designed to ensure that children in residential care are visited, supervised and reviewed on a more systematic basis than before and that the changing needs of the children are not lost sight of. Full recognition is given to the role of parents, carers and, indeed, the children themselves in this process. The introduction of the regulations gives effect to a central recommendation of

the Inquiry Team. The provisions of the regulations relating to care plans and services to children in residential care, records and after care are also in line with recommendations made by the Inquiry Team.

1.17 It is intended that Part VIII of the Child Care Act, 1991, which provides for a new statutory system for the renewable registration of children's residential centres operated by voluntary bodies will be brought into force by the end of 1996. The new regulations required to give full effect to those provisions are currently being prepared in the Department of Health.

Family Support Services

1.18 A significant proportion of the additional funding made available for the implementation of the Child Care Act has been allocated for the provision of a range of new locally-based family support services. The introduction of the Child Care (Placement of Children with Relatives) Regulations, 1995, with effect from 31 October, 1995, provides health boards with the option of placing children in care with their extended family in appropriate cases. These measures are also in line with recommendations in the Report of the Inquiry Team which emphasise the importance of family support services in reducing as far as possible the need for the reception of children into care.

Guide to Standards

1.19 A draft guide to standards in children's residential centres has been circulated by the Department of Health to all health boards and children's residential centres. This gives guidance to all agencies concerned with the provision of residential care for children on the standards which should obtain in centres. The guide addresses a range of issues relating to residential care and pays particular attention to the need to ensure that children in care are not exposed to any risk of abuse. The guide also highlights the importance of agreed child protection procedures for residential centres which would define policy in relation to the prompt reporting and investigation of any suspicions or allegations of abuse or neglect of children while in residential care. Such a policy would also ensure that staff are equipped with the necessary skills to recognise and deal with any signs or symptoms associated with bullying, scapegoating, harassment or abuse.

1.20 The draft guide is currently being finalised in the light of submissions received from the relevant interest groups, both statutory and voluntary, involved in the provision of residential care services. The guide represents a code of good practice in residential care. As such, it reflects aspects of a number of recommendations of the Inquiry Team, including those relating to children's rights in residential care, child protection, the provision of information for children and parents, health and other services to children in care and the recording of information. Other relevant recommendations will be taken on board in the context of the finalisation of the guide.

Vetting of Applicants for Employment

1.21 New directions have also been issued by the Department of Health in relation to the recruitment and selection of staff for children's residential centres. Under these directions, employers must obtain Garda clearance on all persons being considered for appointment as a member of staff of a children's residential centre. These directions have recently been extended to include the recruitment of staff to *any* area of the Health Services where they would have substantial access to children or other vulnerable individuals. The directions also require that posts in children's residential centres be advertised and appointments be made by open competition. These measures are in accordance with recommendations made by the Inquiry Team.

Reporting of Allegations of Child Abuse

1.22 The recommendations of the Inquiry Team concerning the reporting of allegations of child abuse will be taken into account in the context of the consultative process that is currently underway arising from the recent publication of the *Discussion Document on Mandatory Reporting: Putting Children First.*

Social Services Inspectorate

1.23 It is proposed to establish, on a statutory basis, an Inspectorate of Social Services which will be attached to the Department of Health. The Inspectorate will be responsible for quality assurance and audit of child care practice in all areas of personal social services, including the children's residential sector. It will also undertake inquiries on behalf of the Minister for Health. It is intended that the enabling legislation will provide for the privileged publication by the Minister for Health of reports of such inquiries prepared by the proposed Inspectorate.

1.24 It would be the intention that the proposed Inspectorate would have a lead role in preparing a Statement of Children's Rights in Care and a National Child Care Policy Statement as well as developing national standards for inspections of child care services and uniform complaints procedures, as recommended by the Inquiry Team.

Other Recommendations

1.25 Discussions are being arranged with the health boards and the Conference of Religious in Ireland concerning the introduction of service agreements between health boards and children's residential centres and the composition and functions of boards of management of such centres. A revised job description for the post of resident manager is the subject of ongoing negotiations with the staff interests concerned. These developments relate directly to certain recommendations of the Inquiry Team.

1.26 The Children's Rights Alliance organisation is currently conducting research into the most appropriate arrangements for promoting children's rights.

This research, which is being partly funded by the Department of Health, is relevant to the recommendation of the Inquiry Team that a children's rights officer be appointed by each health board. The Department of Health is currently reviewing arrangements for the collection of statistical information on children in care with a view to expanding its data base and standardising statistics. The recommendations of the Inquiry Team in regard to children in residential care will receive serious consideration in the context of this review.

1.27 Some of the recommendations contained in the Report of the Inquiry Team relating to good standards of practice in residential care are reflected in the new regulations and the guide to standards referred to above. Others will be pursued with the health boards and the management of children's residential centres, and will involve the Social Services Inspectorate, when established. Those recommendations which are of relevance to other Departments or agencies are being brought to their attention.

Conclusion

1.28 Important lessons are to be learnt from the Inquiry into Madonna House, lessons which must inform the future approach to arrangements for the protection of children in residential care. The recommendations of the Inquiry Team provide a blueprint for action on a number of fronts. Particular attention will be paid to those recommendations which have yet to be implemented in the development of further initiatives for promoting the welfare of children in care and improving standards in the children's residential services generally.

PART TWO

Abridged Report of Inquiry into the Operation and Management of Madonna House

(The symbols *** indicate those segments of the report which cannot be published for legal reasons.)

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Introduction

This Inquiry was established by the Sisters of Charity with the assistance of the Department of Health to review the operation of Madonna House in the light of allegations of misconduct made against certain members of staff.

The Inquiry Team are concerned to emphasize at the outset of this Report that we were not constituted to investigate allegations of criminal offences with a view to their possible prosecution in Court. The Inquiry Team are of the view that any investigation of allegations of a breach of the criminal law is a matter solely for An Garda Síochána. In the course of this Inquiry we were advised that there were continuing Garda investigations into particular allegations concerning persons associated with Madonna House. In the course of our work we provided relevant information and assistance to An Garda Síochána and Health Boards, but our role was limited to such assistance.

In addition, the Inquiry Team wishes to emphasize that it had no role as regards any threatened, or pending, civil proceedings concerning Madonna House, its staff or residents, nor was the review process itself in the nature of a disciplinary tribunal.

The purpose and remit of the Inquiry was to carry out a review for the Sisters of Charity of the management and operation of Madonna House. This process was principally concerned with an inquiry into the qualifications, competence, and the manner in which care duties were discharged by staff members at Madonna House in the light of various allegations made.

This Inquiry was voluntary in nature. The Inquiry Team did not hear evidence on oath. It did not have any power of subpoena and could not require any particular person to assist us, nor indeed could we dictate the manner or extent of any such assistance. The Inquiry Team in its work adopted a procedure of seeking information and explanations from various current and former staff members, former residents, and other persons connected with Madonna House in an informal and private setting.

In the experience of the Inquiry Team, the process of identifying reliable information where an allegation of child abuse has been made is both slow and continuous. We are satisfied that new information relevant to the terms of Inquiry of this review may well emerge in the foreseeable future. The Inquiry Team made a policy decision during the course of this review that sufficient factual information

had been obtained for the purposes of the preparation and publication of this Report. The Inquiry Team do not suggest that any new information that may emerge might not affect some component of this Report, but in view of the terms of reference and the urgency of its subject matter it has been decided to publish this Report at this time.

Where any person sought the assistance of a legal representative in the course of the work of the Inquiry Team, this requirement was fully respected. In addition, where a person declined to answer a particular matter, whether on the basis of legal advice, or otherwise, this position was fully respected. The Inquiry Team were at all times conscious of their duty to be fair to all persons connected with our work. The Inquiry Team made clear to any person assisting us in our work that we would accept any oral or written submission, clarification, or further information which initially or on further reflection the person concerned felt appropriate to subsequently bring to the attention of the Inquiry Team.

***

This form of voluntary Inquiry does not attract the statutory protections normally associated with tribunals of inquiry. The Inquiry Team have been advised that there does not exist any adequate statutory or other appropriate legal protection for the work of this type of voluntary Inquiry in the nature of an indemnity for its members. In the view of the Inquiry Team, this deficiency particularly inhibited and delayed the course of work of the Inquiry Team.

The Report of the Inquiry Team constitutes 12 chapters. If these chapters were read in isolation, it might appear that the provision of child care at Madonna House from the date of its inception until its closure was seriously deficient. This is not the case. The Inquiry Team are satisfied that the child care service provided by the Sisters of Charity at Madonna House had many remarkable and impressive features. In addition, many children were cared for in Madonna House who would otherwise have been left in circumstances of serious distress and neglect. In the view of the Inquiry Team, the Sisters of Charity were at all times concerned to try to provide a warm and caring setting for any child in need, irrespective of any consequential burden in the operation of Madonna House. This need was frequently satisfied in circumstances where the urgency or complexity of a given child's situation could, in fact, only be met by an admission to Madonna House. This is not to in any way diminish the significance of the matters covered by the course of this review. The concern of the Inquiry Team is that any person reading the subsequent chapters of this Report must understand that though the allegations described are very serious they nonetheless relate to a relatively small number of children.

***

The Inquiry Team have sought to avoid, so far as possible, making any finding of fact, either expressly or by implication, which would have a bearing on any criminal investigation, civil proceedings, or other disciplinary proceedings. The Inquiry

Team, on legal advice, classified the range of allegations by employing legal definitions of sexual assault and assault. The Inquiry Team are of the view that this legal classification of the nature of these allegations may not properly represent a proper description of a given allegation. We have been advised that the legal term "sexual assault" can encompass a relatively minor assault as well as a more serious sexual assault. Similarly the term "aggravated sexual assault" includes situations where a sexual assault may involve serious violence, or a threat of serious violence, or may be the cause of injury, humiliation or degradation of a grave nature to the person concerned.

In the view of the Inquiry Team, the lesson to be learned from this Inquiry is that both the concepts and models of proper child care practice employed at a residential home such as Madonna House, or elsewhere, should be systematically reviewed by all persons concerned in the provision of care. In the view of the Inquiry Team, there was a consistent theme throughout the course of our work that many of the persons who assisted the Inquiry in explaining the operation of Madonna House did not properly comprehend the necessary parameters for their child care task. This situation is, we believe, not exclusive to Madonna House and is a timely warning for other residential care homes in this country.

CHAPTER 1

Allegations and Setting Up of Review

1.1 Allegations – Phase One

In April 1993, one young woman, who had been in Madonna House for a number of years, alleged to her foster parent that she had been sexually assaulted by a member of the staff of Madonna House during her stay there. This was reported by her foster parent to the Resident Manager of Madonna House and to the relevant Eastern Health Board (EHB) social worker. The girl also made a statement to Gardaí and gave the name of another girl who she said had alleged similar experiences. Some girls were then interviewed by the Gardaí and their respective social workers. A number of these girls alleged in formal statements to the Gardaí that they had also been sexually assaulted. Criminal proceedings in relation to some of these allegations resulted in the conviction and imprisonment of a staff member.

Allegations – Phase Two

During the course of the investigations into Phase One, another young woman made allegations to the Gardaí. She alleged that another member of the staff of Madonna House made sexual advances to her when she was aged 11, and had an on-going inappropriate relationship with her which continued after she had moved from Madonna House. The Gardaí submitted a file to the Director of Public Prosecutions who directed that there should be no prosecution.

1.2 Action Taken After Allegations

Following the allegations, the two staff members against whom allegations were made were suspended from duty and put on leave with pay. Both were subsequently dismissed.

The EHB established a Liaison Group, chaired by the Programme Manager Community Care, to co-ordinate the interviewing of current and former residents, the collection of information and the flow of information to the relevant authorities.

This group included social workers, administration staff and a clinical psychologist, with legal advice available as required. Links were established with the Gardaí who were conducting parallel enquiries.

It was agreed that all children currently in residence in Madonna House would be interviewed by social work staff of the EHB. This was to ascertain whether the children alleged inappropriate experiences of any kind during their stay at

Madonna House. It was also agreed that former residents who had spent substantial periods of time in care in Madonna House would be interviewed by the social workers. Any new allegations would be reported to the Gardaí, in accordance with the Child Abuse Guidelines (Department of Health, 1987).

1.3 Setting up of Inquiry Team

In September 1993, agreement was reached between the Religious Sisters of Charity (Sisters of Charity), owners of Madonna House, and the Department of Health that an Inquiry Team would be established which would submit a report to the Order, which they would furnish to the Minister for Health, the terms of reference being as follows:–

> *"To review the operation of Madonna House in the light of allegations of misconduct made against certain members of staff"*

The Inquiry Team would work with the co-operation of the management of Madonna House and the EHB. This would not be a Public Inquiry and was specific to Madonna House. It was an Inquiry by the Sisters of Charity and for which persons from outside the Order had been made available by their employing Health Boards – two members from the EHB and two from other Health Boards. The Team commenced its work on the 28th September 1993.

Relevant legal and professional child care expertise was available to the Team.

The Resident Manager of Madonna House agreed to step down temporarily to facilitate the conduct of the Inquiry. An Acting Manager was appointed by the Sisters of Charity.

1.4 Membership

Mr. Fred Donohoe (Chairman)	Programme Manager (retired) Community Care, Eastern Health Board
Mr. Ger Crowley	Head Social Worker Mid-Western Health Board
Ms. Mary Gordon	Clinical Psychologist North Eastern Health Board
Dr. Mary Hynes	Director of Community Care Eastern Health Board
Sr. Mary Magdalen	Sisters of Charity

1.5 Parallel Investigations

In carrying out its review, the Inquiry Team had to keep in mind the parallel investigative processes which might arise. The Team was conscious of the need to keep these processes and any industrial relations issues separate from its work.

1.6 Questions Arising from the Allegations

The Inquiry Team considered the following issues to be of particular concern namely:–

What was the mandate of Madonna House?

What were the aims and objectives of Madonna House?

What structures were established or evolved to further these?

What was the relationship of Madonna House with the Order and with Statutory Agencies?

What was the management style and culture?

In the light of allegations of misconduct:–

To what extent was the management aware of the need to safeguard children against possible abuse by staff and others?

Were the staff properly selected and instructed?

Were the operating procedures and staff training such that they were likely to prevent abuse and should it occur, facilitate disclosure or discovery?

Were disclosures made, to whom and what action, if any, was taken?

Had members of staff concerns about these issues and, if so, what action was taken?

1.7 Conduct of Review

The work of the Team may be divided into the following:–

(a) Interviews with the Madonna House Committee.

(b) Interviews with management, staff and some former staff of Madonna House.

(c) Meetings with personnel from the EHB.

(d) Review of relevant reports and literature.

(e) Interviews with former residents.

(f) Interviews with parents of children in care.

(g) Liaison meetings with EHB and Garda Síochána.

(h) Meetings with other persons who had significant connections with Madonna House.

(i) Meetings with the legal advisor to the Team.

It was agreed that the role, terms of reference and reporting arrangements of the Inquiry Team would be explained to each interviewee. Each of them would be advised that the Team could not treat disclosures as confidential, especially if issues of child protection were involved. All those interviewed would be asked to

reflect on their experiences of Madonna House and its services, bearing in mind the Inquiry Team's terms of reference.

They would be also invited to contact the Inquiry Team if, on further reflection, they wished to raise any other relevant issues.

The four members of the Management Group of Madonna House – The Resident Manager, Assistant Resident Manager, Secretary/Administrator and the Senior House Parent – were each interviewed by the full Inquiry Team. Members of the Inquiry Team had additional interviews with the Resident Manager, Secretary/Administrator and Senior House Parent.

For the staff generally the procedure adopted by the Inquiry Team was that they would be interviewed by at least two members of the Team. An agreed check list covering the information to be sought was used to conduct semi-structured interviews. (Appendix II.)

To avoid possible barriers to communication, it was agreed by the Team that Sr. Mary Magdalen of the Sisters of Charity, as a member of the Team, would not attend the initial interviews with staff.

At the outset the Team intended to interview management, senior staff and some other selected staff members. In early interviews there were major discrepancies in the information given by different interviewees. This, coupled with the absence of adequate records, led to a decision to interview all staff members, which was later extended to include staff who had left within the past three years and who wished to attend or communicate with the Inquiry Team.

Members of the Inquiry Team had meetings with staff of the EHB, notably Managers, Social Workers and some other relevant professionals.

In addition, members of the Inquiry Team met with staff of Dublin Institute of Technology, College of Catering, Cathal Brugha Street (Cathal Brugha Street College), professionals and others providing services to Madonna House.

CHAPTER 2

Problems of Definition and Context

2.1 Introduction

Agreeing on appropriate definitions of child abuse is an ongoing concern of legislators, child protection agencies, childcare professionals, educators and researchers. Child abuse is a highly complex issue which does not easily lend itself to definition or measurement. Corby (1993) has identified three general considerations that should be taken into account.

First, child abuse is a socially defined construct which is not an absolute unchanging phenomenon but alters over time and place. This is evident from the current different levels of definition of child abuse between Ireland and Sweden, where, for example, all physical punishment of children is forbidden by law. The second issue, according to Corby, relates to the knowledge base of those who define and their aims, goals and intentions. He contrasts the emotive term "battered child" used by Kempe and his colleagues in their original definition because they wished to draw attention to the issue: "a battered child is any child who received non-accidental physical injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardians (Kempe & Helfer 1980). Corby contrasts this definition with that of Gil, a sociologist, who defines child abuse in terms of broader political aspects of the treatment of children: "inflicted gaps or deficits between circumstances of living which would facilitate the optimal development of children to which they should be entitled and their actual circumstances, irrespective of the sources or agents of the deficit". (Gil, 1975). Corby concludes that the definition by Kempe & Helfer would limit the number to those children identified as physically abused or exposed to physical abuse by their parents, whereas Gil's definition would include all children living on the margins of poverty. He also points out that the absence of precise and consistent definitions of abuse leads to difficulty in establishing incidence rates and has a harmful effect on research. The third consideration put forward by Corby is the process by which child abuse is defined in practice as opposed to law and research. He found a lack of agreement and confusion among professionals on the seriousness of different types of abuse and concluded that "the only safe definition of child abuse is that it is a conclusion reached by a group of professionals on the examination of the circumstances of a child normally (in Britain) at a case conference."

In the area of child abuse nowhere is the gap between the knowledge bases of professionals more evident than between the law and the social sciences. Developments in cognitive and developmental psychology in this context led to a reappraisal of the cognitive capacity of children and a realization that their cognitive

skills may have been undervalued. Perceived deficits in this area cast doubts on childrens' fitness to act as witnesses, and hence to have their complaints heard in Court. Spencer & Flin (1993) discuss the relevant psychological research which has a bearing on childrens' ability to act as witnesses.

2.2 Formal Definitions of Child Abuse

Broadly speaking, definitions of child abuse can be classified as having a research, normative, legal or operational purpose.

Research
Researchers studying child abuse do not all come from the same methodological tradition and may differ in their definitions of abuse in terms of the abusive relationship and the nature of the abusive acts, i.e. some researchers define sexual abuse as abuse involving contact, while others include non-contact abuse as well.

Normative
Normative definitions of abuse are based on the values and beliefs of individuals (including clinicians and researchers), professional organisations, and society in general. They describe the limits and boundaries of appropriate and inappropriate behaviour of adults towards children. Usually included in such definitions are the concepts of the dependence of children and their inability to give informed consent, and children's rights to protection from sexual interference from adults.

Legal
In general, legislators favour broad terms and non-specific definitions to allow for flexibility. Child abuse within the context of the criminal law in Ireland is defined in terms of existing legal definitions of criminal acts, e.g. sexual assault, aggravated sexual assault, etc. In the Child Care Act, 1991, child abuse was defined as physical, sexual, emotional abuse or neglect.

Operational
Operational or practice definitions are the definitions of child abuse contained in the guidelines of statutory agencies with responsibility for the protection of children and the codes of practice of relevant professional bodies. The purpose of such operational definitions is to guide and inform the practice of professionals working in the area of child abuse prevention, protection, and management. Such definitions should be clear, discriminatory and informative, but in practice tend to lack some or all of these characteristics.

In the Child Abuse Guidelines (Department of Health 1987) child abuse is defined as:

> "Parents, carers (i.e. persons who while not parents have actual responsibility for a child) or others can harm children either by direct acts or by a failure to provide proper care, or both. Such acts include physical injuries, severe neglect, and sexual or emotional abuse."

While some contextual factors and possible injuries to the child are contained in a check list in appendix "A" of the child abuse guidelines, there is no amplification of what constitutes "acts (which) include physical injuries, severe neglect and sexual or emotional abuse".

The failure to provide formal definitions in the Child Abuse Guidelines leaves a hiatus in the definition of what does or does not constitute child abuse, allows for arbitrary interpretation, and can give rise to confusion and denial. That there are major difficulties associated with making the leap from mere labels to definitions which name the issues and are sufficiently clear to enable reporting were clearly demonstrated in Madonna House.

Major Forms of Child Abuse
Four major forms of child maltreatment have been identified – neglect, emotional or psychological abuse, physical abuse and sexual abuse. These categories are not mutually exclusive.

Neglect
The neglect of children is usually a passive form of abuse involving omission rather than acts of commission. According to Skuse & Bentovim (1994), it comprises both a lack of physical caretaking and supervision and a failure to fulfil the developmental needs of the child in terms of cognitive stimulation. Although direct observations or parenting may raise suspicions about the presence of emotional abuse or neglect, the diagnosis is usually suggested by its consequences for the child in terms of emotional and behavioural adjustment.

The failure to provide adequate supervision and physical caretaking is demonstrated when children present in the following way:

- malnourished, inadequately dressed, dirty, without proper shelter and sleeping arrangements.
- Abandoned, without supervision.
- Ill, lacking essential medical care.
- Failing to attend school regularly.
- Exploited, overworked.
- Exposed to moral danger.
- Non-organic failure to thrive.

Neglect is defined in the D.H.S.S. 1991 Guidelines as "the persistent or severe neglect of a child or the failure to protect from exposure to any kind of danger, including cold or starvation, or extreme failure to carry out important aspects of care, resulting in the significant impairment of the child's health or development, including non-organic failure to thrive."

Parental neglect may be due to poverty, ignorance, or parental incapacity due to conditions such as learning disability or psychological disturbance.

Psychological or Emotional Abuse

This type of abuse is related to the quality of the relationship between the care giver and the child and involves several dimensions of care giver behaviour. For the purposes of practical intervention it can be difficult to define. The D.H.S.S. 1991 Guidelines give the following definition:

> "actual or likely severe adverse effect on the emotional and behavioural development of a child caused by persistent or severe emotional ill-treatment or rejection. This category should be used where it is the main or sole form of abuse".

Finkelhor & Korbin (1986) conclude that emotional and psychological abuse can be confirmed if there is persistent and chronic presence of the following:—

> Rejection: chronic denigration or humiliation of the child.
>
> Terrorising: threats of abandonment or harm to the child and exposure to marital or family conflict and violence.
>
> Isolation: failure to allow access to social contacts and resources necessary for normal development within the community.
>
> Role reversal: where the child is expected to take on an adult role in order to meet the needs of the adult.
>
> Corruption: where the child's moral development is at risk due to corrupt care practices.

2.3 Physical Abuse

Physical abuse involves tissue damage to the child and is defined broadly in the 1991 D.H.S.S. Guidelines as "actual or likely physical injury to a child, or failure to prevent physical injury (or suffering) to a child including deliberate poisoning, suffocation, and Munchausen's syndrome by proxy" (see below). Injuries can range from minor bruising to serious fractures, damage or even death. Also included are burns and scalds. Shaking is a frequent cause of brain damage in children.

Deliberate poisoning is unusual and difficult to detect from accidental poisoning. Meadow (1988) suggested that it may present in any one of four ways:

> The presentation is the same as if the child ingested the substance accidentally and is rushed to hospital.
>
> The child presents with inexplicable symptoms and signs without a history of poisoning.
>
> The child presents with a recurrent unexplained illness that has features compatible with poisoning, such as recurrent episodes of drowsiness or hyperventilation. (There is an overlap here with Munchausen's syndrome by proxy.)
>
> The child may be murdered and have died by the time medical attention is sought.

Munchausen's syndrome by proxy was first described by Meadow in 1977. One parent, usually the mother, fabricates illness in her children and presents the problem to doctors. The acute symptoms and signs of the illness cease when the child is separated from the presenting parent who usually denies any knowledge of the cause of the problems. There is a strong tendency for other children in these families to be or have been similarly affected. Failure to thrive and non-accidental injury are also commonly associated.

Deliberate Suffocation of children has been the subject of a number of reports in recent years. The commonest form is smothering, in which the abuser, usually the child's mother, uses a pillow or other object to cause mechanical obstruction to a child's airways. The condition usually presents in infancy either as alleged apnoeic attack or apparent sudden infant death syndrome (SIDS). In cases of survival the differential diagnosis needs to be determined by special investigation in hospital.

Intention

A decision must be made on whether the injury was accidental or non-accidental and the degree of responsibility if a child suffers serious injury even accidentally. Speight (1989) described pointers to the diagnosis of non-accidental injury:

> The delay in seeking, or failure to seek, medical help.
>
> An account of the accident that is vague, lacking in detail and which varies with each telling, with innocent details related in vivid ways that ring true.
>
> An account of the incident that is not compatible with the injury observed.
>
> Parental affect that is abnormal and does not reflect the degree of concern and anxiety one would expect in circumstances following a genuine accident.
>
> Other aspects of the parents' demeanour give cause for concern, including hostility, the rebuttal of accusations that have not explicitly been made, attempts to leave (with or without the injured child) before medical investigations are complete.
>
> The appearance of the child and the interaction with the parents. Many abused children look sad, withdrawn and frightened, sometimes showing frozen watchfulness. The child may say something or arouse suspicion.

Minor bruising, while frequently a precursor to more serious abuse, is usually seen as less serious than a series of unexplained bruises which are likely to give cause for concern.

Age of Child

Generally, the younger the child suspected of being physically abused the greater the likelihood of official registration, as young children are more vulnerable and less accessible to monitoring.

Contextual Factors

Stress factors in the family context, e.g. emotional stress, poverty, single parenthood combined with poverty, should be considered in determining the degree of risk to the child.

In practice there are many factors which need to be taken into account in deciding whether or not a particular situation is abusive, including the seriousness of the injury, the intention and the chronicity. Other factors in the general context are also to be taken into account in considering future risk to the child, i.e. stress factors in the family and the age of the child. Generally the younger the child suspected of being physically abused the greater the concern.

A cultural tolerance of physical punishment, particularly of older children, demonstrates an ambivalence in our society towards physical abuse. The effect of this is that the underlying principle of using physical punishment is not totally rejected as a practice. This is referred to as "sanctioned abuse" by Stein (1993). Finally there is the issue of proving physical abuse in Court where proof is necessary if, for example, a child is to be taken into care.

2.4 Sexual Abuse

One of the most widely known and most useful definitions of sexual abuse is that given by Schechter and Roberge (1976): "the sexual exploitation of children refers to the involvement of dependent developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to and that violates the social taboos of family roles". In order to include the crucial element of the intention to abuse, Furniss (1991) suggests adding to this definition "and which aim at the gratification of sexual demands and wishes of the abuser".

Sexual abuse covers a wide spectrum of abusive activities which have been described by Colbourn Faller (1989):

1. NON CONTACT SEXUAL ABUSE

   (a) "Sexy Talk" includes statements the offender makes to the child regarding the child's sexual attributes, what he or she would like to do to the child and other sexual comments.

   (b) "Exposure" includes the offender showing the victim her/her private parts and/or masturbating in front of the victim.

   (c) "Voyeurism" includes instances when the offender observes the victim in a state of undress or in activities that provide the offender with sexual gratification. These may include activities that others do not regard as even remotely sexually stimulating.

2. SEXUAL CONTACT includes any touching of the intimate body parts. The offender may fondle or masturbate the victim and/or get the victim to fondle and/or masturbate them. Fondling can be on top of or inside clothes. Also includes "frottage" i.e. where offender gains sexual gratification from rubbing their genitals against the victim's body or clothing.

3. ORAL-GENITAL SEXUAL ABUSE involves the offender licking, kissing, sucking or biting the child's genitals or inducing the child to do the same to them.

4. INTERFEMORAL SEXUAL ABUSE sometimes referred to as "dry sex" or "vulvar intercourse", involves the offender placing his penis between the child's thighs.

5. PENETRATIVE SEXUAL ABUSE, FOUR TYPES

   (a) "digital penetration" involves putting fingers in the vagina, anus or both. Usually the victim is penetrated by the offender, but sometimes the offender gets the child to penetrate them.

   (b) "penetration with objects" involves penetration of the vagina, anus or occasionally mouth with an object.

   (c) "genital sexual abuse" involves the penis entering the vagina, sometimes partially.

   (d) "anus sexual abuse" involves the penis penetrating the anus.

6. SEXUAL EXPLOITATION includes situations of sexual victimization where the person who is responsible for the exploitation may not have direct sexual contact with the child. Two types of which are:

   (a) "child pornography" includes still photography, videos and movies and, more recently, computer generated pornography.

   (b) "child prostitution" majority of cases involve children of latency age or in adolescence; but children as young as four and five have been known to be abused in this way.

7. SEXUAL ABUSE IN COMBINATION WITH OTHER ABUSE
   The sexual behaviours described above include many of the types of sexual abuse noted in the literature and found in experience in working with victims, adult survivors and offenders. However, there are many variations and combinations of these acts, and sexual abuse may be found in combination with other abuses, such as urination and defecation and in some cases physical abuse is an integral part of the sexual abuse; in others drugs and alcohol may be given to the victim.

In addition to the behaviours described above by Colbourn Faller, there is a further range of behaviours not in themselves inappropriate but which establish a context where boundaries of personal space and privacy can be crossed and where if abuse arises it is more difficult to detect. These behaviours include touching, tickling, stroking, hugging and efforts to engage the child. The seriousness of the abuse depends on several factors including the age of the victim, the age of the perpetrator, the age difference between them, the severity of the sexual act, the presence of coercion, and the chronicity.

The nature of child sexual abuse differs substantially from other forms of abuse in that secrecy is a core element. It happens behind closed doors and in quiet places, never in the open. According to Furniss (1991) it is "a syndrome of secrecy for the child and the family and a syndrome of addiction for the abuser". The secrecy is determined and maintained by external factors, by aspects of the abusive interaction itself and by internal psychological factors in the child. It is important to understand the role of the abuser in creating and maintaining this powerful scenario of secrecy.

The external factors include the lack of forensic proof and medical evidence in all but a minority of cases, which means that the verbal accusation of the child and the admission of the abuser are crucial in the establishment of abuse. The child may deny the abuse has taken place because of fear, or may be punished for the disclosure. Many abusers will not admit responsibility for sexual abuse because of the punitive consequences. Childrens' communications are often not believed for legal reasons and can be held to be less reliable and less valid than the statements of adults. The belief of children that they are responsible for the negative outcome for the abuser can be a further strong reason not to disclose.

Furniss shows how the secrecy of the sexual abuse is further maintained in the interactions between the abuser and the child victim. During the sexual abuse intense stimulation can induce in the child high levels of pain and arousal. High anxiety levels can be further increased by the child's helplessness and inability to leave the scene. This highly charged and confusing sensory experience is made unreal by the actions of the abuser in creating a context of silence, darkness, ritualized physical contact, avoidance of eye contact and rigid and ritualized forms of interactions. Sexual abusers in states of sexual arousal behave very differently from normal which can be a very frightening experience for the child. During the most intensive body contact abusers disconnect themselves from the child, who is not allowed to name or experience the abuse as abuse.

"Entrance and exit rituals" are described by Furniss as having a central part in maintaining the secrecy. These rituals may consist of an innocuous greeting of the child by the abuser which initiates the sexual abuse, and a further innocuous remark to signal the end. It is as if the abuser is pretending to himself and to the child that no time has elapsed in between and no sexual abuse has taken place. These entrance and exit rituals create a physical space and a time space which allow the transformation from caring person to an abuser, and back again to being a caring person. These time periods can become lost and split off time units in the child's life.

In "The Child Sexual Abuse Accommodation Syndrome", Summit (1983) describes how the secrecy makes it clear to the child that something bad and dangerous is happening, however gentle or menacing the intimidation may be. In this secretive and helpless situation, the child has the impossible task of trying to make sense of what is happening. Without a protective intervention, the only option left for the child is to learn to accept the situation and to survive as best as possible. Children do this in different ways. Some pretend that the abuse is not

happening to them, or that the lower part of their body does not exist. Some will pretend to sleep. Others will go to extreme lengths to separate themselves from the experience and create "pockets of survival" which allow them to survive the abuse. These coping strategies allow psychic survival, but the cost can be high for the child in terms of emotional damage.

Furniss also describes how the sexual abuse of children as an addictive behaviour is similar to other forms of addiction. The abuser knows that the abuse is wrong and is damaging to the child. The compulsion, guilt feelings and tension relief are also present in other forms of addiction. However, sexual abuse is different from other forms of addiction in the sexual nature of the abusive acts and the sexual gratification obtained by the abuser.

Groth (1979) describes two basic types of sexual offenders. The "fixated offender" has an enduring and exclusive sexual interest in children, and the "regressed offender" who is capable of adult sexual relationships but when under stress turns to children for sexual satisfaction. While some theorists use the term paedophilia as applying only to the "fixated" offender the term is widely used when an adult has a conscious sexual interest in pre-pubertal children.

Various theories have been put forward in an attempt to explain sexually abusive behaviour. Finkelhor (1986) suggests that there are four factors, many or all of which may come into play in the creation of one particular person's paedophilic interest:

1. *Emotional Congruence.* Sexual abusers choose children for sexual partners because children have some compelling emotional meaning for them. The abuser may be emotionally immature and have arrested psycho-sexual development.
2. *Sexual Arousal.* The abuser finds children, rather than adults, sexually arousing.
3. *Blockage.* Some individuals are frustrated or blocked in their efforts to obtain sexual and emotional gratification from adults.
4. *Disinhibition.* The conventional inhibitions against having sex with children are overcome or are not present in some adults. Sex abusers avoid the normal controls or have a higher level of acceptability for sexually abusive behaviour.

Two parallel field studies on separate groups of victims and of perpetrators of sexual abuse (Conte et al, 1989: Berliner & Conte, 1990) provide a valuable insight into the process whereby abusers identify, recruit and maintain the compliance of the child victim. The abuser responses demonstrated a capacity to identify vulnerable children, i.e. the child who was friendly, receptive, needy or alone. Victims described a range of abusive behaviours prior to the abuse, including special treatment of the child, encouragement of secrecy, "accidentally on purpose" coming into a bedroom or bathroom when undressed, brushing against the child's private parts, not respecting privacy. These behaviours act as a selection mechanism with

the purpose of identifying those children who are vulnerable to victimization. For some children the abuse began before they became aware of the sexual nature or of the wrongness of the adult acts. Other children experienced anxiety or discomfort without knowing precisely why.

The shift to sexual behaviour identified in these studies was occasionally abrupt but more often gradual. Berliner & Conte comment that most of the children did not realise that they were being sexually abused initially. The sexualization process often began with normal forms of physical contact in the context of every day activities such as bathing, hugging, wrestling, tickling, all of which provide opportunities for a gradual progression to sexual contact.

Some children blamed themselves for what was happening and others were confused. Almost all described some form of coercion, either to gain co-operation or to prevent reporting. A majority described threats to the child of physical harm, including killing, of abandonment and rejection by the child's parents, and of the consequences for the abuser if the abuse became known. Coercion was also indirect and often accompanied by bribery. Emotional coercion was also used in many cases.

Abusers interviewed by Conte et al claimed to have a special ability to identify vulnerable children and to manipulate that vulnerability as a means of gaining sexual access to children. Sexual abusers of children rationalise their actions as loving and caring for children or educating them in sexuality. In the ambiguity of sexually abusive relationships, the clarity of the abuser's intention and explicit methods of communicating with victims while exploiting the dependence of the child clearly demonstrate that the process used by abusers is deliberate, systematic and highly sophisticated.

2.5 Other Forms of Abuse

Included in this category are child protection concerns for children where the situation does not fit into the categories of neglect, emotional, physical or sexual abuse, but where the social and medical assessments indicate that they are at significant risk of abuse. This could apply to siblings or other children in the household where a child has been abused, or to new born in at risk families. Also included in this category are children where a concern arises due to circumstances other than an adult directly inflicting harm to a child, i.e. alcohol, drugs, solvent abuse, pregnancy under sixteen years, threatened or attempted suicide.

2.6 Child Victimization

Finkelhor & Dziuba – Leatherman (1994) argue that because certain aspects of child victimization e.g. child abuse, stranger abduction, are studied separately, the recognition and development of the general victimology of childhood has been inhibited. From statistics and knowledge about the victimization and maltreatment of children, they define such a field and conclude that children are disproportionately more prone to victimization than adults are. They point out that

children suffer from certain types of violence that have been largely excluded from criminal charges e.g. assaults against children by other children, including violent attacks by siblings. Other problems are the practice of corporal punishment of children and the effects of bullying and peer abuse.

Three categories of child victimization are suggested by Finkelhor & Dziuba-Leatherman. First there are the "pandemic" or very frequent victimizations that occur to a majority of children, including assault by siblings, physical punishment by parents, peer assault. Second there are the "acute" victimizations which are less frequent, occurring to a minority, although perhaps a sizable minority of children. Among these would be abuse, neglect and family abduction. Finally there are "extraordinary" victimizations that occur to a very small number of children but attract a great deal of attention. These include homicide, child abuse, and non family abduction. Finkelhor & Dziuba – Leatherman comment that there has been much more public and professional attention paid to the extraordinary and acute victimizations than the pandemic ones. This does not reflect the concerns of children themselves or reflect the influence of their "alarming frequency" on children's everyday existence.

Reasons why the victimization of children is so common are suggested by Finkelhor & Dziuba – Leatherman; the weakness and small stature of many children and their dependency status, their inability to retaliate or effectively deter victimization, and the social toleration of child victimization. They also highlight the absence of choice by children over whom they associate with, mistreating families in which they may live and hostile neighbourhoods and schools with hostile and delinquent peers. They conclude that children have difficulty gaining access to the structures and mechanisms in society that help separate people from dangerous associates and environments.

The spectrum of vulnerability for victimizations created by the dependency of children ranges from physical neglect, which is closely related to dependency, to forms of victimization, such as stranger abduction, which are defined without reference to dependency and exist in similar forms for both adults and children. Finkelhor & Dziuba-Leatherman stress the importance and utility of a developmental prospective on child victimizations where the impact of various victimizing behaviour on children from birth to 18 years (the legal definition of childhood) can be identified. They also suggest that more of the victimization of children occurs at the hands of relatives because the responsibilities created by children's dependency status fall primarily on parents and family members. In reviewing the links between gender and different forms of victimization Finkelhor & Dziuba – Leatherman conclude that some victimization types may have unique gender patterns reflecting their particular dynamics but that this aspect of the subject needs further research.

Finkelhor & Dziuba – Leatherman list acts of child victimization according to their order of magnitude: homicide, stranger abduction, psychological maltreatment, family abduction, sexual abuse, neglect, physical abuse, rape, robbery, vandalism, assault, theft, physical punishment and sibling assault. These were derived

from 10 separate sources in the United States, including Uniform Crime Reports 1991 (Federal Bureau of Investigation, 1992), National Study of the Incidence and Severity of Child Abuse and Neglect, 1989, National Family Violence Resurvey, 1985. Most categories of child victimization mentioned by Finkelhor & Dziuba – Leatherman were represented in the information given to the Inquiry Team.

This typology helps illustrate the diversity and frequency of children's victimization and the totality of the environment of the various dangerous victimizations with which children live.

2.7 Consequences of Child Abuse

There is little doubt that all abuse of children is likely to result in harmful consequences of both a physical and psychological nature. Most studies of the consequences of child abuse differentiate between initial and long term effects.

In physical abuse the most serious outcome is the death of a child. There is no official register of non-accidental child deaths in Ireland and no breakdown of the seriousness of injury in reported cases. Many physically abused children suffer considerable emotional and psychological problems in their early childhood and have low self-esteem and difficulty in trusting other people (Lynch & Roberts, 1982; Erikson et al, 1989). Several researchers have found that physical abuse in itself is not the main issue but rather the quality of parenting and chronicity of the abuse (Steele, 1986; Colem & Frerchi, 1987). The psychological consequences of abuse are at the core of negative developmental outcomes (Claussen & Critterden, 1991) and are often the most profound and enduring (Garbarino & Vondra, 1987).

Physically abused children tend not to perform as well socially and intellectually as their non-abused peers (Lynch & Roberts, 1982) but this may also be linked with socially disadvantageous circumstances (Kaufman & Ciccetti, 1989). Many physically abused children tend to be aggressive (Patterson et al, 1989) and attribute blame to themselves for their punishment (Herzberger et al, 1981).

Research into the effects of sexual abuse on victims is more abundant than that into physical abuse and neglect. Negative consequences of sexual abuse, often lasting for many years, include emotional disturbances, aggression and detrimental effects on the sexuality of adolescents (Beitchman et al, 1992). Sexually abused children appear to be four times more likely to suffer from a psychiatric disorder during their lifetime and three times more likely to suffer from substances abuse (Saunders et al, 1992; Scott, 1992). Precocious sexual behaviour occurring in between a quarter and a third of all sexually abused children has been established as a clear outcome of sexual abuse (Friedrich & Grambsch, 1992). The concept of Post-Traumatic Stress Disorder (PTSD) has been applied to a wide range of victimizations (Eth & Pynoos, 1985; Terr, 1990). Finkelhor & Dziuba-Leatherman (1994) conclude that the link between a history of victimization and becoming a victimizer of others is firmly established. The results of current research may alter

existing diagnostic formulations regarding addictions and some psychiatric disorders (Herman & Ven der Kolk, 1987; Miller et al, 1987; Putnam, 1993).

Not all children are equally affected by similar experiences. Garbarino & Vondra (1987) describe "stress resistant children" who despite apparently rejecting parents survived as reasonably well adjusted adults. Mrazek & Mrazek (1987) list 12 factors that account for survival behaviour most of which are related to the child's cognitive abilities and personality. These include rapid responsivity to danger, formation and utilization of relationships for survival, the conviction of being loved, cognitive restructuring of painful experiences and optimism and hope. Also included are positive life circumstances including access to good health, education and social welfare services and having relatives (especially grandparents) and neighbours available for support. In addition, there may be abuse specific protective factors in the environment, including the quick and full acknowledgement of an offender regarding abuse.

2.8 Implications for Services for Children in Care

Children who come into care have greater needs than most other children. They are likely to have suffered abuse and neglect, and are often seriously emotionally distressed or damaged. Their behaviour may be withdrawn or aggressive. Their self esteem is low and they have difficulty in forming trusting relationships. Those who were sexually abused may exhibit sexualised behaviour which can be threatening and frightening to carers and create a problem for the protection of other children in both residential and foster homes.

It is likely that there will always be a number of children requiring residential care. These children present the greatest challenge to the childcare system. In considering the kind of system needed to protect, care for, nurture and love these children some areas of difficulty need to be immediately addressed.

2.9 Control and Restraint

Of particular importance is the area of control and physical restraint on which there has been a strong emphasis in the history of residential care. If unchecked, this can very easily lead to abuse. The extent to which it is permissible to restrain or restrict the liberty of children in residential care has been the subject of many inquiries in the U.K.

At present there are no guidelines on what are the appropriate boundaries of restraint. The absence of national guidelines has left it to individual residential homes to develop their own guidelines. The problem for staff of residential children's homes is that they are faced with difficulty and uncertainty in situations of control, particularly with violent children.

Given the Judgment of Mr. Justice Geoghegan in the High Court in July, 1994 that Health Boards have no powers of detention regarding children in their care, careworkers are left without guidance on the boundaries of restraint and on their

own legal liabilities. Also to be taken into consideration are children's rights of protection under common law against physical assaults. In this regard the law has wholly failed both in law and legislation to provide any guidelines.

It is not possible to examine any policy on physical restraint in isolation from the particular system of which it is a part. Value judgements are made on the creation of a therapeutic and caring environment as opposed to a controlling and restrictive one. Permissible forms of restraint should only be used as a last resort if someone is being attacked. It is interesting to note that in one area in Scotland when the children were consulted on the restraint policy, they felt strongly that it had to be available as a last resort for their own safety. Creating a culture where the focus is on co-operation and caring, as opposed to control, requires skilled, committed, and qualified staff. An emphasis is placed on identifying warning signs of conflict, employing de-escalation skills, and using minimum force techniques.

2.10 Complaints

The manner in which complaints or alleged abuse by children in care against staff or carers are dealt with is an integral part of child protection policy. Such complaints should be listened to in a non-judgemental way and referred to the appropriate Health Board for investigation. The involvement of an independent "reviewing officer" should be initiated by the Health Board. The family of the child should also be informed. The Manager of the residential home and one other staff member should hold responsibility for dealing with complaints against staff.

Strictly enforced guidelines alone will not ensure good management within the Residential Childcare system, and the welfare and protection of children in care. In order to ensure a safe, healthy and open environment for both children and staff there has to be an ethos of good practice based on respect. The main building blocks on which a system is built are the management and staff.

Working in the demanding field of Residential Childcare requires that individuals should be of the highest personal and professional calibre, with a stable balance of their own emotional lives, a zest for living despite constant experience of adversity in children's lives and have the capacity to communicate with, understand, empathise and work with the children in their care.

Staff need on-going resourcing if they are to be supported in their demanding work. As well as programmes of in-service training, the supervisory needs of all levels of staff should be seen as an essential part of a healthy system. Attitudes which perceive supervision to be unnecessary and in someway an admission of weakness have to change forthwith. While managers of residential homes provide administrative supervision to their staff there is a need for a separate process in a separate forum for psychological supervision of the issues emerging for each individual childcare worker. Managers of Residential Homes should be required to have their own personal supervision and also be encouraged to seek external consultancy if it is necessary.

2.11 Legal Difficulties in Cases of Child Abuse

The Inquiry Team is aware of areas of difficulty or confusion in the legal process which may influence the decision to prosecute in certain cases. An apparent co-relation between failure to prosecute and the lapse of time between the event of the alleged abuse and the making of the formal complaint to the Gardaí was noted. It would appear that the greater that time leg between both these events the less likely the chances of a successful prosecution being initiated. However, this situation appears to be changing. In a number of recent judgments, Courts questioned whether the period between the offence and the complaint was justified in some way by the extended influence over time by the domination of the alleged victim by the alleged perpetrator.

In their decision to grant a judicial review in the case of *G. and The Director of Public Prosecutions and Anor.*, Justices Finlay and Denham accepted, without giving a specific opinion, that the possibility of the lapse of time between the alleged offences and the time of prosecution could be prejudicial to the applicant. They commented further:

> *"In cases in general of sexual harassment or interference with young children, the perpetrator may, if he or she is related to or has a particular relationship of domination with the child concerned, by that domination or by threats or intimidation, prevent the child from reporting the offence. The Court asked to prohibit the trial of a person on such offences, even after a very long time, might well be satisfied and justified in reaching a conclusion that the extent to which the Applicant has contributed to the delay in the revealing of the offences and their subsequent reporting to the prosecution authorities meant that as a matter of justice he should not be entitled to the order. This issue may well be raised and fall for determination in this case, and* I express no opinion on it, *other than to say it is an issue which the Court would have to consider" (Mr. Justice Finlay)*
>
> *"When women and children come to the legal system it would be a disservice to them if it were perceived that they sought vengeance rather than the Rule of Law and justice. Insofar as there are new developments and knowledge in our society on issues that relate to the charges laid in this case then these matters must be dealt with in a fair and just way by the Courts" (Justice Denham).*
>
> *".....reasons for the delay, which may include factors such as the relative ages of the complainants at the time of the alleged offences, the question of any domination the applicant may have had over them, and further matters about our society is becoming more and more aware in relation to charges such as are laid here, may be factors among others for determination" (Justice Denham).*

Both Justice Finlay and Justice Denham express the view that these were matters that should be determined in the judicial review.

In Canada the case of K.M. -v- H.M. reached trial in 1987. A civil jury found that K.M. had been repeatedly sexually assaulted by her father between the ages of eight and sixteen, and she was awarded damages. However, it was ruled that her

action was statute barred, as she had discovered or ought to have discovered her cause of action at age sixteen. The trial Judge dismissed her case as being out of time as over a dozen years had passed before she initiated her second claim. In 1989, the Ontario Court of Appeal dismissed her appeal. She was given leave to appeal to the Supreme Court of Canada. In 1991, a unanimous decision of the Court was that the Plaintiff's appeal should be allowed and held that her cause of action did not emerge until she entered psychotherapy. It was stated in the Judgment that "the Courts will not allow a limitation period to operate as an instrument of injustice".

The Inquiry Team concludes from the foregoing, that while there seems to be a growing perception that the lapse of time should not be a consideration, especially where the alleged abuser has exercised influence on the victim leading to a delay in reporting the abuse to the authorities, there were no legal precedents in this country to put the matter beyond doubt.

Children's dependence on adults is central to the whole issue of child abuse, and it is very common for victims not to disclose the abuse until they reach adulthood. In many cases significant life events trigger the disclosure.

There is a need for statutory requirements to deal with this issue in order that, of itself, a delay between the alleged offence and the reporting to the Garda authorities should not be grounds for preventing a prosecution.

Of further concern is the relationship between the number of cases of child sexual abuse confirmed by the Health Boards and referred to the Gardaí, and the number of cases recommended for prosecution. One study in the E.H.B. region in 1988 (McKeown et al, 1993) showed that 507 were referred by that Health Board to the Gardaí. In 55 of the cases (10.8%), there was a decision to prosecute and in 38 cases (7.5%) the prosecution was successful.

The views of practitioners working in the field of child protection confirm that these figures are not atypical. The gap between the number of cases of sexual abuse clinically confirmed by Health Boards and the number subsequently recommended for prosecution would appear to be unacceptably wide. In effect, this could suggest that the complaints of extremely vulnerable children, including children with disability and emotional and behavioural disturbance, and also those children vulnerable because of their care status, are not necessarily accommodated by the law as it stands. This uncomfortable situation poses an immediate challenge to the very core of our state institutions and raises fundamental questions on the rights of children, and in particular the rights of the most vulnerable of our children to protection by the law. The manner in which the complaints of victims are dealt with also has enormous implications for the treatment and monitoring of abusers.

In cases where there were decisions not to prosecute, the available information from practitioners suggests that reasons for deciding against prosecution tend to

be factors relating to the child, their developmental immaturity, and their incapacity to be "a good witness" under adversarial conditions. The results of a survey during 1986 of all files reaching the Office of the Director of Public Prosecutions showed that of 90 cases, where the Director of Public Prosecutions decided not to prosecute, 50 were for reasons related to the victim, including non-corroboration of evidence, delay in making the complaint, vague or unreliable statements, and nine cases where the children (whose average age was 5.3 years) were deemed to be too young to give a witness statement and therefore unable to give evidence.

Just as it is the right of any accused person to expect protection and justice from the law, so also do the younger citizens of the State have an equal right to protection and justice from the law.

The secretive nature of child sexual abuse means that for the abuse to be recognised, either a complaint from the child or an admission from the abuser is required. If we accept that some abusers will require treatment and monitoring for life, immediate consideration should be given to the development of a legal framework where mandated counselling and treatment is available as a possible alternative to a prison term.

2.12 Research on Child Abuse and Neglect

The lack of basic research on the subjects of child abuse and children in care leaves wide gaps in our knowledge of the incidence rates and patterns of victimization experiences with children. Given our increased awareness of the complex issues of child abuse, this situation can no longer be tolerated.

There is a growing body of international research in the areas of child abuse and the needs of children in care and, in tandem with a National Research Policy, it is important that Ireland should "plug in" to this resource. If Government is serious about protecting children, it must be prepared to make substantial and sustained investments in co-ordinating concerted actions and research programmes, facilitating permanent and comprehensive data systems, and supporting Universities in the training of researchers. The development of a reflective research culture with a focus on the psychological experiences of children needs to be encouraged, rather than the *ad hoc* responses to crises and scandals.

The first step could be the establishment of a small unit within the Economic and Social Research Institute which would lead in a national initiative. This would have the effect of leading researchers in the third level education sector and the healthcare sector. Most of the resources to achieve this are already in position in the third level sector, Health Boards and voluntary bodies. The additional resources to support such a plan would be modest.

2.13 Conclusions

The absence of clear normative and operational definitions of child abuse needs to be addressed with urgency so that we name and give significance to the value

that children have in our society and their right to protection. The essential secrecy of child abuse and, in particular, child sexual abuse has also been reflected on a professional and societal level, where most of the debate of child abuse takes place separately and in privacy, i.e. within Health Board case conferences and the Family Law Courts, whose proceedings are not usually reported by media. Public and political debate, when it occurs, can be greatly influenced by controversies and scandals, as well as by the role of advocacy groups. For such public, and political, debate to be fully informed, it is important to define what it is that we are talking about.

If residential care is to meet the needs of extremely vulnerable children who have been damaged by child abuse and neglect, it needs to be valued, resourced, and integrated fully into the spectrum of community-based family support services. Informed decisions have to be made based on research findings so that a needs driven rather than service led development can be put in place within a legislative framework that protects all children, including the most vulnerable. The legal process has not addressed core issues in residential care and it is totally ambiguous in its approach to child abuse, failing in many cases to protect.

At the present time there is a greater awareness of child abuse in our society than at any previous time. In his analysis of the historical cycles of disclosure of child abuse followed by reversal to the status quo, Summit (1988) comments on how societies respond to such disclosures of child abuse:–

> *"Child abuse is so central that as a society we choose to reject our knowledge of it rather than make the changes in our thinking, our institutions and our daily lives that sustained awareness of child abuse victimization demands".*

As a society we have an obligation to make those changes in our thinking, our institutions, and our daily lives.

CHAPTER 3

Institutional Abuse: Literature Review

3.1 Introduction

The idea that children might be abused by care staff who are paid to care for them has been largely unthinkable until recently (Peake, 1992). A number of reports of the abuse of children in residential homes, assessment and treatment centres and residential schools for children with disabilities and emotional and behavioural difficulties (Hughes et al, 1986; Utting, 1991; Levy & Kahan, 1991; Westcott & Clement, 1992; Kirkwood, 1993) have shocked both the public and professionals working in the childcare system, not least the many child care staff committed to high standards of practice. This, however, is not a new social phenomenon: children in the past mainly suffered in silence and there are poignant accounts of their experiences in care (Arnold, 1985; Doyle, 1988; Drennan, 1994).

This literature review was undertaken to inform ourselves on the research on institutional child abuse. It also seeks to make a positive contribution to the debate on how children's needs are best served in residential care.

3.2 Defining Institutional Abuse

When first identified, the problem of child abuse and neglect was perceived as occurring within the family context with parents as the perpetrators (Kempe et al, 1962; Helfer and Kempe, 1974). This concept was later expanded to include three levels of child abuse: intrafamilial, institutional and societal (David Gil, 1975).

Eliana Gil (1982) defined institutional abuse as: "any system, programme, policy, procedure or individual interaction with a child in placement that abuses, neglects or is detrimental to the child's well-being". This definition can be applied to the out-of-home care of children in residential homes, hospitals, mainstream schools (residential and day), special schools (residential and day), playgroups, nurseries, day-care, therapeutic facilities and hostels. Foster care from the child's perspective is seen by Westcott (1991) as sharing many of the characteristics of residential care, that is, care provided in an extra-familial setting by unrelated adults who hold power over the child's current and possibly future placements.

Three distinct forms of institutional child abuse were identified by Eliana Gil (1982). The first is physical, emotional, sexual abuse or neglect by an individual staff member or foster parent. The other forms can only occur in an out-of-home setting. 'Programme abuse' occurs when programmes within institutions fall below accepted standards or rely on harsh or inhumane techniques to modify behaviour

(e.g. over-medication to control children's behaviour or oppressive techniques used to teach children). 'System abuse', according to Gil (1982), is "perpetuated not by any single person or programme, but by the immense and complicated child care system, stretched beyond its limits and incapable of guaranteeing safety to all children in care". This form of maltreatment relates to the shortcomings of agencies who take children into care and are subsequently unable to care for them, e.g. misplacement and misdiagnosis due to inadequate assessment resources, or remaining in care when this is not in the child's best interests.

Research indicates that the abuse of children in out-of-home care covers a very broad spectrum from isolated incidents of inadequate supervision to injuries resulting in the death of a child. Finkelhor et al (1988) describe the sexual abuse of children in day nurseries in the U.S. Goodman et al (1991) report on the death of a child in foster-care. Levy and Kahan (1991) in their inquiry into the "Pin-down" regime in Staffordshire describe emotional and programme abuse. Organised sexual and emotional abuse and the development of a sophisticated and abusive power structure are detailed in the Castle Hill Report (Brannen, Jones and Murch, 1991).

The term "sex ring" is used to describe an adult perpetrator or perpetrators simultaneously involved with several children, who are aware of each others participation in sexual activity. They were first identified in the U.S. (Burgess et al, 1981) and have also been identified in the U.K. (Wild and Wynne, 1986; Wild, 1989). They are characterised by repeated abuse of multiple victims by a paedophile. The abuser is usually male and may be a family friend or acquaintance. Institutional sex rings in schools and children's homes have also been described. Children may be bribed or rewarded. The scale of the problem is unknown, but police investigations in the U.K. have revealed as many as 160 rings (Smith & Bentovim, 1994).

3.3 Incidence of Institutional Abuse

There is a dearth of systematic research into the incidence and prevalence of institutional abuse in Ireland. Apart from a number of Inquiry reports in the U.K., there has been minimal research on this topic. Most of the literature on the incidence of institutional abuse derives from the U.S.

Thomas (1982) believes that the abuse of children in care is largely unrecognised and claims that the failure of society to recognise this problem reflects an underlying assumption that removal from a troubled home provides a better standard of care. Rabb and Rindfleisch (1985) found that the lack of definitions and guidelines on what constitutes abuse, and the absence of policies dealing with reported maltreatment, leads to disagreement on what incidents should be reported. Their overall findings showed that institutions may have been reporting no more than one in five suspected incidents of institutional maltreatment to State child protective services. They found an average complaint rate of 39 per 1,000 residents in care and concluded that residential complaint rates may be twice as large as the rates of intrafamilial complaints.

Nunno and Motz (1988) comment that in one State in the U.S. the reporting rate per 100 children in the State's mental health facilities was three times higher than the rate for the State's population. In a study of 609 reported and confirmed cases of institutional maltreatment, Groze (1990) found that most confirmed reports involved inappropriate treatment with physical abuse being the second most frequent type of allegation. Although sexual abuse was alleged less frequently, nevertheless allegations were confirmed in 1 in 5 cases. Overall, a reporting rate of 58.7 per 100 residents was reported by Groze and confirmed in 8.5 per 100 residents.

This higher rate of both allegations and confirmations than previously reported is supported by Rosenthal et al (1991). In a descriptive study of abuse and neglect in residential and foster care, the authors found that of 290 reports, 55% concerned physical abuse, 21% neglect and 24% sexual abuse. 27% of incidents involved multiple assaults. 29% of reports were confirmed. Perpetrators denied all or some of the allegations in 57% of the confirmed reports. The authors also noted sexual abuse occurring in foster homes where the perpetrators were the natural children of the foster parents.

3.4 Dynamics of Institutional Abuse

The abuse and neglect of children in residential care is a complex and multifaceted problem, as it is within the family. While both have features in common, institutional abuse has unique characteristics that must be taken into account in order to understand its causes and effectively prevent it. The abuse occurs in a bureaucratic environment and is perpetrated by adults not related to the child (Rindfleisch and Bean, 1988). Groze (1990) argues that the fundamental differences between institutional and familial abuse mean that the development of conceptual models of institutional mistreatment from a family systems' perspective may be faulty.

3.5 Denial

The belief that residential care provides a better standard of care than the families from which the children were removed underpins the disbelief that abuse can occur in institutions. Some researchers have minimised the incidence (Matsushima, 1990). The denial of allegations by administrative and managerial staff who fear the loss of both their own and the institutions' credibility is described by Nunno and Motz (1988) and Rindfleisch and Rabb (1984).

3.6 Issues of Power and Powerlessness

Research on children entering care in the U.K. shows that poverty and deprivation is a factor (Bebbington and Miles, 1989). The results of Irish studies support this (McKeown, 1991; O'Higgins, 1993).

Children in institutions are particularly isolated both socially and geographically (Shaughnessy 1984; Peake 1992), which compounds their vulnerability and makes

it particularly difficult for them to identify and locate sources of help. These children doubly experience the distorted power relationship found between adults and children. They experience both the power imbalance in individual staff/child relationships as well as experiencing the powerlessness of their position within the institution itself. This severe powerlessness appears to be a key factor inhibiting children from reporting their abuse (Sloan, 1988). For many children their powerlessness in previous abusive relationships is re-experienced. (Peake, 1992). Children with disabilities have a special vulnerability (Westcott, 1993).

Abusers in residential placements are made even more powerful because of the power they can exert over the child's subsequent placements (Moss, 1990) and their knowledge of the system which enables them to cover up their behaviour and arrange opportunities for abuse. They also have access to confidential and intimate information on the child which they can use to undermine the child's credibility (Single, 1989).

3.7 Staff Issues

Lack of suitably qualified and competent staff can lead to institutional abuse (Levy & Kahan, 1991). Following the Inquiry into Kincora Children's Home in Northern Ireland, Hughes et al (1986) advocated that management of child care organisations should give priority to enabling existing residential staff to obtain professional qualifications and to the appointment of qualified staff. Procedural guidelines, without ambiguity, are recommended by Hughes et al (1990).

The importance of regular, open and supportive supervision of residential care staff is stressed by Blatt (1990), Krantz and Frank (1990) and Reyome (1990).

3.8 Barriers to Children Disclosing Institutional Abuse

Children in care have an increased vulnerability to further abuse. The difficulties some children may have in disclosing abuse in care have been explored by Peake (1992) who emphasises the need for professionals to alter their practice to enable more children to speak out.

Children in residential homes are distanced from their families and social workers, often in residential homes in their own grounds away from town and village centres. Some of these children are estranged from their families of origin. Emotionally damaged children may not recognise abuse, or blame themselves for their involvement. The special needs of all children placed in residential care are a further isolating factor.

Attention is drawn to the special vulnerability of disabled children by Westcott (1993) who identifies several contributing factors. Besides the general marginalization of disabled people by the able-bodied they include:

— dependency on others for physical and social needs;

- compliance and obedience encouraged and rewarded by adults as desirable behaviour;
- lack of knowledge about sex and a limited or non-existent sexual vocabulary;
- communication difficulties;
- isolation and rejection by the able-bodied majority, which may in turn create opportunities for others to respond inappropriately;
- limited control and choice for children with disabilities.

Peake (1992) points out that children who have previously been abused may not have disclosed this abuse and may feel they have to maintain silence about current abuse as well. If the child has told about previous abuse, the likelihood of the child telling again will depend on the consequences of the previous disclosure. The scope for an abused child to tell someone outside the residential system is limited and sometimes non-existent. Often there is limited time available for visiting social workers and psychologists.

The effect of staff living on the campus is to underline that the campus is their home. If children are then abused by staff, the sense that staff can do what they want in their own homes becomes part of the silencing process for the child. When a child is being abused by a member of staff who is one of a couple working together in the Home, the abused child can feel less able to speak out.

Staff groups do not always reflect the ethnicity of the children for whom they care. Gilligan (1991) compares the status of the travelling people in Ireland to immigrant or social minority groups in other countries. In such a case if a child wants to tell of abuse by a staff member, the odds can be completely stacked against the child.

3.9 Barriers to Children Being Believed

Peake (1992) stresses that when dealing with institutional abuse, it is important never to lose sight of how hard it is for children to tell about abuse. She says, "work with children who can disclose needs to be conducted in a way which increases the likelihood that other children will feel they too can speak out". She also asserts that parents and other placing authorities need to know of the concerns so that they are alert to possible meanings of changed behaviour in their children and can assess possible risks.

In Peake's view, the pre-existence of clearly stated definitions of abuse and guidelines/procedures for the investigation of institutional abuse creates a climate which is qualitatively different from institutions where such do not exist. A comprehensive investigation along established lines is less likely to militate against believing children and also helps the process of the investigation.

Without a consensus about what constitutes good practice in different settings, it is difficult to identify situations in which children can actually be abused (Levy & Kahan 1991; Stein, 1993). Peake (1992) comments that adults connected with a child sometimes only report abuse in residential care after it has been established. In hindsight, they felt intuitively that all was not well.

The credibility of children with a history of delinquent or difficult behaviour may be challenged (Peake, 1992). Provocativeness and gender were found by Muller et al (1993) to be significant factors in the attribution of blame to the child.

Bloom (1992) points out that a child alleging sexual abuse by a staff member is frequently scapegoated by peers and staff. In cases where there is sexual abuse of an adolescent with a history of promiscuity, the victim is likely to be blamed and the abusive staff member's behaviour minimised.

Patterns of staff relationships can inhibit individual staff members in talking about their knowledge or consensus. If the abuser has a senior position, there are important power issues. In an establishment with a high national profile and no members of staff voicing any reservations about abuse, this can militate against belief of a child disclosing such abuse (Peake, 1992).

Peake also recommends that any plans to develop guidelines for dealing with allegations of institutional abuse should include criteria with regard to the abilities and expertise of those involved in the investigation. Where there are large numbers of children involved from different families and different placing agencies, there is an urgent need for good inter-agency communication and co-operation. Any investigation of institutional abuse should have adequate resources, information and support. Peake (1992) advises that it is useful to establish a working group on child care in each authority to decide on issues to do with policy and practice, and organise reference information.

Local authorities who place children in residential settings need to have a view about the capacities they have to protect the children in their care, over and above what is offered by the courts. This is because of the low level of prosecutions in cases of child sexual abuse, especially where there is no corroboration or where children are very young or unable to communicate because of disability. Peake asserts that it is not sufficient for a local authority "to act only in the event of a successful prosecution or the prospect of one".

3.10 Barriers to the Reporting of Institutional Abuse

Even in countries such as the U.S. where there is mandatory reporting of child abuse and neglect, failure to report persists in spite of efforts to educate professionals about the problem (Zellman, 1988). Many of the factors already discussed will also act as barriers to the reporting of institutional abuse. However, there are additional administrative, organisational and personal factors which inhibit reporting.

3.11 Absence of Procedures/Policies for Reporting and Investigating Institutional Abuse.

Most authors argue that the lack of procedures and policies is one of the most effective barriers to reporting. In the U.S. reports of abuse increased following the implementation of formal policies and procedures (Groze, 1990; Rindfleisch and Hicho, 1987). Hughes et al (1986), who investigated allegations in Kincora Childrens' Home in Northern Ireland, suggest that formal procedures for investigating complaints protect not only the children but also the staff.

3.12 Institutional Abuse Viewed as the Problem of the Individual Member of Staff, not the Institution.

Wardhaugh and Wilding (1993) have noted that the early hospital inquiries in the U.K. all began from the 'bad apple' assumption – that the scandal they were investigating was explicable in terms of the corrupting influence of particular individuals. This approach was found to be inadequate and the focus of investigations changed to looking at the organisation in which the abuse had taken place.

Treating institutional abuse as a personal rather than a professional problem means that the abusive incident is usually dealt with internally. Possible consequences include no formal documentation of the incident (Singleton, 1983). The staff member is reprimanded and then moves on to another institution where he/she can continue to abuse (Singleton, 1983; Winks 1982), children are held responsible for their own protection and the consequences of their behaviour (Thomas 1990) and children moved on to a new facility (Moss 1990). In one study Rosenthal et al (1991) reported that following allegations of sexual abuse, victims were moved in 92% of all reports and in 94% of the confirmed cases.

3.13 The Closed Nature of Institutions

Wardhaugh and Wilding (1993) identified four links between enclosed and inward-looking cultures and the corruption of care:

- the ability of such an organisation to stifle internal criticism and complaints;
- the enormous difficulty of internal criticism which can mean that the cost of challenging powerful group norms is often too great;
- the professionally isolated organisation comes to judge itself by its own internal standards and lacks an empowering, externally reinforced concept of good and proper practice;
- enclosed organisations develop and maintain a pattern of practice which is routine and conservative with a focus on control, order and the absence of trouble.

The "dangerously small" gap between such a pattern of institutional care and corruption is emphasised by Wardhaugh and Wilding (1993) who point out that

the downward slide is more noticeable when aspirations and expectations are higher.

Several authors have noted that tensions can arise between the management of institutions and external bodies (Rindfleisch and Hicho, 1987; Nunno and Motz, 1988). This dissatisfaction can result in investigations being conducted with suspicion on both sides (Nunno and Motz, 1988; Rindfleisch and Rabb, 1984).

3.14 Counter Transference

Counter transference, defined as the totality of the emotional reaction, both unconscious and conscious of the person making the report of abuse is identified by Pollak and Levy (1989) as providing an explanation for the fear, guilt, shame, anger and sympathy that can arise in the process of reporting. Effective and timely reporting may be compromised. They suggest that transference issues should be addressed both in training and in practice.

Gil and Johnson (1993) concur with this and point out that for personnel working with sexually abused children their own history of childhood abuse can become an important transference issue.

3.15 Belief Systems Surrounding Institutions

The role of child care institutions in society is fundamental to the quality of care offered to children. If institutional placements are automatically assumed to be superior to leaving the child with his/her family, Rindfleisch and Rabb (1984) assert that "few questions are raised about the quality of care a child receives".

Thomas (1990) has explored the relationship between society, institutions and institutional abuse, and argues that residential child care has failed to achieve a coherent philosophy for its existence. He asserts that the fundamental question of the purpose of institutional care has not been addressed, with a resulting ambiguity about the role and functions of institutional and foster placements.

Several authors have argued that institutions have come to be viewed by society as a panacea for the problem of abused, disabled or difficult children. According to Blatt and Brown (1986), this is frequently driven by the needs of society rather than the needs of the child. Placements are often made as a last resort for many children (Shaughnessy, 1984).

The integration of institutions into their local communities is urged by Thomas (1983) and Solomons et al (1981) who argue that child abuse and neglect is the responsibility of the local community.

3.16 Effects of Childrens' Disclosure of Sexual Abuse on Agency Staff.

The sexual abuse of children by a trusted staff member raises major clinical, social and systemic issues (Rosenbaum et al, 1990). They found that the responses of

staff in a particular residential treatment centre ranged from initial disbelief and rage to a need to understand what had happened. Following the abuse, staff who had previously seen the agency as trusting and well functioning became suspicious and frightened. The inability to predict what might happen next caused further anxiety. Splits and alliances developed between staff who had previously worked well together. For some children and parents the abuse aroused many of their old angry feelings from the times when they too were abused. The residents became more insecure and more aggressive. Staff struggled to support each other and to focus on continuing to provide good treatment.

The survival process helped staff to cope as the agency recovered its equilibrium. Rosenbaum et al describe how staff came to see themselves as having a positive role in stopping the abuse, and developed a greater awareness of the difficulties involved in the assessment of allegations of sexual abuse made by emotionally disturbed children, who themselves have a history of previous sexual abuse. The need for vigilance in investigating allegations of abuse by parents, children and staff was recognised. An advocacy system was instituted so that the rights of staff and children would be addressed. With the increase in meetings and more open discussion, better communication and working relationships developed within the agency.

Following the accusation of a staff member of sexually abusing a child in care, Bloom (1992) comments:

> "feelings of anger, fear, anxiety, distrust and guilt can radiate across an agency like the aftershocks of a major earthquake. Where trust has been established, relationships are shaken; where there is no trust, relationships are fractured".

He advocates that in responding to the crisis, management of the agency has three concurrent responsibilities:

- The overriding concern must be for the safety, protection and well-being of the child.
- Steps must be taken to support the child emotionally and to protect the child from possible attempts at retribution by staff members or peers.
- Other vulnerable children likely to be affected should be identified and supported.

While clearly affirming its primary duty to the children, the agency must also safeguard the rights and dignity of the alleged abuser and must publicly communicate this intention to staff.

The best management of these responsibilities will also prove to be critical in restoring the equilibrium of the agency and in maintaining its integrity. Bloom argues that while a defensive response by management to an allegation of abuse within the agency is a natural reaction, it is not as satisfactory as "forthright unambiguous management of the abuse related circumstances, paired with clear and

direct communication of the agency's response to the situation". The abusive situation should serve as a signal to initiate a risk management analysis of recruitment, orientation, training, supervision and articulated philosophy.

A prolonged period of crisis in a residential facility following allegations and investigations of multiple incidents of child sexual abuse perpetrated by staff, and culminating in the closure of the facility, is recounted by Lynch et al (1991). Mount Cashel, in Newfoundland, Canada was founded in 1898 by the Irish Christian Brothers to serve the needs of homeless boys. At times it accommodated up to 200 young people but by the 1970s had evolved into five units accommodating 40 young people in all. In 1980, police investigations into allegations of child sexual abuse during 1975 were reopened. During the investigations, which attracted intense media coverage, the decision to close Mount Cashel was made.

The feelings and responses of the staff and residents were diverse. For staff it was a time of great anxiety, fear and vulnerability and for many was beyond understanding. There was anger that for the sake of justice many more injustices were taking place. Although there was a realisation by most that victims were doing what they had to do, this did little to ease the stress. Staff also felt that the care they had provided to the young people was unrecognised and unappreciated. Residents felt depressed and stressed. School performance suffered and some dropped out of school. For some boys memories of previous abuse in the family home or in previous foster homes came back to them. Some became aggressive and destructive.

Management formulated a plan to minimise the degree of additional damage and permit the system to be maintained. A need for a new service initiative was identified and the staff and residents became involved in the development of a proposed model.

3.17 Protecting Children in Institutions

Many of the methods for reducing institutional abuse focus on resolving difficulties mentioned earlier in this review. The development of residential care as a quality service is the key to preventing different forms of abuse (Stein, 1993), and involves the recognition of residential care as a positive choice of many young people. The issue of guaranteeing to children a higher standard of care than experienced in the community in the care of their parents is addressed by Rindfleisch (1990) who asserts that out-of-home care cannot be justified if this guarantee is not supported by reality.

Following the many crises of institutional and foster abuse, major inquiries and reviews made recommendations to ensure that children in care would be protected from further abuse. Central to this body of recommendations is the importance of individualised care planning and taking into account the special educational or therapeutic needs a child might have. The recruitment and training of qualified staff and support and supervision for staff in challenging and potentially stressful work is advocated. The need for clear definitions of abuse and guidelines

on all aspects of practice, including appropriate and inappropriate sanctions and punishments, is identified. (Hughes et al, 1986; Department of Health/Social Services Inspectorate, 1990; Goodman et al, 1990; Levy & Kahan, 1991; Utting, 1991; Skinner, 1992; Kirkwood, 1993)

Studies on the effectiveness of child abuse prevention programmes have shown that they can bring about an awareness and knowledge regarding the subject of abuse in the children themselves (Conte et al, 1981; Saslawsky & Wurtele, 1986; Tutty, 1992) and in their parents and teachers (Kleemerer et al, 1988). An evaluation of parents and teacher participation in the Stay Safe Programme (an Irish abuse prevention programme) showed a significant improvement in knowledge about and attitudes towards sexual abuse, in the likelihood of their believing a child's disclosure of sexual abuse, and in their confidence in dealing with the issue. Among the children, increased knowledge of safety tactics and where and how to find help, as well as a general increase in self-esteem, were noted. (Lawlor and McIntyre, 1991).

3.18 The Role of Inquiries

There is no real tradition of child abuse inquiries in Ireland, unlike the U.K. where there has been approximately fifty such inquiries in the last twenty years. Since the mid 1980's in the U.K., there have been seven independent inquiries and four reviews into abuse in residential child care.

While recognising the value of certain findings and recommendations of inquiries, Hill (1990) argues that equally important are the unintended consequences which have meant that the general public has been able to distance itself from responsibility for protecting children. In addition, he asserts that the dominant role in the statutory sector of child protection procedures may have inhibited the development of preventive practice strategies.

In reviewing the literature on the institutional abuse of children, Westcott (1991) concludes that the recommendations of the Staffordshire Child Care Inquiry (Levy & Kahan, 1991) contain very many similarities to the recommendations of the 'Kincora' report (Hughes et al, 1986) and the 1990 Social Services Inspectorate report in Staffordshire, yet little progress had been made in combating institutional abuse since the publication of the earlier reports.

Agreeing that many of the recommendations of inquiries have not been acted upon, Stein (1993) concludes that the focus and strength of these inquiries lie in their detailed analysis of immediate events, including contexts leading to abuse. However, he criticises their failure "to explore more critically and widely the concept of abuse in residential care". Ferguson (1994) highlights the important social function of inquiries in focusing public and political attention on hitherto ignored social problems and under-resourced services.

3.19 Conclusions

The literature highlights the vulnerability of children in residential and foster care to abuse. It also suggests that abuse of children in these care settings cannot be viewed solely from the perspective of individual acts of abuse and neglect by individuals perpetrators, but must be understood to result from a number of interrelated system factors. These include, in particular, the needs of the individual child, the personality and skills of carers, the ethos, policies, support, supervision and general resources of the specific and wider child care systems, as well as the perceptions of the community at large, all of which determine the potential for abuse.

Recommendations of inquiries and reviews, as well as the findings of research studies, make proposals that alleviate, or would seem likely to alleviate, the problem of institutional abuse. However, little evaluation has taken place and there is clearly a need for research to establish their effectiveness. The absence of basic research on residential and foster care in Ireland needs to be addressed.

Caution has been expressed by some authors that changes in policy and procedures do not automatically bring about increased reporting and a reduction in the incidence of institutional abuse. The power of closed and inward looking organisational systems to exclude outside criticism, as seen in the failure of a Social Services Inspectorate visit in 1987, to comment on the 'Pindown' regime, demonstrates this.

This review of literature does not purport to be exhaustive, but in the view of the Inquiry Team, represents a fair summary of the relevant materials.

CHAPTER 4

Child Care Services

4.1 Introduction

Child Care and Health Legislation gives powers and duties to Health Boards to intervene in childrens' lives to protect them from abuse or neglect and, when necessary, to make arrangements for their care.

Health Boards provide a range of family support services in order to avoid the need to remove children from their families. However, some children for one reason or another cannot remain in their families and the Health Boards are obliged to make alternative arrangements for their care.

The most recent expression of public policy in regard to the care and protection of children is expressed in the Child Care Act, 1991. This states that each Health Board, in promoting the welfare of children in its area who are not receiving adequate care and protection, shall have regard to the rights and duties of parents. The Health Board must also regard the welfare of the child as the first and paramount consideration and, in so far as is practicable, give due consideration, having regard to his/her age and understanding, to the wishes of the child. Each Health Board must also have regard to the principle that it is generally in the best interests of a child to be brought up in his/her own family.

Children can be admitted to care with the consent of their parents on a voluntary basis under the provisions of the Health Act, 1953.

Children can be admitted to care without the consent of their parents on a compulsory basis under the provisions of the Children Act, 1908.

The substantial provisions of the Child Care Act, 1991 have not yet been brought into operation.

Gilligan (1994) describes "care" as serving four separate functions:–

> "The first of these is **maintenance**. That is to meet the child's basic developmental needs in terms of normal physical and psychological care appropriate to the child's age and stage of development.
>
> The second of these is **protection**. The reality is that children who enter the care system are rendered especially vulnerable to abuse and exploitation. Given that the decision to admit to care should improve the lot of a child, or, at the very least, should not worsen it, it is important that the care system

is alert and active in terms of protecting children from abuse; it should also serve the positive purpose of protecting and promoting the rights and interests of the child, as child and as citizen.

The third function is **compensation**. This serves to help children recover from the deficits in their lives which led to or were caused by the events that prompted admission to care. This may entail extra educational support, special remedial health care, or special therapeutic interventions to cleanse the child of the emotional detritus of past trauma. While it may not be possible to reverse what has happened to a child, it may still be possible to help the child make up ground lost because of past adversity.

The fourth function may be said to be that of **preparation**. That is equipping children with the emotional resilience and practical techniques and knowledge to make their way in the world when they leave care to live in their own family or elsewhere".

There are two main forms of substitute care provision:–

Foster care where children live with approved families in the community.

Residential care where children are cared for in non-family groups by professional staff.

Madonna House is part of the residential care service caring mainly for children coming from the EHB region.

4.2 Residential Care

At the time of the foundation of the Irish State, there were approximately 7,500 children in various forms of residential care. This had decreased to approximately 1,000 by the late 1980s. The number of children in foster care over the same period fluctuated. In 1925, the figure was 1,907; this decreased to under 1,000 in the 1970s and currently stands at approximately 2,000 (Gilligan, 1993b).

In the 1980s there was a substantial increase in the proportion of children in care who were fostered, and a corresponding fall in the proportion of children in residential care (Gilligan, 1993b). Decreasing numbers in residential placements reflect a similar pattern in all the countries of the European Union (Colton and Hellinckx, 1993).

A number of reports have focused substantially on residential care. These include the Cussen Report 1936, Tuairim Report 1966, Kennedy Report 1970, and the Task Force Report 1980. In 1988, the Economic and Social Research Institute published an analysis of the Department of Health's Child Care Statistics (O'Higgins and Boyle, 1988).

The Kennedy Report 1970 was particularly significant and led to a change from large residential institutions to smaller community based centres. The Task Force Report 1980 recommended the provision of a range of small residential units

serving the needs of particular communities. It saw the role of the residential services, in co-operation with other elements of the children's services, as meeting clearly defined deficiencies in the lives of certain children. The report also stated that residential care did not have the purpose of separating deprived children from the rest of society, although there may be strong tendencies in our society which impel it in that direction.

The early 1970s saw the establishment of a professional course recognised by the Central Council for Education and Training in Social Work, which over the next ten years trained Child Care Workers. Training currently takes place in a Certificate and Diploma course in Cathal Brugha Street College and in some Regional Technical Colleges. These courses are recognised by the National Council for Educational Awards.

The 1980s also saw considerable expansion in the responsibilities of the Department of Health and the transfer of certain functions and responsibilities for particular Homes from the Department of Education to the Department of Health. The Department of Health now has overall responsibility for residential care services for non-offenders.

In recent years there have been some critical public commentaries on Residential Child Care in the form of autobiographical or journalistic accounts of the past.

In 1991, the Resident Managers Association and the Streetwise National Coalition 1991 (Streetwise) organisation surveyed 60 Child Care Centres in Ireland. (Streetwise, 1991). A picture emerged of a service which has undergone substantial change in recent years. The survey identified deficiencies in current provision of:

- emergency places with assessment capacity;
- specialised services for older children presenting challenging behaviour;
- aftercare services.

Throughout the Child Care System, it is not always possible to secure appropriate placements. Short-term and emergency facilities experience difficulty moving children on to long-term placements. Post-care children are very vulnerable and aftercare services are not adequate for their needs.

The 1991 survey found that the level of trauma experienced by children coming into care can be significant. This results in considerable challenges to Community Care Services and Residential Centres attempting to care for such damaged children. High levels of stress are experienced by both management and staff of Residential Centres.

Some Resident Managers do not consider that they have sufficient numbers of qualified staff to provide the necessary care for the children being referred. Difficulties in staff retention and maintaining motivation in a poorly resourced service

leads to low staff morale, perceived low professional status, stress and a sense that residential care is of less value than foster care.

4.3 Types of Residential Care

Legal provision for the regulation of Residential Child Care has not kept pace with changes in the service. Some Residential Centres which originated as Industrial Schools are certified and subject to regulation, while others such as Madonna House are approved for payment purposes but are not subject to detailed regulation.

There is no recognised formal classification of Childrens' Residential Centres. The Inquiry Team felt that the following is a useful categorisation:

1. Group Homes funded by Health Boards, some developed from the Industrial Schools, usually with a small number of units, centrally managed, caring for both sexes of various ages.
2. Special Schools funded by Department of Education, developed from the Reformatory System (single sex).
3. Residential Child Psychiatric Facilities.
4. Adolescent Centres variously funded and organised.
5. Probation Hostels funded by Department of Justice.

Madonna House was loosely modelled on a village development in the Netherlands. It corresponds to category 1 in funding, referral sources, upper age limits for children, and in the reasons for referral. However, it is different in its large size and throughput, and in its unique "campus site" with a central kitchen and dining area, a school and pre-school play-group.

4.4 National and EHB Statistics

The provision of Child Care Services in Counties Dublin, Kildare and Wicklow is the responsibility of the EHB. For administrative purposes, the region is divided into ten Community Care areas, each having a Director of Community Care and a multidisciplinary team to provide services.

The population of the region is 1.25 million, and includes 385,000 persons under the age of 18 years. The birth rate fell from 17.3 per 1,000 in 1986 to 15.8 per 1,000 in 1991 so that there are fewer children under the age of 5 years, but overall the EHB is responsible for a greater number of older children because the age of a "child" was increased from 16 years to 18 years by the Child Care Act, 1991.

Nationally, 2944 children were in the care of Health Boards at 31st December 1991 (Department of Health, 1993). Of these:–

2,161 (73.4%) were in foster care,

742 (25.2%) were in residential care,

1,466 (49.8%) were in care on a voluntary basis,

1,478 (50.2%) were in care under Court orders.

'Parent or parents unable to cope', 'neglect and parental illness' were the reasons most frequently cited for admission to care.

In 1991, the number of children admitted to care was 1,013.

During 1991, 955 children were discharged from care, of whom 763 (79.9%) were reunited with their families or relatives.

At the 31st December 1991, the EHB was responsible for 1135 children, 38.5% of the national total, with 364 children (32%) in Residential Care.

The number of children in care in the EHB Region increased by 38% between 1985 and 1993.

Table 1

Number of children in care in
Eastern Health Board region 1985-1993

Year	Number of children	% increase
1985	976	
1993	1,349	38%

Table 2

Number of children in foster care in
Eastern Health Board region 1985-1993

Year	Number of children	% increase
1985	585	
1993	895	52.9%

There has been a significant increase in the use of foster care. However, Residential Care remains a substantial part of the EHB's child care resources. It is provided in 45 separate facilities with approximately 400 places. Some are managed by the EHB, but the majority are managed by religious or voluntary organisations and funded by the EHB.

The decrease in Residential Child Care provision throughout Europe has occurred for a variety of reasons including:—

- the decline in the number of orphans;
- impact of research on the adverse effects of some types of residential care on children's psycho-social development;

- increased toleration of deviant behaviour in society;
- increased professional preference for maintaining children with their families or in substitute families (Colton and Hellinckx, 1993).

These factors may lead to a perception of residential care as the option of last resort, which may have a negative effect on the morale of service providers.

However, according to Berridge (1994) "outcomes for children placed in residential facilities are not demonstrably inferior to those for foster families". U.K. literature also demonstrates that "residential child care can and usually does make a positive contribution" (Department of Health Social Services Inspectorate, 1993).

The Inquiry Team is confident that residential child care services will continue to be needed and will have an indispensable role in providing:

(1) care for children and adolescents who are unwilling or unable to live within a family or foster family;

(2) care and therapeutic services for seriously emotionally damaged children;

(3) care and containment for behaviourally disturbed children;

(4) care of sibling groups who cannot otherwise be kept together;

(5) care and assessment/preparation for longer-term placements or independent living;

(6) care and specialist respite/support as part of broader protective and supportive interventions with families.

The current large scale withdrawal of religious congregations from the provision and management of residential care services is creating a vacuum. This will add to the challenges to be met in developing a comprehensive service in the future.

4.5 Guidelines

Outlined hereafter is the development of guidelines in relation to child abuse and associated issues in Ireland since 1980.

1980

The first guidelines were issued by the Department of Health concerning 'actual suspected or potential non-accidental physical injury to children' (Department of Health, 1980). These guidelines were to provide guidance for health agencies and health personnel on the identification, management and prevention of non-accidental injury to children. They contain no reference to other forms of child abuse.

Directors of Community Care and Medical Officers of Health were designated as the persons to whom cases must be notified, and who have overall responsibility for monitoring and co-ordination.

These guidelines were issued to health agencies and health service personnel.

1983

New guidelines were issued concerning confirmed or suspected non- accidental physical injury (including injury resulting from sexual abuse) to children (Department of Health, 1983). This is the first reference to child sexual abuse in Departmental guidelines.

Their purpose was to provide guidance generally for personnel working with children and particularly for Health Agencies on the identification, investigation and management of this problem. It is of note that the guidelines were directed to organisations other than Health Agencies and that Health Boards were to circulate guidelines to 'Children's Residential Homes'.

1987

The most recent Child Abuse Guidelines were issued in 1987 (Department of Health, 1987).

In these Guidelines, Child Abuse is given a broader definition than previously. Specifically added was "failure to provide proper care, severe neglect and sexual or emotional abuse".

Responsibility of persons outside the Health Board Service was outlined in Section 4.15 "Action By Others". This Section made specific reference to Residential Care staff. It states that when the suspicion of a person other than Health Board personnel, General Medical Practitioner or Hospital/Clinic Personnel is aroused he/she should notify the Director of Community Care/Medical Officer of Health immediately after consultation with his/her superiors.

Section 6 deals with sexual abuse and repeats the action guidelines outlined in section 4.15 above.

Health Boards were to circulate guidelines to all relevant agencies, including Children's Residential Homes.

1990

The Department of Health organised a workshop on 'Advice and Complaints Service for Children in Care'. This was attended by Senior/Head Social Workers and Resident Managers, including the Resident Manager of Madonna House.

Follow-up documentation on the workshop was circulated to Residential Homes and Senior/Head Social Workers.

Notification of Child Abuse in EHB Region

There has been a major increase in the notification to Health Boards of child abuse cases in Ireland in the 1980s and 1990s. The Department of Health has compiled national statistical information for the country on child abuse referrals since 1982. The latest information available at national level is for the year 1991. In that year 3,856 reports of alleged abuse were recorded.

Table 3 shows the number of alleged and confirmed child abuse cases in Ireland, and in the EHB region, in the period 1984 to 1989. The table highlights the large increase in all child abuse notifications, in child sexual abuse notifications and in confirmed cases which took place nationally during those years. The table also shows that the EHB region experienced a disproportionately large increase in these parameters during the period compared to the country as a whole.

Table 3

Number of cases of alleged and confirmed child abuse
in Ireland and in the Eastern Health Board Region 1984-1989

Category	Year						% Increase
	1984	1985	1986	1987	1988	1989	1984-1989
Ireland							
All child abuse notifications	479	767	1,015	1,646	2,673	2,352	391.0
CSA notifications	88	234	475	929	1,055	1,242	1,311.4
CSA as % of all notifications	18.4	30.5	46.8	56.4	39.5	52.8	
All confirmed child abuse	182	304	495	763	1,243	1,658	811.0
CSA confirmed	33	133	274	456	465	568	1,621.2
CSA confirmed as % of all confirmed	18.1	43.8	55.4	59.8	37.4	34.3	
EHB							
All child abuse notifications	257	353	504	793	1,398	1,699	561.1
CSA notifications	29*	81	201	452	568	644	2,120.7
CSA as % of all notifications	11.2	22.9	39.9	57.0	40.6	37.9	
All confirmed child abuse	100	137	273	350	722	1,032	932.0
CSA confirmed	11	42	134	211	248	301	2,636.4
CSA confirmed as % of all confirmed	11.0	30.7	49.1	60.3	34.3	29.2	

*Estimated

Source: Report on Child Care and Family Support Services, EHB 1994.

EHB data indicate a decrease in the number of referrals in 1990 and 1991, but an increase again in 1992 to 1,327, of which 612 (46.1%) related to child sexual abuse.

The increase in the number of cases reported in the last decade coincided with increased public and professional knowledge of this issue. By the late 1980s, most

child care professionals had developed an awareness of child abuse, and were at least broadly familiar with the reporting requirements and procedures.

The Irish Association of Care Workers.

The Irish Association of Care Workers (I.A.C.W.) has a number of objectives. These include the promotion of the welfare of children in care and the promotion of high standards in services.

The I.A.C.W. provided the Inquiry Team with the policy documents which it has developed for its members.

1. Constitution of the I.A.C.W.
2. The Rights of the Child in Care.
3. Code of Ethics for Care Workers, Second Edition, 1990.
4. Ten Point Plan on Aftercare, 1990.
5. Discussion Document on Policy and Procedures, 1992.

The Rights of the Child in Care document states that the child in care has the same fundamental rights as any other child in society. Certain specific rights relevant to being in care are outlined.

The Code of Ethics for Care Workers (Second Edition, 1990), is stated as governing the conduct of care workers. It deals with responsibility to clients and to colleagues/agency.

The Aftercare Plan 1990 was formulated to highlight the need for aftercare services.

The Discussion Document on Policy and Procedures, February 1992, contains three sections:

1. Policy and Procedures – Minimum Standards of Care. This was intended to serve as a guideline for individual agencies formulating their own policy and procedure statement.
2. Guidelines for Grievance Procedures.
3. Guidelines for Disciplinary Procedures.

These documents draw attention to a number of matters which were central to the work of the Inquiry Team. They also give basic guidelines on how some of these issues should be addressed or processed.

Religious Sisters of Charity Policy and Code of Ethics of Child Care Services.

This document outlines the vision of the Sisters of Charity and the principles which should guide the operation of services. Detailed consideration is given to the rights of children in care. A number of staff of Madonna House made reference to receiving copies of this document. (Appendix I)

CHAPTER 5

Madonna House

5.1 Introduction

Madonna House is a Residential Home for Children owned by the Sisters of Charity, and located adjacent to the Order's Linden Convalescent Home at Stillorgan, Co. Dublin. Its current status is as a Residential Home approved by the Minister for Health for the reception of children. At present it is financed by way of an annual budget allocation from the EHB with some funding from the Order and from private donations. The Sisters of Charity provide a wide range of health and education services in hospitals and schools, in residential units and family support services in the community.

5.2 Establishment – 1955

At the request of the then Archbishop of Dublin, the most Reverend Dr. J. C. McQuaid, the Order established Madonna House at 129 Merrion Road, Dublin as a centre for the temporary care of very young children whose mothers were ill or undergoing hospital treatment. It was officially opened in January 1955, with 50 places. At the outset it was not envisaged that the Home would be dependent on financial help from the State, but the Order found it necessary to apply for funding to the then major responsible authority for child care in the area, the Dublin Board of Assistance. Following a visit by the Chief Executive Officer and some members of the Board, approval was sought from the Minister for Health for payment of a capitation rate for children whose admission was requested or approved by the Board. Approval was given by the Department of Health.

5.3 Re-location to New Premises and Re-Organisation

In time the demand for the services of the Home increased leading to a need for a review of the objectives and a need for new accommodation. It was decided to construct a new Home, at Linden, Stillorgan, Co. Dublin, with 50 places. This opened in August 1971.

Re-organisation

The following excerpt taken from a management review of the service in 1972 after 17 years of operation illustrates the considerations which led to this move:–

> *"Transfer and Expansion of Madonna House*
>
> ***Background:***
> *Madonna House has now been functioning for 17 years during which time there has*

been a progressive increasing demand for its services. This has become more marked in recent years not only in the numbers being catered for but in the nature of the individual cases.

It might be said to be no more than part of the trend in social conditions but it has emphasised the need for Madonna House to expand its function both in size and character.

Aims:

Not only has the period of children's stay at Madonna House tended to be somewhat longer but there is also an increased proportion of repetitive cases. This tends to bring the family unit more into the picture but also prompts the necessity for catering for the children in other respects. Accordingly it is felt that the immediate extended aims of Madonna House should be:

(a) to increase its accommodation,

(b) to extend the age range,

(c) to specialise in the family unit, and

(d) arising from (b) and (c), to afford teaching facilities.

Broadly the service now being contemplated is a more comprehensive one with regard, wherever practical, for the group plan.

(a) **Accommodation:** *The present premises are over-crowded and do not afford the necessary facilities for recreation and normal activities of the children irrespective of their age. Apart altogether from this the existing premises are required in the development of Elm Park and accordingly alternative premises have been made available by the Order at Stillorgan. These will enable us to cater for approximately 45 children with full and proper facilities in all respects.*

(b) **Age Range:** *In order to cater for the family requirement where this arises it is intended to extend the age limit to say 7 years.*

(c) **Family Unit:** *Emphasis will be laid in our planning for avoidance of any semblance of institution and we will seek to provide more of the atmosphere of home. In this respect some of the bedrooms are being adapted for the accommodation of families as a unit rather than splitting up the individual members into their respective age groups.*

(d) **Teaching:** *It is the intention to employ a full time teacher and subject to further specialised advice present intentions are to appoint a person qualified in the Montessori system.".*

5.4 Developments — 1970s

In the early 1970s, regional Health Boards and Community Care teams were established. A considerable expansion in social work services followed which influenced child care practice. Increasingly, admissions to care required Health Board

approval, and, over time, Health Board social workers were assigned to children in residential care.

By 1972, Madonna House had become almost totally dependent on capitation payments from the EHB. The extension of the age range to 7 years changed the service from a 'Residential Nursery' for very young children to a 'Residential Home'. Indeed, the planning of the new accommodation emphasised that the service would be provided in a Family Unit on a common campus. The management followed the general trend of the time with the group home development. This sought to provide care in settings which endeavoured to replicate some features of the natural family. However, this proved impractical as the major demand was for unplanned emergency admissions.

The 'village' model developed at Madonna House incorporating five Units, Bartres, Avila, St. Judes, Prague and Padua on one campus with pre-school playgroup, school, administration block, central kitchen-cum-dining room and playground, remains unique. The commitment to accepting emergency and unplanned admissions also distinguished Madonna House and, in time, it became the principal emergency Residential Child Care facility in the EHB region.

5.5 Policy and Organisational Structure

Madonna House Policy Document, 1987

The policy statement in 1987, from which excerpts are quoted below, indicates changes which had occurred since the foundation of the Home and how the Home was adapting to them:

> *"Children live in "family" groupings of 10/12 children of both sexes aged 0-10 years. Children with and without handicap live together, accepting and learning to care for each other and those more vulnerable than themselves. While still operating seven day 24 hour emergency service, Madonna House today provides short to medium term care for 55 children from all backgrounds and denominations who are at risk. Children from broken homes, those who are beaten or neglected, those whose parents are absent or incapable of looking after them. Children at risk from neglect in the non-accidental category. Child abuse has become a serious problem in Ireland. A high percentage of children now coming into care are on "Fit Persons Orders". Every child in need of care is accepted. Children are referred by Social Workers of the Eastern Health Board area. Night time referrals come from the Garda Síochána or Hospital Casualty Departments.*
>
> *Apart from the increase in numbers the trend in social conditions has brought about a change in the type of services required. Such changes in social conditions and their attendant problems result in children now entrusted to care being those who have been rejected, who are hurt, who mistrust, who are angry and provoke, children who at times would seemingly destroy the very people who approach them with care and concern. Knowing our first commitment is to the children already in our care, two houses are set aside for short-term/emergency admissions of children who display a high degree of emotional disturbance. The care required, therefore, demands experienced and trained staff including teachers and play therapists.*

Madonna House strives to provide a family atmosphere for the children in its care, applying Christian humanism values and loving each child, with an unconditional love, as a person in his/her own right, creating a climate of healing and growth, providing a genuine experience of acceptance, good experience of care, comfort and control, opportunities for exploration of play, decision making and increased independence, encouraging self reliance and initiative. Providing adult help in understanding his/her present situation to help him/her to keep the past, present and future linked and give him/her a firm sense of his/her own identity.

Staff, having a clear understanding of their role, act with confidence as members of an interdisciplinary team, communicating with others when planning and carrying out specific functions, showing ability to develop and carry out programmes of daily activities suited to the specific needs of the children in their care, exploiting each group potential for the social, intellectual and emotional development of the children. Respect for the families of children must be shown at all times regardless of the knowledge of conditions at home. In the child's interest, contact is maintained, family links nurtured and safeguarded and extended where possible.".

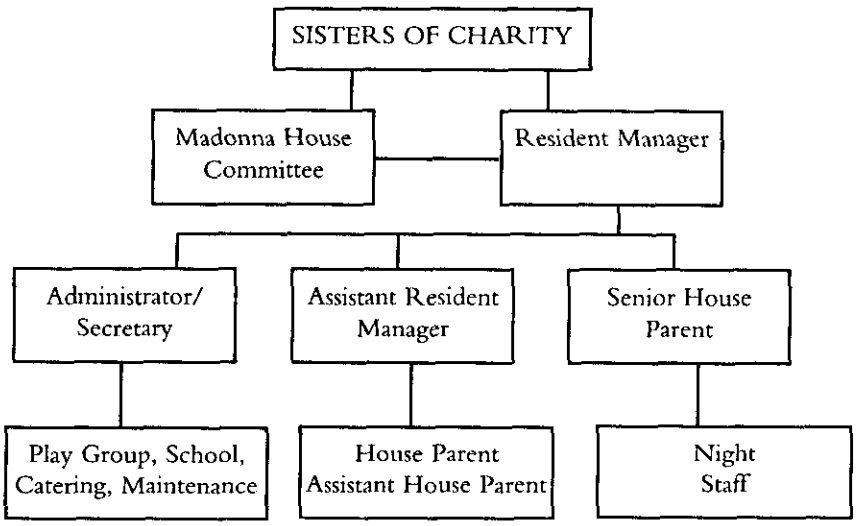
This policy document expressed an appreciation of the changing social environment, the impact of child abuse and the complexity of children's needs and the need to develop a range of appropriate responses.

The more significant changes noted included an increase in the age range, a move from short to medium-term care and an increase in the total number of children.

Organisational Structures

The stated organisation structure for the administration of Madonna House is depicted in Figure 1:—

Figure 1



Madonna House Committee

In the development of the new Madonna House, the Order had the assistance of a voluntary group of individuals whose professional advice included such areas as building construction, fund-raising, law and accountancy. The membership changed over the years and the numbers reduced as the physical development was completed. At present there are seven members.

Management Group

The management functions were discharged by a Management Group consisting of the following:

Resident Manager
Assistant Resident Manager
Secretary/Administrator
Senior House Parent

Organisation of Services

The main services are organised in five Units staffed by a team of child care workers of varying grades.

Pre-school Playgroup and School

A pre-school playgroup and school are located on the campus.

Meals

The main meal at mid-day is prepared in the central kitchen and served in a central dining-room. Other meals are taken in the five Units.

5.6 Patterns of Admissions and Discharges

For administrative purposes the Eastern Health Board is divided into 10 Community Care areas (Figure 2). Shown below (Table 4) is the number of Residential placements in 1993 by Community Care Area:

Table 4

Residential Placements in 1993 by Community Care Area*

Area	Number	(1992)	Population (0-19 years)
1	12	(29)	40,562
2	10	(6)	31,976
3	22	(36)	27,376
4	29	(32)	57,338
5	54	(57)	42,923
6	91	(58)	49,142
7	78	(88)	35,209
8	139	(106)	73,649
9	2	(4)	50,283
10	17	(7)	37,092
Total	**454**	**(423)**	**445,550**

*Residential placements include children attending Residential Centres on a daily or sessional basis. This affects the figures per community care area to varying extents.

Figure 2


COMMUNITY CARE AREAS
1: Dun Laoghaire
2: Dublin South East
3: Dublin South Central
4: Dublin South West
5: Dublin West
6: Dublin North West
7: Dublin North Central
8: Dublin North
9: Co. Kildare
10: Co. Wicklow
DUBLIN
KILDARE
WICKLOW
Balbriggan
Naul
Skerries
Garristown
Lusk
Rush
Oldtown
Balyboghill
Donabate
Kilsallaghan
Swords
Malahide
Portmarnock
Ward
Dublin Airport
Mulhuddart
Santry
Darndale
Baldoyle
Ballymun
Beaumont
Finglas
Kilbarrack
Coolock
Blanchardstown
Tolka Valley
Raheny
Howth
Artane
Maynooth
Castleknock
Glasnevin
Drumcondra
Dollymount
Leixlip
Cabra
Fairview
Palmerstown
R. LIFFEY
Phibsboro
Lucan
Chapelizod
James' St
Ringsend
Irishtown
Sandymount
Ballsbridge
Ballyfermot
Inchicore
Celbridge
Drumnagh
Ranelagh
Clondalkin
Crumlin
Harold's Cross
Rathmines
Donnybrook
Rathgar
Milltown
Booterstown
Walkinstown
Terenure
Blackrock
Kimmage
Rathfarnam
Monkstown
Dun Laoghaire
Newcastle
Churchtown
Stillorgan
Saltynoggin
Saggart
Tallaght
Ballinteer
Dalkey
Ballyboden
Sandyford
Foxrock
Rathcoole
Whitechurch
Cabinteely
Kilmey
Fortunestown
Stepaside
Ballybrack
Brittas
Loughlinstown
Shankill
Kilternan
Little Bray

The Inquiry Team analysed records and returns in relation to Madonna House for the period 1984 to August 1993. General information is available from 1984 to 1989 and more detailed information from 1989 onwards.

Information was supplied to the Team by Madonna House and the E.H.B (EHB, 1994a; 1994b). It included the Units to which children were admitted, specified the Community Care Area and the legal status of the placements. In addition, use was made of the Department of Health annual statistics on children in care from 1982 to 1991, the last year for which figures are available. (Department of Health, 1986, 1988 to 1993)

Drawing information of this nature from different sources creates predictable difficulties. The number of admissions to Madonna House is not necessarily the same as the total number of children e.g. if a child entered Madonna House on 6 occasions, this is recorded in Madonna House returns as 6 admissions. However, in the Department of Health statistics this will be recorded only once, or possibly not at all. (This could occur if the child was transferred to foster care before the end of the year.) The small number of admissions from outside the EHB have been excluded from this analysis.

Children in Care in the EHB and Nationally 1982-1991

The number of children in care in the EHB region rose from 903 in 1982 to 1,135 in 1991. This represented a growth of 25.7%, higher than the national increase of 20.3%.

During this period the percentage of children nationally in foster care rose dramatically. The percentage increase in the EHB region was 124.3% compared to 69.9% nationally. In 1991, 65.8% of children in care in the EHB region were in foster care compared with 73.4% nationally. Thus, while the percentage in foster care in 1991 in the EHB region was still below that nationally, the increase in the preceding 10 years was almost double the national figure.

The increase in the percentage of children in care under court orders in the EHB region was 203.1% compared to 185.3% nationally. In 1991, 60.3% of children in care were under court orders compared to 49.3% nationally. These cases tend to be more complex and more time consuming in child care management.

The decrease in the number of children in residential care was less in the EHB region (–23.5%) than nationally (–30.8%). Despite a drop of over 100 residential care places in the EHB region, by 1991 it had 49.1% of the places available nationally compared to 44.4% in 1982.

The proportion of children aged 12 years and over in care is lower in the EHB region than nationally (38.8% as opposed to 42.3%)

Children in Care Madonna House

In the 10 years from 1984 to 1993 there were 1,113 admissions to Madonna House.

Figure 3 shows a dramatic decline in the number of admissions per annum since 1984/1985. Despite this decline the average occupancy based on the end of month figures has remained relatively static. 1987, which had the lowest number of admissions, was the year with the highest average occupancy. It was not until 1991 that occupancy fell below 50 children for the first time.

Figure 4 shows the admissions and discharges of Madonna House in respect of each of the 10 Community Care areas for the 5 year period 1989 to 1993. It shows that the areas with the highest number of admissions during the period in descending order were Area 3, 7, 5, 4 and 6.

Areas 1, 2 and 8 have significantly lower admission rates to Madonna House. As Madonna House is located in Area 1, and close to Area 2, the low admission rate from these areas is noteworthy. Areas 9 and 10 (Counties Kildare and Wicklow) have very few admissions to Madonna House.

Figure 5 shows the admissions to Madonna House for each of the Community Care Areas for the years from 1989 to 1992 and up to the end of August 1993. Areas 4 and 6 show a significant rise in the numbers admitted in the first 8 months of 1993.

However, the total numbers are relatively small and the admission or discharge of one or two families could significantly alter the pattern of usage by a Community Care Area Team. Consequently, there is a danger of over-interpretation of such data.

Figure 6 shows a classification of admissions to Madonna House for the years 1989 to 1993. Of the 447 children admitted, the majority came in on a voluntary basis (270) with a number being the subject of Court Orders (81 Place of Safety Orders and 51 Fit Person Orders.) There were 45 admissions at the request of the Gardaí.

Overall there was a rise in the percentage of voluntary admissions in the period . The number of children in the categories other than voluntary admissions is small and therefore any conclusions in relation to trends must be tentative.

Children in Madonna House on 8th October 1993

There were 51 children in Madonna House on 8th October 1993, 30 boys and 21 girls (Figure 7). Of these, 22 entered care in 1993, 15 in 1992, 5 in 1991, 3 in 1990 and 6 had entered throughout the 1980s. The longest stay was that of a boy who entered as an infant in 1981. The 6 children who were longest in care were all boys.

Children in Care in April, 1994

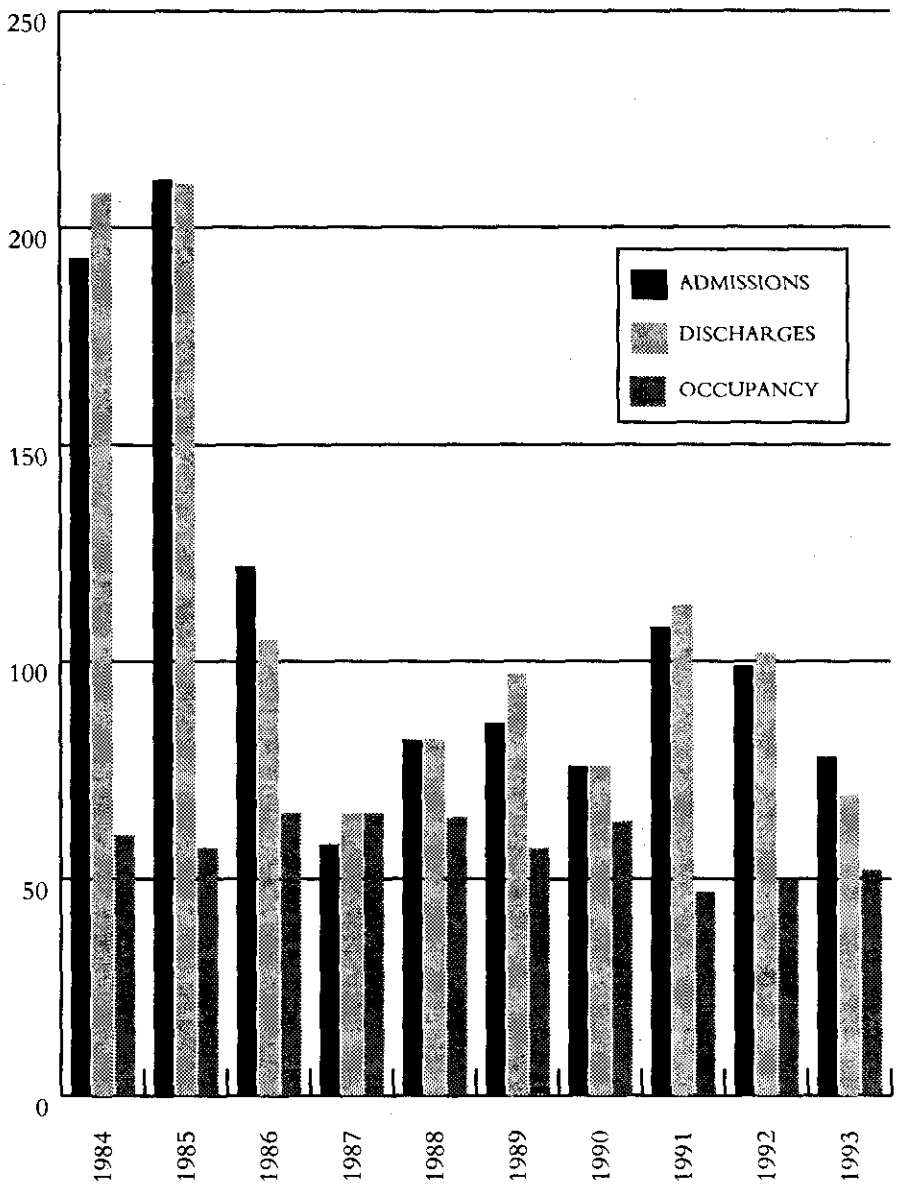
There were 32 children in Madonna House in April 1994, 18 boys and 14 girls. Area 7 with 10 children had the highest number with 5 children from Areas 3, 4, 5 and 6. Areas 8 and 10 had one each (Figure 8).

Figure 9 classifies the children by current age and gender.

Figure 3

MADONNA HOUSE ADMISSIONS AND DISCHARGES 1984-1993

Totals for each Year and Monthly Occupancy



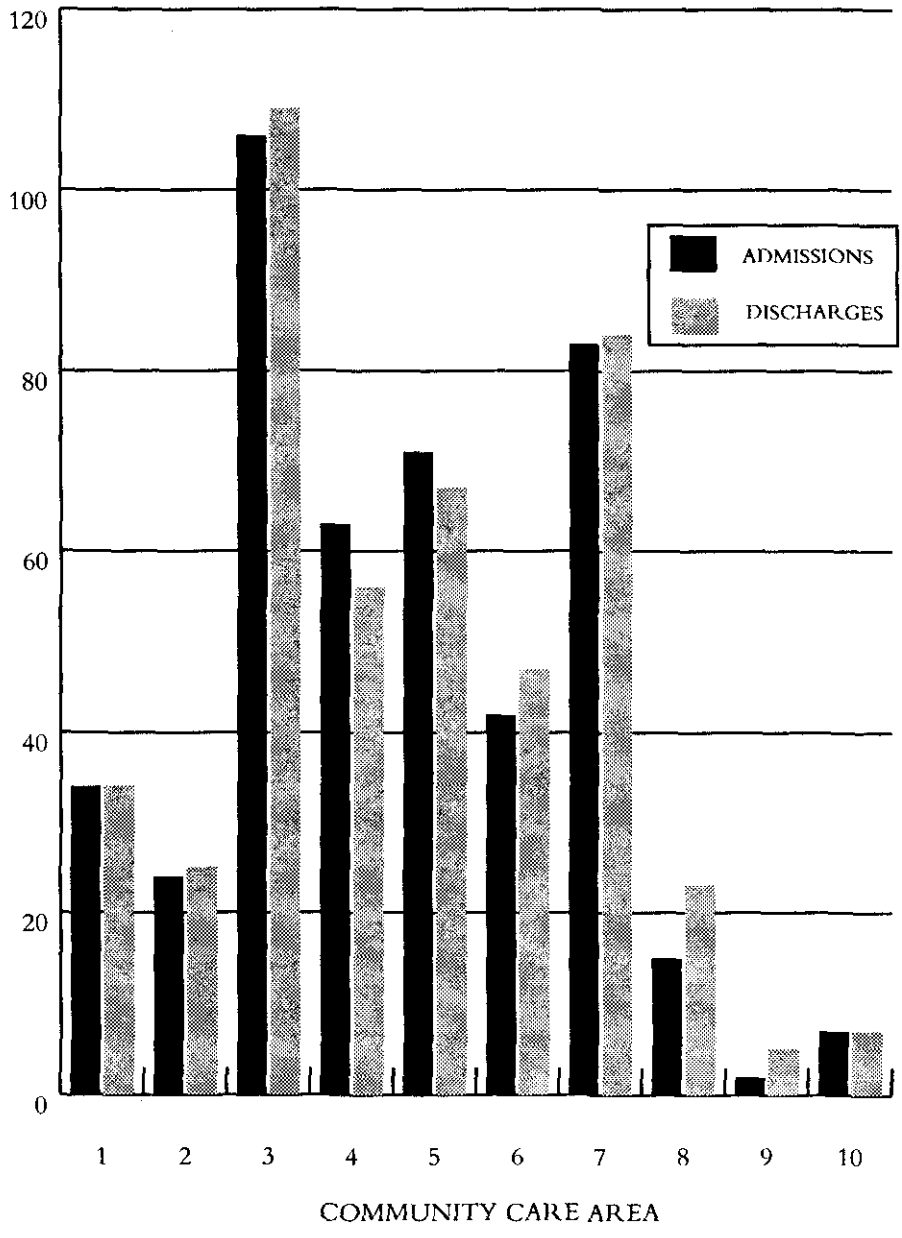
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
ADMISSIONS	193	211	122	58	82	86	76	108	99	78
DISCHARGES	208	210	105	65	82	97	76	113	102	69
OCCUPANCY	60	57	65	65	64	57	63	47	50	52

1993 figures to August 31st.

Figure 4

MADONNA HOUSE ADMISSIONS AND DISCHARGES *1989-1993*

Totals for each Community Care Area

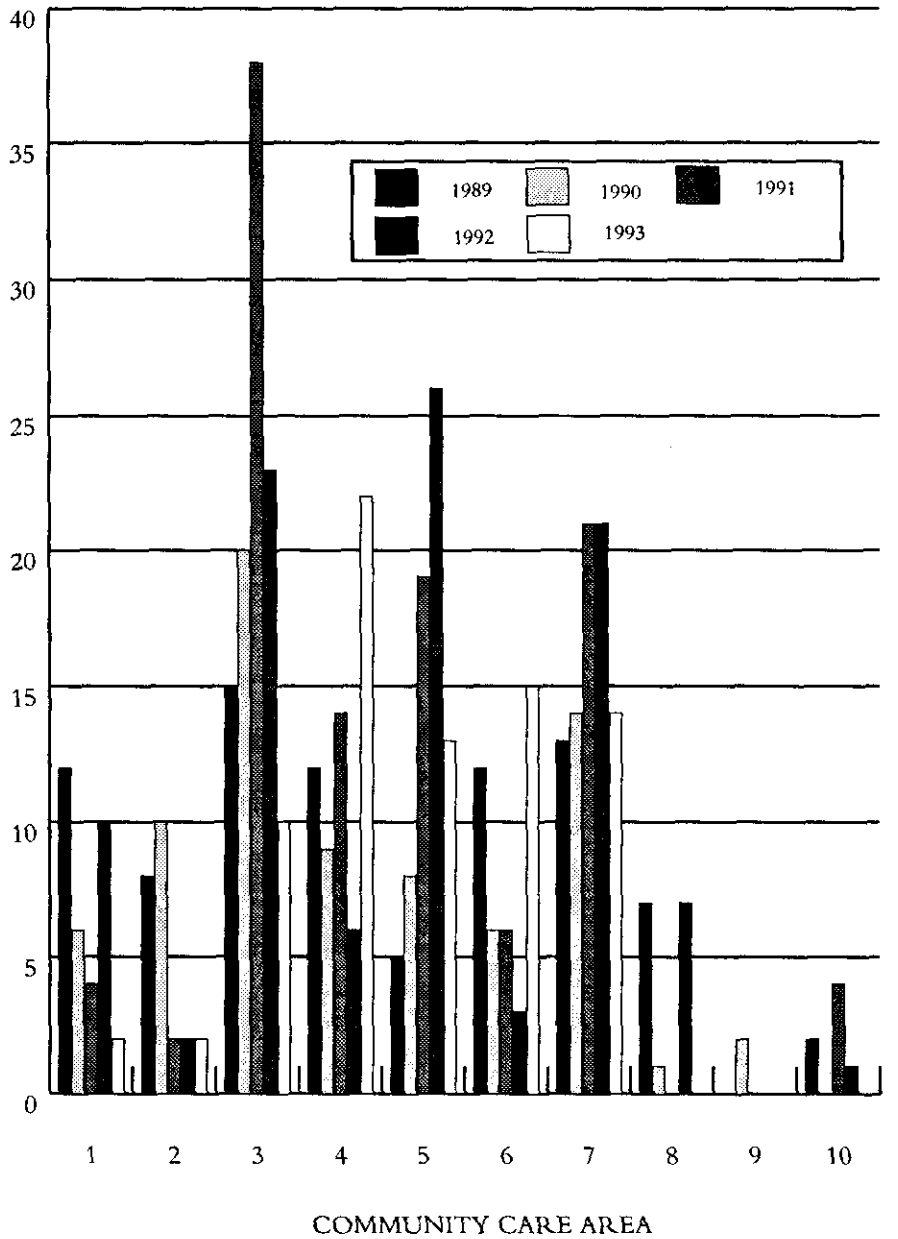


	1	2	3	4	5	6	7	8	9	10
ADMISSIONS	34	24	106	63	71	42	83	15	2	7
DISCHARGES	34	25	109	56	67	47	84	23	5	7

Figure 5

MADONNA HOUSE ADMISSIONS 1989-1993

Totals for each Community Care Area

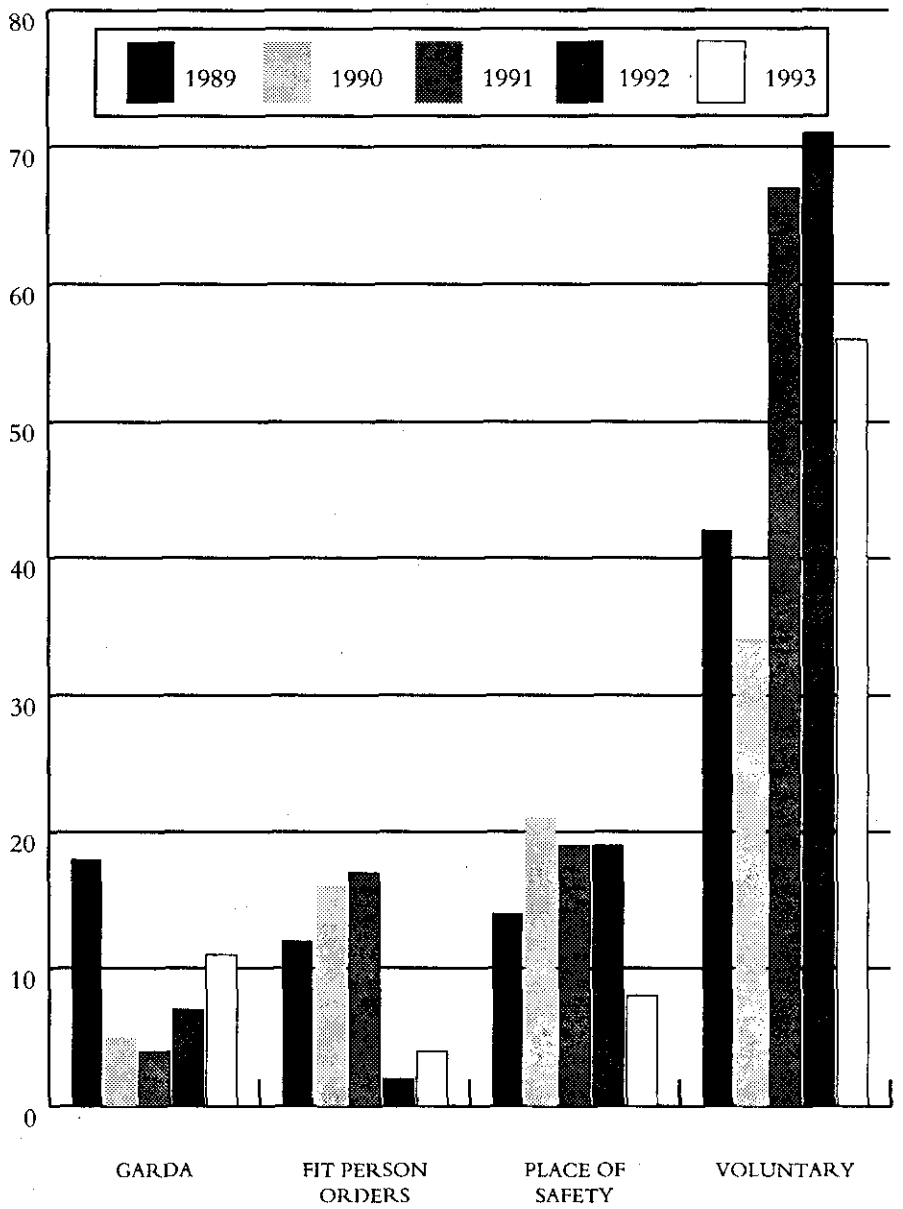


	1	2	3	4	5	6	7	8	9	10
1989	12	8	15	12	5	12	13	7	0	2
1990	6	10	20	9	8	6	14	1	2	0
1991	4	2	38	14	19	6	21	0	0	4
1992	10	2	23	6	26	3	21	7	0	1
1993	2	2	10	22	13	15	14	0	0	0

1993 figures to August 31st.
Total 447 admissions.

Figure 6

Status on Admission



	GARDA	FIT PERSON ORDERS	PLACE OF SAFETY	VOLUNTARY
1989	18	12	14	42
1990	5	16	21	34
1991	4	17	19	67
1992	7	2	19	71
1993	11	4	8	56

1993 figures to August 31st.

Figure 7

MADONNA HOUSE RESIDENTS AT 8/10/1993

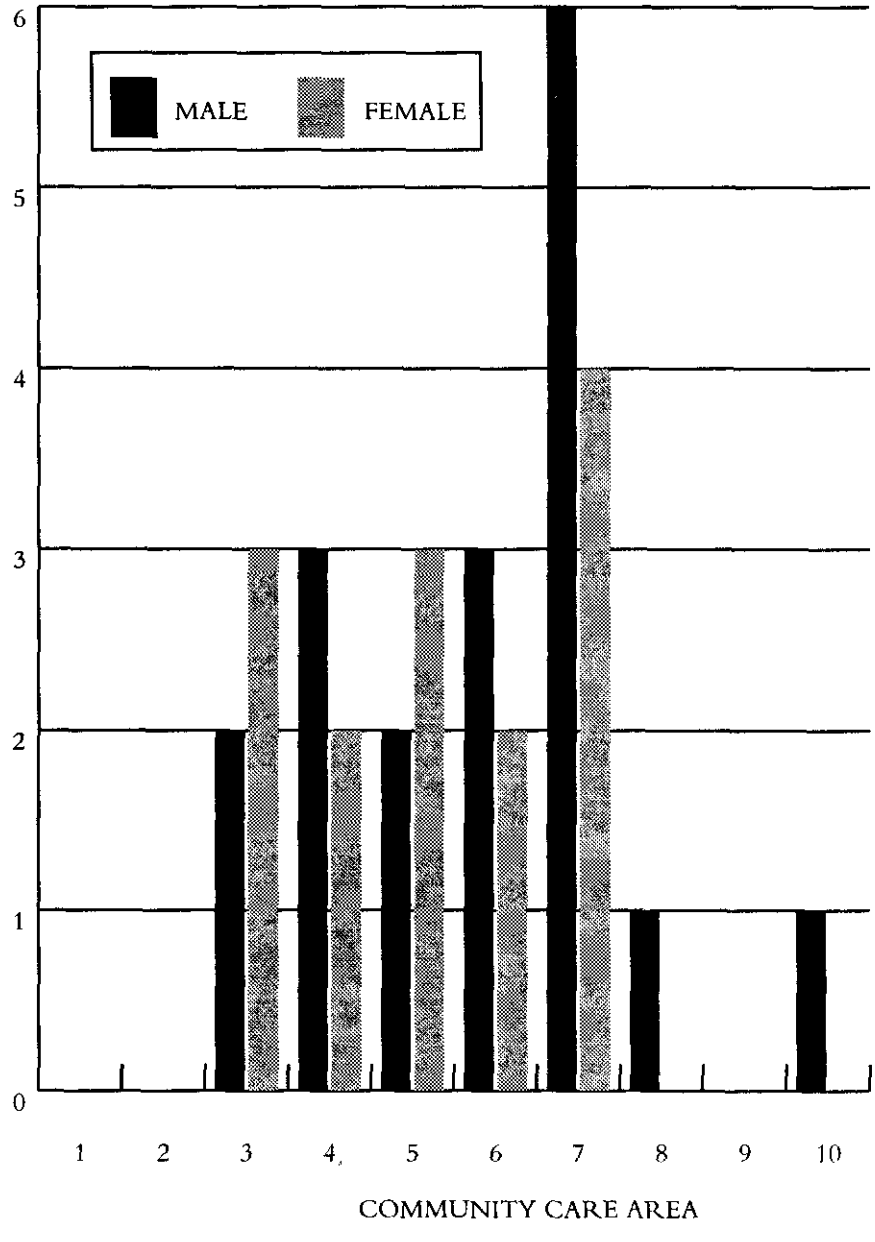
Number of Children by Year of Birth and Gender

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
BOYS	4	0	0	1	3	2	5	4	5	3	2	1
GIRLS	1	0	2	2	2	2	4	1	2	2	2	1

Figure 8

MADONNA HOUSE CURRENT RESIDENTS

Community Care Area and Gender



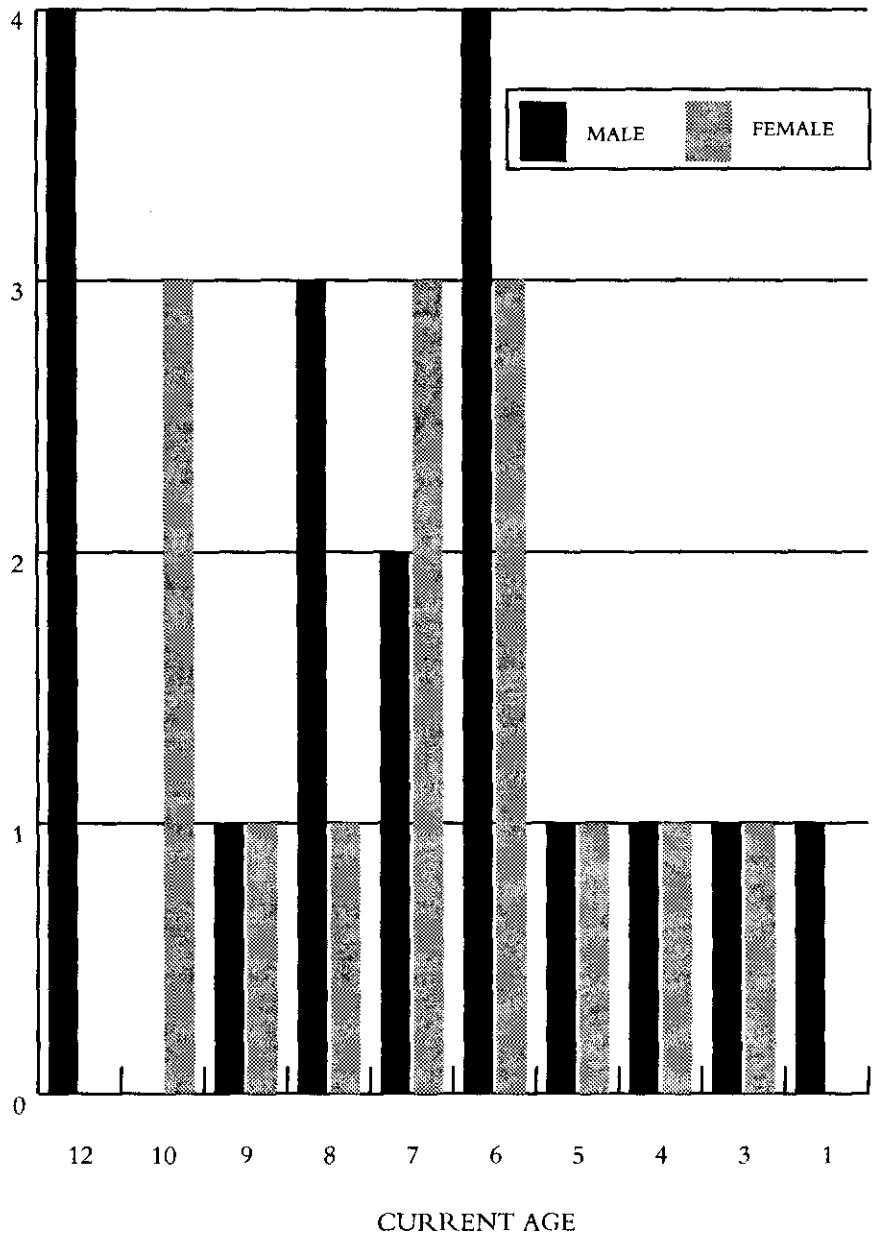
	1	2	3	4	5	6	7	8	9	10
MALE	0	0	2	3	2	3	6	1	0	1
FEMALE	0	0	3	2	3	2	4	0	0	0

As at 15/04/1994.

Figure 9

MADONNA HOUSE CURRENT RESIDENTS

Current Age and Gender



	12	10	9	8	7	6	5	4	3	1
MALE	4	0	1	3	2	4	1	1	1	1
FEMALE	0	3	1	1	3	3	1	1	1	0

As at 15/04/1994.

CHAPTER 8

Personnel and Services Units

8.1. Introduction and Guidelines on Recruitment

A review of the literature and of experience in the U.K. and elsewhere, and discussions with Irish practitioners, identify a number of important issues regarding personnel policy and practice:

1. The professional capacity of staff is one of the most important factors in determining the quality of care received by children in Residential Care.

   "Staff are the really important ingredient in the care package offered to children and families; much depends on their personal and professional skills and knowledge, and the confidence which comes from them. Buildings can be improved, bedrooms can be made more attractive, but staff make or break the system. Staff are the key resource, but currently are trained too seldom and too little, insufficiently supported and sometimes appointed too casually" (Skinner U.K., 1992).

2. Comprehensive and sophisticated selection and recruitment procedures are essential for all staff in Residential Centres.

Such procedures must be driven by a commitment that views children's protection and welfare as paramount. Various Inquiries have demonstrated that any adult having access to children may be a potential abuser. This is not confined to professional staff, but includes ancillary staff, volunteers etc.

> *"All organisations working with children should develop formal staff selection and recruitment practice, which emphasise child protection practices at every stage in the process" (Social Services Inspectorate, U.K. 1993)).*

Current Irish practice in the selection of foster parents includes a lengthy and rigorous assessment and preparation process. This includes medical and police checks, numerous interviews and independent checking of references. Similar procedures have been recommended for selection of residential care staff (Warner 1992; Hughes et al, 1986; Brannan et al, 1992).

> *"The selection process should reflect the psychological and other demands of caring for groups of very damaged children, and the heightened vulnerability of children in residential care" (Gilligan 1994).*
>
> *"Some diversity in experience and training is arguably a positive factor, bringing various resources to the service which may mean that children are more likely to find an adult with whom they can communicate" (Whitaker et al 1984).*

3. Appropriate Induction Programmes are necessary for all staff and should be followed by on-going and regular staff appraisals, supervision and in-service training (Skinner, 1992; Warner, 1992)

The induction process is an opportunity for staff to be introduced to the policies, practices and procedures of the Home. This should include training in child protection (Social Services Inspectorate, 1993). This process is the foundation for the relationship between the staff members and the management and serves to clarify mutual expectations and responsibilities.

The nature of residential care work is such that staff must regularly deal with children who have been traumatised and who, as a result, will exhibit challenging behaviour. *"Residential work is frequently stressful because of the clustering of many residents with serious problems"* (Howe, 1992). Regular supervision which reviews day-to-day work and professional development is essential in helping child care staff deal with issues which will arise for them in an emotionally charged work environment. In-service training and supervision are vital if professional standards are to be developed and maintained.

Guidelines on Recruitment

In 1979, guidelines on the recruitment of Child Care Workers in Residential Homes were agreed between the Resident Managers Association, the Local Government and Public Services Union and the Departments of Health and Education.

"Child Care Worker" for the purpose of these guidelines means House Parents and Assistant House Parents and Trainee Assistant House Parents.
These guidelines include statements that:–

1. Vacancies for Child Care Workers should be advertised in the public press.
2. Persons appointed should have attained a sufficient second level education standard to enable them to avail of opportunities for formal training in Child Care.
3. Minimum procedures for selection of Child Care Workers should include:–
   (a) short listing on basis of application form;
   (b) interview board to include a 3rd person (other than Resident Manager) and professional "who can provide a competent objective view of the suitability of the candidate";
   (c) full investigation of testimonials should be available to the interview board;
   (d) Garda check;

(e) full medical examination and comprehensive report on physical and mental health;

(f) during probation period an agreed assessment process to be in operation.

Because of the importance of domestic staff, it was recommended that similar procedures should be used for the selection of such staff.

These guidelines included sample application forms and job descriptions for House Parent and Assistant House Parent posts and a background note on Residential Care.

The guidelines state that a copy of these documents should accompany the application forms forwarded to each candidate.

In 1982, the Resident Managers Association published a booklet on Guidelines and Principles for Child Care Practice, which states that residential staff are recruited according to the guidelines agreed in 1979.

In the mid-1980s, the Resident Managers Association produced a handbook for Managers of Children's Centres to facilitate their administrative task. This handbook confirmed the 1979 guidelines and reproduced them in full. The task of the Residential Child Care Worker was spelt out in some detail. It also included information on Dismissal Procedures and Employee Grievance Procedures.

An Inter-Departmental Committee on the operation and financing of Children's Residential Homes reported to the Minister for Health in September 1983. The principal recommendations of this were communicated to Madonna House by the EHB in 1985. The Committee recognised the importance of and necessity for trained staff. Among its recommendations is included the following "unless otherwise suitably qualified, all new entrants to the child care service should begin participating in a training course within 2 years of taking up their appointment. The long-term aim to be that care staff in all homes should have undergone an appropriate formal course of training."

As far back as 1984, in correspondence with the Department of Health regarding the outstanding financial deficit, the Resident Manager of Madonna House demonstrated an awareness of the importance of issues such as maintaining records relating to staff and monitoring of staff performance. The Resident Manager also demonstrated knowledge that a qualification bar existed on the Assistant House Parent salary scale i.e. that staff without a recognised qualification in child care should not be paid above that point. This same correspondence suggests that qualifications and experience were considered to be of equal value by Madonna House management.

8.2 Personnel Management

In 1989, detailed job descriptions were drawn up in respect of the positions of the Assistant Resident Manager, the Secretary/Administrator and the Senior House Parent. (Appendix IV). In relation to staff selection, the Assistant Resident Manager's duties as described included assisting the Resident Manager with staff recruitment, development and training. The Assistant Resident Manager has described this job description to the Inquiry Team as "a work of fiction". There is no evidence of his being involved in anything other than sitting in at interviews for new staff. He has stated that the actual responsibility for staff selection, securing of references etc. rested with the Resident Manager.

Two other Staff Members had some involvement in staff selection, but in discussion with the Inquiry Team distanced themselves from authority or responsibility in this regard.

The Resident Manager acknowledged her awareness of the relevant guidelines regarding recruitment and states that she "didn't specifically decide" not to follow them. It was "not a conscious decision ... had to get right staff immediately etc".

The Resident Manager stated that she had "always had C.Vs and letters of application ... would have file and kept it and from that if I felt they had what was needed post offered to them ... there were often times because of resources ... because of pressure from staff ... because of numbers in house and someone out sick ... staff left on their own ... had to pull from what I had available and from those I interviewed get the qualifications I was looking for. If I had to advertise when places came up you are talking about a month; in the meantime what happens to staff or the number of children".

8.3 Qualifications, Recruitment, Development and Training

In 1991, Utting reported that in the U.K. the vast majority of staff in local authority homes were unqualified. However, only 20% of officers in charge were unqualified. (Utting, 1991)

In 1991, a study on Residential Care in Ireland reported on a survey of 60 Child Care Centres. (Streetwise, 1991) It found that, in the Group Homes, the care staff to child ratio varied from 1 staff to 1.5 children, to 1 staff to 2.5 children. The majority of Homes were found not to employ either domestic or teaching staff. While Madonna House cannot be compared directly to Group Homes, the background and circumstances of many of the children are similar. In September 1993, there was 52 children in Madonna House. The total number of staff employed at that date was 54 full-time and 4 part-time. The Madonna House staff/child ratio thus compares favourably with the national position.

The survey also showed that in 1991, a large number of child care staff in Ireland had no formal qualification. There was considerable variation in the different types of centres as outlined in Table 5.

Table 5

Child Care Staff Qualifications

	Diploma in Child Care	Other Qualification	No Qualification
Group Home	55%	10%	35%
Adolescent Units	37%	31%	32%
Special Schools	24%	4%	72%

An analysis of the qualifications held by the care child care staff, excluding members of the Management Group in Madonna House, shows that the number of professionally qualified child care staff is only 2 out of 41. More than 50% of the staff have no qualification. One third of the staff have some relevant qualification, mainly certificates in Nursery Nursing or some nursing qualification. This contrasts very sharply with the national figures outlined above, especially with regard to Group Homes.

Deployment of Staff

Within Madonna House, staff were deployed as follows:—

Management Group (4)

Resident Manager
Assistant Resident Manager
Secretary/Administrator
Senior House Parent

Core Care Staff

Table 6

Care Staff

Unit	House Parent	Ast.H/Parent	Trainee	Night Staff	Total
St. Judes	2	3	1	2	8
Prague	1 (Snr.)	3	2	2	8
Avila	2	3	1	3	9
Padua	2	2	1	3	8
Bartres	3	3	–	2	8
Total	**10**	**14**	**5**	**12**	**41**

One House Parent and one Assistant House Parent had a recognised child care qualification. The term "trainee" refers to an employment grade. Three trainees were pursuing a professional child care course.

Non – Care Staff

Playgroup	2 – Both qualified Montessori Teachers
School	2 – Both unqualified
Kitchen/Housekeeping	4 – Two trained in "Catering Industry"
Maintenance	1

Relief Staff

Night relief staff	4 part-time
Day relief staff	1 full-time

None are professionally qualified.

Total Staff

The total staff number was therefore 54 full-time and 4 part-time.

Staff Qualifications

Table 7 shows the qualifications of core staff, excluding members of the Management Group, non-care staff and relief staff.

Table 7

Staff Qualifications

	Judes	Prague	Avila	Padua	Bartres	Total
Prof Qual in Child Care	–	–	–	1	1	2
Other relevant qualification	2	3	2	5	2	14
No qualification	5	5	6	2	4	22
Student	1	–	1	–	1	3
Total	8	8	9	8	8	41

Long serving staff members were paid at the top point of salary scales, regardless of qualifications. One staff member, who is engaged totally in domestic duties, is paid at the top point of the House Parent scale. Staff employed without professional child care qualifications were placed at different points of the salary scale without apparent justification.

Unqualified staff were employed with no stipulation that they undergo training within a set time period. Many did not proceed to professional training.

The Resident Manager told the Inquiry Team that she accepted the position regarding existing salaries prior to her appointment and that her personnel decisions were based on 'personal assessment'.

Length of Service

There are deficiencies in the files and written records of Madonna House. It is therefore difficult to be confident and certain about many issues. As far as it has been possible for the Inquiry Team to establish, there was a very high rate of staff turnover among junior staff.

Of the 41 child care staff:–

2 staff were employed for more than 20 years;
15 staff were employed between 11 and 20 years;
7 staff were employed between 6 and 10 years;
9 staff were employed between 2 and 5 years;
2 staff were employed for less than 2 years;
6 staff were employed for less than 1 year.

In 1991, 7 staff left the employment of Madonna House. Only 2 of these had been employed on short-term contracts as summer relief workers.

In 1992, 10 staff left the employment of Madonna House. Only 4 of these had been employed on short-term contracts.

In 1993, 8 staff left the employment of Madonna House. Only 2 of these had been employed on short-term contracts.

In the 3-year period 1991 to 1993, at least 25 staff, almost 50% of the total number, left the employment of Madonna House. It appears that 17 of these staff were employed with an expectation that they would work long-term. This turnover is heavily concentrated in the junior ranks. Some factors considered by the Inquiry Team to influence this are touched on throughout the report. The rate of turnover of new staff combined with the retention of older staff could only contribute to an inertia within the organisation.

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8.6 School and Pre-school Playgroup

Introduction

As outlined in the introduction to this Report, one of the functions of care is compensation i.e. to help children recover from the deficits in their lives which led to or were caused by the events that prompted admission to care. This may entail, for example, extra educational support. While it may not be possible to reverse what has happened to a child, it may still be possible to help the child make up ground lost because of past adversity. (Gilligan, 1994)

The UN Convention on the Rights of the Child (United Nations, 1989), ratified by Ireland in 1992, specifies that: "institutions, services and facilities responsible for the care or protection of children shall conform with the standards established

by competent authorities, particularly in the area of safety, health and in the number and suitability of their staff".

In accordance with this Convention, it is a reasonable expectation that an educational service within a Residential Child Care Centre would conform to the standards prevailing in schools in the community.

Policy

In the document of the Sisters of Charity entitled "Policy and Code of Ethics of Child Care Service" (Appendix 1), the rights of the child to an education which is best equipped to meet his/her needs academically and socially are affirmed. The 1987 Madonna House policy document describes the pre-school playgroup as "providing for children during short-term placements, continuing whatever programmes were set in previous schools and allowing teachers assess educational abilities for future placement in special schools and remedial classes". The document goes on to say that "children remaining in Madonna House for longer periods, and who have the ability, attend local schools. Each child is allowed to avail of the education most suited to him/her".

These two policy documents underpin the stated approach to educational provision for the children in Madonna House.

Operation of the Pre-school Playgroup

The pre-school playgroup was staffed by a Playgroup Leader and Assistant, both of whom are fully qualified Montessori teachers and one of whom has, in addition, a qualification in special education. Both staff members communicate mainly with the Secretary/Administrator. The pre-school playgroup was located in an upstairs room. It was well-equipped but staff found it isolated and commented that it was difficult to use the garden. In addition to providing a playgroup service, staff assess how a child would cope with a National School and make recommendations in relation to the child's future education.

The pre-school playgroup operated from 9.30am – 12.30pm and from 2.00pm – 4.00pm Monday to Friday, catering for up to 20 children at times. The children range in age from 2 – 4 years according to one staff member, and from 18 months – 4 years according to the other, who intimated that care staff in the Units were resistant to increasing the age of admission to the playgroup from 18 months to two years. When asked to clarify this discrepancy, the Secretary/Administrator said that children began attending the playgroup between the ages of 18 months and 2 years, depending on the child. Some would be ready for the playgroup somewhat sooner than others. According to the Secretary/Administrator, they initially attended for 1 hour per day, and for the full day from the age of two years, if this suited the child. Playgroup staff expressed concern that the playgroup was seen as a babysitting service by staff of the Units, and the issue of sick children with raised temperatures being sent to the playgroup was mentioned to the Inquiry Team.

Playgroup staff expressed the view that the day (9.30am to 4.00pm) was too long, particularly for the younger children who tended to fall asleep in the afternoon. This tended to cause a degree of tension between playgroup staff and care workers in the Units who, it was stated, wanted the children kept awake in the afternoon so that they would sleep at night. A former playgroup staff member also commented that she felt the playgroup day was very long for the children. At one time children were allowed to sleep for an hour in the morning but this arrangement was subsequently phased out. By the time the children went back to their Units, 70% were ready for bed. Unit staff were occasionally late collecting children so that they remained in the playgroup until 4.30pm. This former staff member added that younger children did not get holidays so that they were in the playgroup throughout the year except for a week at Christmas. She felt that there was pressure to bring the children to the playgroup so that Unit staff could spend more time with older children. When she attempted to raise her concerns with the Resident Manager, it was implied that she herself was not able for the job and no changes were implemented.

The playgroup leader stated that she had sought guidelines on dealing with children who had been abused prior to admission but received none. She expected to be briefed on the background of the children, but only received information informally from child care staff. Some staff were good at passing on such information. A former playgroup worker felt strongly that playgroup staff should be informed of the children's background but this did not occur.

Communication with professionals in outside agencies was through the administration. Playgroup staff were not involved in Case Conferences and one commented on feeling uncomfortable about accessing files. No meetings were held with Unit staff or office staff to evaluate work. The former playgroup staff member, who spoke to the Inquiry Team, indicated that playgroup staff had to 'push' to be invited to Case Conferences. She indicated that even though it was made clear that they had access to files, they were reluctant to seek access. She cited an instance where a child, with whom they had worked for two years and with whom they had built up a tremendous relationship, was fostered without any notice to or involvement by them.

Operation of the School

The school was staffed by a teacher whose teaching qualification is in Speech and Drama and an assistant teacher who has no qualification. Virtually no in-service training was provided.

Both the Resident Manager and the Assistant Resident Manager described the school as catering for the educational needs of the following groups of children:

- children admitted on an emergency short-term basis;
- children whose schooling had been seriously inadequate due to their experiences prior to coming into Madonna House;

- children whose behaviour was such that they could not readily be placed in a school in the community;
- children awaiting assessment of educational needs, who remained in the Madonna House school until their assessment was complete;
- children awaiting placement in a special school, who remained until a place became available.

In the main it was envisaged that children admitted to Madonna House in the course of a school term would attend the in-house school for the remainder of that term, a decision then being made on the most appropriate educational placement. Where possible, children were enrolled in a local National School.

At present two children have been attending the school for two and a half years, both of whom had severely disrupted education prior to admission, and they both exhibit sexualised behaviour. The social worker responsible for these children was informed that there was a facility with small classes available in Madonna House to cater for them. In another case, a boy who was admitted to Madonna House towards the end of August 1993 was placed in the school as it would have been difficult to arrange a place in a local National School at the time. His behaviour was also a factor. The boy had not been behind in his schooling prior to admission. Staff in Madonna House had made the decision and the social worker responsible agreed with the decision. Eight months later the boy was still in the Madonna House school.

The Inquiry Team was informed that the school programme was designed to conform as closely as possible to the National School programme.

Initially Irish had not been included as a subject, but was later added as this was found to place the children at a disadvantage when they transferred to a National School. The curriculum was agreed with the teachers in discussions by The Assistant Resident Manager.

The school operated from 9.30am – 12.30pm and from 2.00pm – 4.00pm Monday to Friday, and school holidays were shorter than in National Schools. While the daily teacher contact hours were comparable to primary school hours, both teachers expressed concern at the length of the day for the children. They tried to introduce an earlier finishing time but Unit staff protested. The children were aged 4 – 12 years, and, on average, 16 children attend the school.

The school experienced some problems with unruly behaviour by the children and difficulties with disturbed children needing special attention, particularly in recent times. Incidents of sexualised behaviour are reported to Unit staff and to the administration. One of the staff would have liked to introduce a "Stay Safe" programme in the school, but was not given the facility to attend a training day, even though she had already obtained the necessary programme materials. When this issue was raised by the Inquiry Team with the Resident Manager, she said that

the emphasis was on child care staff in the Units dealing with the problems covered by the programme.

School staff were involved in Case Conferences, were able to access children's files and were able to contact social workers through The Secretary/Administrator. Although the organisation chart indicated a reporting relationship with the Secretary/Administrator, they reported mainly to the Resident Manager. There has been no formal evaluation of the performance of the school but the Resident Manager commented that there had been no negative feedback from the schools to which the children transferred from Madonna House.

The Resident Manager informed the Inquiry Team that the teachers' salaries were not recouped from the Department of Education. She said that the Department would not accept that children should be educated in an institution. Many social workers remarked that the location of a school on the campus contributed to the institutional atmosphere of Madonna House. One of the former residents commented that she found it difficult to adjust to a school in the community, having first attended Madonna House School.

Conclusion

The pre-school playgroup is well staffed and well equipped, although not ideally located on the Madonna House campus. The main concerns related to the length of the day for very young children, particularly in view of the lack of provision for day-time naps. This concern was identified by playgroup staff and brought to the attention of the Resident Manager, but the issue was not addressed. There was also a need to improve communication between care staff and playgroup staff to facilitate optimum care of the children.

The Inquiry Team is satisfied that while members of the teaching staff at Madonna House had relevant qualifications, it is our view that these qualifications were not sufficiently specialised for the particular needs of the children in Madonna House. While this may be acceptable where children attend for short periods of time, the fact that children who were already educationally disadvantaged may spend more than two years with untrained teaching staff at a critical time in their schooling raises serious questions. There was no indication of any questioning by management of the appropriateness of the duration of attendance of some children, nor did the lack of qualifications of the teachers appear to be an issue of concern. The school was not subject to inspection by the Department of Education Inspectorate. In the absence of any evaluation, the questions raised about the appropriateness of the service provided remain unanswered.

CHAPTER 9

Disclosure

9.1 Introduction

The Inquiry Team were concerned to review the circumstances under which residents and former residents of Madonna House came to make precise allegations of sexual and other abuse.

Aspects of the case histories illustrate the complexity of the disclosure process. The histories referred to in this section do not purport to be comprehensive or exhaustive, but are, in the view of the Inquiry Team, relevant and significant examples of the disclosure process as it operated in fact.

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9.3 Why Children Cannot Communicate Effectively about Abuse

A number of reasons are identified in the literature as influencing children's maintaining secrecy about abusive sexual experiences and these include rewards and threats, enjoyment of the activity and the fact that the sexual attention may be the only form of affectionate physical intimacy experienced by the children. (Sgroi, 1982)

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It is noteworthy that the children in Madonna House as children in care had substantially different life experiences from ordinary children in the community. It was possible to see certain patterns in some of the childrens' responses to the abusive experience and identify those factors which inhibited their effective disclosure of abuse.

A number of children compared their abuse in Madonna House with previous abusive experiences. One child alleging sexual abuse by a staff member said that she had experienced "a lot worse" and was not uncomfortable or shocked by the experience at the time it occurred.

A number of other children expressed the same sentiment indicating clearly that their experiences prior to care had been worse and more traumatic than the alleged experiences in care, and a number of children displayed far greater upset regarding the previous abusive experiences. Indeed one child indicated that she did not find the initial alleged inappropriate behaviour of one staff member as

particularly troublesome, while another child commented that her own alleged abusive experience in care was not that bad compared to the experience of others.

Some of these children took steps which they saw as protecting themselves from further alleged abuse, such as ensuring that they were never in the immediate work area of the staff member in question or of disclosing to older children. One girl stated that she felt that she should have told her friends who had spoken up for her.

Peake (1992) maintains that the ethos of a particular regime of care can often confuse and confound a clear definition of abuse. She states that settings in which control is a major feature can result in a blurring of the boundary between control and abuse. The former residents from Madonna spoke of children allegedly being whacked across the legs, being slapped, deprived of food, put outside their units or made to wear pyjamas during the day. In addition, they made allegations of physical assaults by a particular staff member.

One former resident claimed that a particular alleged assault on her taught her a valuable lesson and that she had never repeated the offending behaviour which had led to this assault.

Another former resident alleged that he and his brother were periodically subjected to "firm" discipline which included on occasion episodes of physical violence. This former resident expressed the view that this discipline was beneficial to himself and to his brother. He characterised the staff member involved as a good friend and felt that the treatment was appropriate to his circumstances.

Another former resident characterised the discipline to which she was subjected as something which initially terrified her but which over time she was disposed to accept as a normal feature of life in residential care.

Yet another girl speaking of the alleged treatment received by her sister said that at the time she went along believing that this was the only way to control her. She described it as terrible when it started but clearly then began seeing it as a ritual. Looking back she feels that she would react very differently if her own children were so treated.

Clearly children who have been traumatised can have heightened vulnerability and if abused in a relationship with somebody on whom they have a degree of dependence, they can become confused about what is appropriate and inappropriate adult behaviour. This confusion can have a powerful and long lasting influence on such vulnerable children, and its effects are visible and identifiable into adulthood.

The vulnerability of the children was heightened by their isolation.

A number of the former residents spoken to by the Inquiry Team had no significant family ties or received very limited support from their family of origin.

Madonna House had a clear policy of openness towards the families of children in care, however, it was not possible to identify any policy or procedures enabling children to initiate contact with significant family members, social workers or other such people outside of Madonna House. In practice real barriers existed to children making contact outside of the centre when they wished to do so and rules governing access to telephones etc. were an actual and psychologically isolating factor.

A range of other factors contributed to the children's effective isolation. These included the distance from their homes and the difficulties which their parents had e.g. in travelling to Madonna House. The attendance at school within the confines of the institution was also significant. Perhaps the most striking communication from the former residents was the absence of long lasting affectionate, emotional bonds with caring and consistent adult figures. Peake contends that the notion that there "is someone rooting" for a child as an important individual is only faintly matched by the key worker system in many residential settings. In Madonna House even this tentative safeguard was lacking as there was no key worker system in operation. Many former residents spoke sadly of not being specially close to anyone and of staff changes. These young adults communicated a sense of loneliness, isolation and rootlessness.

Children with special needs arising from emotional or behavioural difficulties or from specific sensory disabilities can experience particular difficulties and inhibitions in communicating their concerns effectively. Similarly children from the travelling community tend to be especially vulnerable. A former resident who is a member of the travelling community described a staff member cursing at her and calling her "a little tramp". She recalls complaining of this but her complaints being ignored. Another former resident from the travelling community felt he had to hide his allegations of abuse at least partly because of his travelling background. He now sees himself as head of his family and says he could not tell any of the younger members as he feels that he has to be the strong one.

These vulnerable and isolated children were particularly aware of the friendships and relationships among staff and one particular child claimed that it was difficult to disclose the alleged abuse as she perceived the staff member, against whom she wished to make the allegations, as being particularly popular among the staff.

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A number of factors would appear to the Inquiry Team to render some children more or less likely to disclose experiences of concern or abuse in care. These factors include:—

1. age;
2. degree of disability;
3. history of previous pre-care abuse;

4. perception of the response of significant persons to the disclosure/ discovery of the previous abuse;
5. actual physical isolation from significant adults;
6. psychological/emotional isolation;
7. absence of significant committed and involved adult;
8. availability of specific and regular opportunities to spend time with an informed and skilled adult in an appropriate setting;
9. clarity on the anticipated outcome of disclosure;
10. experience of response to previous concerns expressed while in care.

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CHAPTER 10

Experiences and Perceptions of Children and Parents

10.1 Introduction

As part of the work of the Inquiry Team, a number of young people who had spent a large part of their childhood in Madonna House were interviewed. They gave graphic accounts of their experience of growing up in care. In addition, in some instances E.H.B. social workers and parents of children in care gave their perceptions of life in Madonna House for children.

10.2 Children's Prior Experiences

The children's experience in Madonna House must be viewed in the context of their experiences prior to admission. Such experiences included being subjected to physical or sexual abuse, neglect, witnessing parental violence, parental substance abuse, disrupted education and breakdown in previous placements. One young person described how as a 7 or 8 year old she took over the role of mother to her three younger siblings, missing school, stealing from churches to get money for food, searching public houses at night to locate her mother, being locked alone in a flat for hours. Three of these children many years later alleged that they had been sexually abused prior to coming into care.

Another girl described being locked into a flat when she was aged 6 or 7 when her mother went on drinking binges. She cared for her two younger siblings, aged 5 and 2. She too recalled being sexually abused at home. The admission to care was precipitated when they were left abandoned in a park by their mother and this girl went with her siblings to the family's social worker in the local Health Centre.

One social worker spoke of two girls aged 7 and 8 who had experienced at least 10 home moves in Dublin in the 2 years prior to being taken into care. Both girls were allegedly sexually abused by a number of men.

A mother whose children were resident in Madonna House spoke of the extreme violence to which she had been subjected by her husband and which was witnessed by the children from their earliest days. The mother described an incident where her 5 year old daughter rendered her husband unconscious by smashing an object on his head during a violent assault on her. She also described being flung out a top storey window when she was pregnant and going into labour with a broken

leg and broken ribs. Such violence was witnessed on a regular basis by the children. The children themselves were flung against walls and beaten viciously by their father in response to any misdemeanour on their part.

The above examples illustrate the kinds of experiences to which children coming into care have been exposed.

10.3 Importance of Family

The Sisters of Charity Child Care Service is directed towards the rights of the child:

> "– to have his/her family treated with respect and dignity and to be treated at all times as a member of that family, especially in situations where alternative care is being planned,
>
> –to have his/her family and friends to visit as often as possible.....".

The importance of family links was stressed by many of the young people we spoke to. One girl, who was admitted to Madonna House some months after her sister, commented on how good it was to meet her again. Another spoke of being very protective of her two younger siblings. Her dream was to own a house and to live with her siblings as a family. A young man spoke of always wanting to go home and of missing his family.

One girl spoke with a great sense of loss of her family being split up. She and one of her sisters were placed in one Unit while her other two sisters were assigned to a different Unit. She felt that she had missed part of her youngest sister's growing up. Even though she was next door, she did not know what was happening in that Unit at night. She can remember nothing of her older brother who went to live with his grandmother prior to the younger children being taken into care. Efforts were made to foster the four younger children together with one family. It was deeply upsetting for the children when this did not come to pass. Subsequently the two younger children were fostered and their elder sister describes poignantly her sadness when they left Madonna House and the difficulties they all now experience in trying to establish normal family relationships.

One young man spoke of an overwhelming loneliness and sadness due to the absence of a family and the normal network which comes with living with a family in the community.

One social worker had a memory of being distressed when children who had been abandoned and taken into care were subsequently placed in different units within Madonna House. She felt that the children's sense of being part of a family was not facilitated by the accommodation structure of the residential home. However, other social workers spoke of the ability to admit family groups as being one of the strengths of Madonna House.

10.4 Being in Care

Admission to care is a major event in a child's life. One girl, who was aged 5 at the time of admission, spoke of feeling scared and alone on her first day in Madonna House, not knowing anyone. Two of the girls, who subsequently spent many years in Madonna House, initially saw their admission to care as something of a holiday.

Many of the children had good memories of Madonna House, especially in their younger years. They spoke of being happy there, of Madonna House being a good home to stay in, a great place for childhood, of staff being good to children, and of not wanting for anything materially. In particular they spoke warmly of holidays spent in Rosslare and the fun they had there.

The social workers spoken to also cited instances of loving care of children, of concern for the children, of staff being attuned to the needs of children, and being committed to their care and welfare. One social worker referred to a child who looked back on her time in Madonna House as "bliss". Another spoke of two young siblings, one of whom had blossomed in her time in Madonna House, and the other whose speech and communication skills had developed. Children's physical and medical needs were well catered for.

Some children developed a relationship with a member of staff, whilst others did not feel especially close to anyone. Where children developed close bonds with staff members, there is evidence to suggest that they were likely to receive special treats or presents, have nicer clothes to wear and feel special. They sometimes visited the staff member's outside home and stayed overnight or for weekends. Other children spoke of their resentment of such special treatment of some of their peers. One child who was not singled out for special attention spoke to his social worker of Madonna House as a sad place.

Social workers too spoke of children being treated as pets by staff. One such boy who had both sensory and mental disabilities was felt to be overprotected . This close attachment was viewed by the social worker to be a "holding" rather then an empowering one. However, in other cases, children were nurtured and enabled to move on from Madonna House.

A number of the young people who grew up in Madonna House contrasted the treatment of younger children with that received by pre-teens and adolescents. They spoke of Madonna House as being more for babies than for children and of staff being more available to the younger children who got most of the attention and physical shows of affection. One young woman spoke of having to wait until the end of the day, when the younger children were settled for the night, to get attention whereas in foster care her foster mother is available to her at all times. The young people suggested that personal attention was not facilitated by the large numbers of staff who in fact cared for them, the high staff turnover, the shift-work system and the night rota. The impression given was that whoever was on duty looked after the children,and fed them but may not have had time to sit

down and talk to them. However, it was also clear that some staff members tried to encourage children to discuss their problems with them.

The suggestion that the particular emotional needs of a child were not being met was also conveyed by social workers interviewed by the Inquiry Team. They spoke of an apparent lack of individualised care, the large number of children being cared for and the difficulties small children have in coping with changes in staff. One child with multiple disabilities is said to have improved remarkably since he was fostered, becoming more independent and developing many new skills. The social worker involved with him feels that he regresses when he spends a period of time in a residential setting during summer holidays. The need for a key-worker system was stressed. One social worker observed that staff appeared to have the skills to meet the children's emotional needs, but needed to be empowered by the social workers to apply those skills. There appeared to be a gap between the care staff and Management in Madonna House.

The young people interviewed in the course of the Review were especially critical of their treatment as teenagers. They had no choice as to the food they ate and, because of the younger children, could not always watch their chosen television programmes. One young woman spoke of the need to have time alone as one gets older and of staff going overboard asking questions, wanting to know her every movement. Boys and girls in Madonna House were not supposed to go out together. On one occasion a boy and girl were found kissing by staff and were admonished by staff. Teenagers had to stay under a light when they were out in the grounds. This was interpreted by one of the boys as staff being afraid that they were courting.

One of the girls spoke of having a boyfriend when she was aged 13 to 17. It was an entirely innocent relationship but she claimed she was made to feel very guilty by staff. Another girl spoke of being in her night-dress one evening and brushing off one of the boys in the corridor. She claimed she was made to feel "dirty" by staff. This girl also spoke of another incident when she was 15 and a boyfriend gave her a "love-bite". She recalls being collected from a friend's house by the the Assistant Resident Manager. Three staff members questioned her and spoke to her for hours. While she agrees the matter should have been discussed, she considers that it was blown out of all proportion.

Social workers spoke of Madonna House being run as a large institution. One observed that the presence of the school on-site was a contributing factor. One of the boys described life in Madonna House as being confined and dull. He talked about not being allowed off the site and missing out on a whole range of experiences a young boy would automatically encounter when living in the community. He contrasted this with his memories of holidays in the country with his extended family where he was active and free and quite normal everyday interactions seemed exciting. As an example of the consequences of the restricted lifestyle in residential care, he described how classmates had, at a later stage, to teach him how to use public transport. Initially when he mixed with working class boys in school, he felt that in some respects he was better off than they were. However,

he later realised that their normal experiences of family life gave them a richness which was more valuable than his own experience.

Another boy described how he was not "streetwise" when he left Madonna House. Children in his new school thought he was posh and stuck-up and he could not understand many of their everyday expressions.

10.5 Parents of Children in Care

A small number of parents were interviewed by the Inquiry Team. In general, their experience of Madonna House was a positive one. One father spoke of the good physical environment and described most of the staff as being "A1", and of some being "brilliant". He had adverse comments to make about only one member of staff who appeared to him to be aggressive and unpleasant.

One mother seemed negative about one of the Units in Madonna House, and spoke of the children being better cared for in a more individual way in another Unit. She commented that her son was negative about Madonna House whilst her daughter was more positive about her experiences there. However, there were no specific incidents of concern in relation to the care of her children.

One of the main difficulties emerging from parents, children and social workers was in relation to the access facilities for relatives in Madonna House. One room only was available, which has been described to the Team as dismal, cold and not child-friendly. This room could become quite crowded with a number of families, with little privacy, and it was not possible to book the room for special occasions such as birthdays. One mother also spoke of the difficulty in visiting her children in Madonna House which involved taking two buses from her home.

Social workers spoke of Madonna House as encouraging and facilitating parental visits; being open to the views of parents; being patient with a parent who at times showed a rather imperious attitude and could be provocative, and being open to working with the natural parents. One social worker recalled a case conference many years ago in Madonna House to which parents were invited, and interpreted this as a recognition of the parents' position.

This view of the attitude towards parents was not universal. One social worker observed that some parents were greeted warmly and staff made great efforts to help; at other times staff felt parents should not be brought into the reckoning if they had not made a good impression. This concurs with the opinion of another social worker who felt that parents may have been viewed negatively, especially where there was a history of abuse, whereas in other cases parents visited daily and were facilitated.

One of the children spoke of staff liking her grandfather, who was a very important person in her life. However, she had a feeling that staff did not like her mother, perhaps because she felt they thought she was not a good mother.

10.6 Leaving Madonna House and Leaving Care

The policy and code of ethics of the child care service of the Sisters of Charity affirms the right of the child:

> "to be prepared for departure from care as fully as possible, secure in the knowledge that she/he will be welcome to visit and receive suitable support until she/he has achieved a mature level of independence".

It also states that an After-Care Service will be provided for those who have a need for such a service. Leaving Madonna House brought difficulties for virtually all the children to whom we spoke. It must be remembered that this is a selective sample of children who spent a large part of their lives in care in Madonna House.

It must be noted that significant numbers of these children came into the care of Madonna House with a background of distress, financial hardship and serious continuing personal problems. When a child reached a particular age their stay in residential care, in the main, came to an automatic end. These young adults irrespective of their maturity, capabilities, or personal circumstances were released into the general community without any proper supervision or support. In the view of the Inquiry Team, the failure to provide an organised and effective after-care service by all agencies who previously had a role in contributing to the decisions relating to these children may, in certain instances, have contributed to some of these children failing to become productive and valued members of society. The Inquiry Team formed the view that a disproportionate percentage of children whose personal circumstances included a discharge from residential care became homeless, isolated and involved in substance abuse.

Two of the girls who attended special schools felt that they had missed out educationally. They had no State examinations and felt at a disadvantage when applying for jobs.

One of the boys who left at age 14 to go to another Children's Home said that he had not felt ready for the step. He had never slept in a room by himself, and was moved to sleep in the sitting room of his Unit in Madonna House just prior to his transfer. This appeared to be the extent of his preparation, having spent all but the first few months of his life in Madonna House.

In general, the children were ill-equipped to deal with the practicalities of daily living. They did not know how to set about finding a flat, were unfamiliar with rent-books and lacked budgeting skills. Two of the children spent some time in Madonna House in a transition phase, when they paid rent and were expected to look after themselves. However, there was no structured preparatory programme in place. One staff member agreed to help one girl to find a flat.

As outlined previously, some children developed a close relationship with a staff member while they were in care. These relationships were very important to the children. One young woman spoke of the Resident Manager as being like a

mother, and spoke very warmly of receiving a birthday card from her even though she had moved around a lot, and of getting an Easter egg from her even after she had left Madonna House. One young man spoke of a staff member who still maintained contact with him even though she was no longer employed in Madonna House. This, however, was the exception rather than the rule.

One young woman who came into care as a result of being abandoned spoke of her loneliness when she went to live with a family. Staff from Madonna House did not visit. They had become her family and it was like being disowned again. A young man referred to one of the House Parents as being like a mother to him. He still phones her and brings her a present at Christmas. However, she had not kept in contact with him. His sadness was obvious as he spoke of building a relationship with a staff member which then ends. Another girl also spoke of her House Parent as being her mother and described her shock at being left on her own when she moved out of Madonna House. There was no contact with staff and she remembers feeling lonely and said that no-one cared. She occasionally met a staff member for lunch. She called out to Madonna House every two months or so but felt no one had any time for her there. This impression was confirmed by one of the boys who visited with another former resident. They felt in the way. Staff did not appear to care about them. They felt like numbers, now dismissed, and wondered if they had done something wrong.

Another girl had kept in touch with one of the staff members and called occasionally to Madonna House. She had not visited since her allegations of abuse there. She was afraid people would brand her a troublemaker and would talk about her.

Two male former residents described the emotional trauma in their adult life which they linked to an allegation of sexual abuse in care. One recounted an apparent suicide attempt. The other described his abuse of drugs and his fear that his own children would be sexually abused. Some former residents spoke of one of their peers, also a former resident, whom they described as particularly isolated and vulnerable, with serious detrimental effects for him. This person, during the course of our review, was found to have, tragically, taken his own life.

10.7 Conclusion

The Inquiry Team is concerned to again emphasize that the interviews carried out with former residents were limited in number. In the main, though the sample of interviewees was small, a significant number of them had been in care at Madonna House for extensive periods of time. The conclusions that follow must take account of this particular limitation.

The picture which emerges is of a service which focused on the physical and material well-being of the children. Many staff were dedicated and committed to the children in care. Given the histories of the children coming into care, warmth, security and mutual support are likely to be particularly important in their growth and development. (Colton 1988, 176)

While children have good memories of their time in Madonna House, the overall perception is that there was a lack of individualised care and insufficient attention paid to assessing their emotional needs.

Some staff allowed special relationships to develop with children, relationships which ended abruptly when these children left Madonna House. Other staff members regularly brought children to their own homes. While this was perceived in a positive way by the children, such contact poses risks to the child and staff member. (Dileonardi and Kelly 1989, 251) In general, parents were encouraged and facilitated in their contacts with their children. Facilities for parental access were inadequate.

The lack of preparation for leaving Madonna House and for leaving care was striking. No arrangements were in place to facilitate maintenance of links with those who had been key figures in the children's lives. The loneliness, hurt and rejection experienced by the children was very evident.

Many of the children coming into care in Madonna had lived with parents and in families experiencing severe dysfunction. These children's need for stability, security, and age-appropriate experiences had not been met prior to coming into care. They were particularly vulnerable and in need of sensitive caring, over and above that required by the average child. The only means of meeting the emotional needs of the children would be in a relationship with one or two specific adults with whom they could develop this and from whom they would experience warm and personalised care.

Each child had a designated social worker and the files of the E.H.B. demonstrate that they visited the children and that review meetings were held. These meetings, by their nature, considered the broad progress of the child and developed plans for the future. In the context of these overall care plans, one would reasonably anticipate that care staff would have their own processes for ensuring that the children's developing needs were identified and understood, and that appropriate responses were put in place. In fact, there is no evidence from files or interviews that any significant attention was given by management to this issue. The available information suggests that the need for internal personalised care planning was neither appreciated nor understood by management. The absence of any means of ensuring appropriate care was recognised by care staff, and communicated to management. No response is evident.

In the view of the Inquiry Team, it is impossible to ensure good standards of care without some type of designated key worker system. Such systems operate in many child care centres, but do not appear to have been practised in Madonna House. Consequently everyone was responsible and no one was responsible for the detailed personalised emotional care of each child.

Certain staff members did develop affectionate relationships with some children. However, this was haphazard, and could be driven by the needs of staff. The impact of these relationships on those children who had no special friendship or advocate reinforced their sense of isolation, loss and stigma.

CHAPTER 11

Conclusions

11.1 General

Madonna House was established in 1955 for emergency and short stay placements of young children. The upper age limit was extended to seven years and later to ten years but, in practice, the limit was exceeded. The Home was re-located in 1972 in a new building at Linden, Stillorgan, comprising five units on one campus with institutional features, such as a school, a central dining room and central records. It provided services for a variety of age groups with differing needs, disabilities and lengths of stay. The physical standards of the Home were high and it was well equipped.

It became the largest residential centre in the eastern region for reception of children into care, and had an open admissions policy in dealing with the requests for places by the E.H.B. and the Gardaí. Most of the children admitted came from Dublin's inner-city and its northern and western suburbs. Some of the E.H.B. Community Care Areas had very few admissions to Madonna House.

The location and organisation of Madonna House was not compatible with current views on the provision of residential child care services which favour smaller units located in the children's own communities. In the period from 1984 to 1993 there was a total of 1,113 admissions.

11.2 Policy

Madonna House Policy Document 1987 indicated a lack of clarity regarding the organisational policy and failed to recognise the child care service requirements involved in meeting the needs of children.

Madonna House was developed as a children's village apart from the community. This concept was out of date even at the time of construction.

The stated policy of providing for emergency admissions and short to medium term placements was not maintained in practice.

11.3 Activity Levels

The average number of admissions per year for the past decade was 111. Despite a dramatic fall in the number of admissions from 1984-1985, this was not reflected in the occupancy levels which remained stable.

Many children who were admitted had experience of family breakdown, violence and abuse.

The acknowledged lack of more appropriate placement options and an inadequate approach to care planning within Madonna House led to difficulties in meeting the conflicting needs of children of different age groups and durations of stay.

The very large number of young children under 5 years of age in residential care in Madonna House was considered to be wholly inappropriate by the Inquiry Team. The placement of young children in residential care for long periods is inappropriate to their needs and cannot meet their developmental requirements.

11.4 Allegations – Phase 1

A total of 15 children to date have made specific assault allegations against Staff Member A to the Gardaí and the Health Board. Five others have described behaviour by Staff Member A which constituted alleged abuse.

The sexual abuse for which Staff Member A was subsequently convicted took place over an approximate five-year period between 1985 and 1990.

From the available reports and assessments, the allegations of sexual abuse of the children by Staff Member A covered a wide spectrum of abusive activities over a longer period:

- The children's ages ranged from 7 to 15 years.
- The abusive activities involved the use of sexualised language, and a wide category of inappropriate behaviour constituting serious sexual assaults.
- Both male and female children were involved.
- Rewards of money and treats were used.
- There were elements of fear and coercion.
- The alleged abuse took place in secrecy, mostly in the immediate work area of Staff Member A and on one occasion outside of the home.

The long-term effects of child sexual abuse vary according to factors associated with the abuse and the resilience of individual children. The Inquiry Team are satisfied that in particular cases the alleged abusive conduct of Staff Member A has caused continuing emotional damage to some of the children concerned.

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11.5 Allegations — Phase 2

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11.6 Allegations — Phase 3

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11.7 Allegations — Phase 4

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11.8 Other Concerns

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11.9 Controls and Management

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11.10 Personnel

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11.11 Finances

The Budget and sub-headings were agreed annually in negotiations with the E.H.B.. However, because salaries paid to some of the management group exceeded those allowed by the E.H.B. and the Department of Health, an annual deficit of approximately £20,000 arose. This was the subject of ongoing disagreement between the E.H.B. and Madonna House.

The Inquiry Team was concerned by the inadequate vouching system and at the high level of expenditure by way of petty cash. For example, the payment of wages to two ground workers from petty cash was unsafe.

11.12 Children's Experiences

The Inquiry Team could identify no significant differences in the experiences and histories of the children admitted to care in the 1970s and early 1980s from those of the young children admitted to care more recently.

Of the nine former long-stay residents of Madonna House interviewed by some members of the Inquiry Team, all except one had allegedly experienced incidents of either physical or sexual abuse while in care in Madonna House.

Relationships with staff in Madonna House were experienced by many former residents as warm and affectionate but felt to be inconsistent and limited by the personal needs of staff.

The almost complete absence of an aftercare service for those former residents who had spent most of their lives in Madonna House resulted in feelings of loneliness, hurt and rejection.

Members of the Inquiry Team were concerned at the level of emotional distress of two of the former residents resulting from their sexual abuse and about the emotional vulnerability of other former residents.

11.13 Pre-School Playgroup

The Pre-school Playgroup had qualified staff and was well resourced. The inappropriate use of this service, including attendance of very young children for long hours, demonstrated a lack of sensitivity to the needs of young children.

The professional advice of the Pre-school Playgroup leader in this regard was rejected by the Resident Manager.

11.14 School

The employment of inappropriately qualified teaching staff and their management could not ensure appropriate special education provision for the children for whom the school was intended.

11.15 Relationship with Gardaí

Gardaí had a good working relationship with Madonna House. The readiness of Madonna House to take children at any time, day or night and at weekends, eased very difficult situations.

11.16 Parents

Parents of former and current residents expressed their appreciation of the kindness and care given to their children and the openness of staff to them.

11.17 Care Planning

There was no system in place to establish adequate personal histories of children or to record systematically their progress in Madonna House. Such information as was collected was not shared effectively.

11.18 Future of the Service

The Inquiry Team in the course of the review came to the conclusion that Madonna House was unsuitable for the continued provision of residential care for children it had previously cared for.

In the light of the current needs of children requiring residential care, the Inquiry Team concluded that the location, lay-out and organisational culture of Madonna House militated against the provision of high quality child care. Consequently,

the Inquiry Team communicated to the Sisters of Charity its view that Madonna House should be phased out and services developed in local communities.

11.19 Lack of Co-Operation

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11.20 Commentary

This Review was limited to the operation of Madonna House and attempts to understand the story of Madonna House. It was not a public inquiry with submissions from interested parties. Recent public allegations of institutional abuse in this country and elsewhere suggest that the issues under review are of widespread concern. While the conclusions are based on the experience of Madonna House, the issues raised are likely to be of relevance to a broad range of residential services caring for vulnerable groups.

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A variety of factors contributed to the way in which Madonna House developed and operated. In considering some of these factors and associated issues, it is important not to overlook fundamental contextual problems. In this regard we would echo the comment of William Utting that "the major problem is simply that the residential care of children is commonly regarded as an unimportant, residual activity. Thinking about it today it is still dominated by historical attitudes towards looking after children; as women's work in which the skills are inherent or intuitive and the commitment of the work force is exploitable". (Utting, 1991)

Furthermore, we would assert that an historical belief in the superiority of substitute care within a Residential Home to children's own troubled families created "little impetus to pay attention to the quality of care children actually receive". (Rindfleisch and Bean 1988)

It would be easy and even reassuring to adopt the 'bad apple' perspective whereby Madonna House could be seen as unique and the significant individuals within the organisation as also unique. Early reviews of public service organisations in other countries concentrated on individual behaviour and made this 'bad apple' assumption when care became abusive. It is becoming clear that the corruption of care can most meaningfully be understood as the "product of particular kinds of social systems". (Wardhaugh and Wilding 1993)

The Inquiry Team takes the view that it is more accurate and more productive to view Madonna House and the abuses that occurred in the context of a dysfunctional social system. This is not in any way to minimise the responsibility of individuals but is an attempt to develop a reliable understanding of what occurred.

The Inquiry Team felt that it was appropriate to consider external contextual factors and related factors.

11.21 Children's Rights

A specific and clear statement of children's rights in care has not been developed. This absence can result in confusion and facilitate ambivalence in both adults and children. Such a statement based on the needs and rights of children would serve as guiding principles for service development and professional practice. The United Nations Convention on the Rights of the Child (United Nations, 1989) was ratified by Ireland in September 1992. The underlying principles of this Convention "emphasise the paramountcy of the child's welfare; the child's rights to express views and to be permitted freedom of expression, thought and association; the child's rights to be free from discrimination, inhumane treatment, unlawful restrictions of liberty and all forms of sexual, physical and mental violence; the child's rights to information, education and health care and the child's rights to have these rights widely known" (Lindsay, 1992). Article 3.3 of the Convention emphasises the need for substitute care to conform to the highest possible standards.

The Task Force Report on Child Care Services, 1980, stated that children's needs and rights are distinguishable because they are "persons in the process of formation ..... and are not independent".

The United Nations Convention recognises that children have independent rights. However, children are often dependent on adults to assert these rights. This is the responsibility of parents and the State as guardian of the common good.

Children in care have unique vulnerabilities directly related to their status in care. "Children in care are especially vulnerable since they suffer a threefold risk of abuse. The first level of risk they face is on the basis of their status as a child. The second level of risk relates to the abuse or traumatic experiences which led to their entry into care and which are likely to have provoked or deepened a sense of powerlessness or worthlessness. These in turn heighten their vulnerability to abuse, exploitation or unscrupulous domination. The third level of risk relates to their dependence and isolation in care" (Gilligan, 1994). This special vulnerability of children in care means that they will have special needs which must be specifically addressed.

The constitutional recognition of the rights of the family has influenced the framing and interpretation of the law concerning children. A concern that children's rights might be given, or be seen to be given, less value than the rights of their parents has led to recommendations that Articles 41 and 42 of the Constitution be amended to include a statement of the constitutional rights of children (McGuinness, 1993).

There is an urgent requirement for a Statement of Children's Rights in Care to be developed.

11.22 Child Care Act, 1991

The Child Care Act, 1991, which is being gradually implemented, has the general purpose of up-dating the law in relation to the care of children, particularly children who have been assaulted, ill-treated, neglected or sexually abused or who are at risk.

A number of provisions are aimed at promoting the welfare of children. The regional Health Boards are given responsibility for promoting the welfare of children who are not receiving adequate care and protection and are given power to provide, or to have provided, child care and family support services. This broad provision is likely to have considerable implications which have yet to be tested, and it places an obligation on the Health Board to identify those children who are not receiving adequate care and protection and put in place services to promote their welfare. The obligation and responsibility of a Health Board to children it has taken into its care can only be viewed as demanding the highest possible care standards and vigilance by its officers in the maintenance of these standards.

Certain provisions of the 1991 Act, which are not in force yet have particular relevance to Residential Child Care Services. The most important of these are found in Parts VI, VIII and IX. Health Boards are empowered to provide children's residential centres and to maintain a registration system for residential facilities for children. Health Boards will be required to carry out reviews of children in care and enabled to provide aftercare services. The Minister for Health is required to make regulations to secure the welfare of children placed in such centres. This may include requirements relating to staff numbers and qualifications, records, food and accommodation.

The Minister for Health is also required to make regulations governing the placement of children in residential care and this may include provision for supervision and visiting of children.

The implementation of these provisions would provide a comprehensive legislative and regulatory framework. The absence of a regulatory framework in relation to residential care services, including Madonna House, allowed the continuation of practices which fell below reasonable standards.

The existence of such a framework will not, in itself, guarantee that good standards of care will always be maintained. However, it is one of the essential elements necessary to ensure that children receive appropriate care. The need for statutory regulation is demonstrated by the failure of Madonna House Management to follow established voluntary guidelines. This failure was not immediately obvious, and suggests that inspection will need to be sophisticated, rigorous and continuous.

11.23 Awareness

Child care professionals are aware that lack of knowledge, skill and personal openness were key factors inhibiting disclosure and discovery of abuse within families prior to the 1980s. The general deficiencies in large scale child care institutions of the past are now all too obvious. However, it is only in recent years that there has been any substantial public or professional awareness of abuse in modern child care services. While a number of Inquiry reports are now available from other countries, the professional literature in this regard is limited and no systematic survey has been conducted to date to establish the incidence of abuse of children in care either in Ireland or the United Kingdom.

An awareness of the vulnerability of children in residential care to abuse and the need for explicit exploration of this issue was not evident in the practice of agencies which interacted with Madonna House. There is little evidence to suggest that in this respect they were substantially different from similar agencies throughout the country.

11.24 Research/Evaluation

Some pointers as to the vulnerability of children in care did exist in accounts of children's stories of the past. However, there is limited research or evaluation of current residential child care in Ireland. In this regard, Ireland is not substantially different to many European countries, with the notable exception of the United Kingdom. While there are some exceptions, the scope and scale of research in Ireland has been limited severely by the availability of resources. In addition to the lack of information, there is little public accountability for residential child care services. It is not customary, for example, for children's residential centres to produce annual reports.

There is an urgent need for a major co-ordinated research initiative on child abuse and neglect, to include the following:

- A comprehensive yearly national data system on—

  1. all forms of child abuse, and
  2. all reported crimes against children.

  This needs to be supplemented by regular national studies to assess the unreported victimization of children, including family violence.

- Appropriately supported specialised research programmes on child protection in health, education, justice, social services and substance abuse programmes.
- A programme to provide universities with support for training researchers in child abuse and neglect.
- Theory and research that integrates the various forms of child victimization.

– Arrangements for national co-ordination of research into child care should be put in place.

The interaction of Madonna House with the larger child care system was fragmented. External agencies and personnel interacted with Madonna House in relation to particular aspects of the service such as the care of a particular child, the annual budget allocation or the placement of a particular child care student. No agency or person had responsibility or authority to take an overall perspective. Moreover, no systems were in place to ensure the communication or sharing of concerns between individuals or agencies interacting with the service.

The broader child care system is experiencing profound social and legislative change. There are widely acknowledged gaps in current service provision and resources, especially in relation to services for older children. Considerable strain exists as services and professionals attempt to respond to ever-increasing demands. Consequently, dependency can develop on a service such as Madonna House which often was the only available placement option in a time of crisis for Health Board staff attempting to provide care for children. This situation of dependency is not conducive to the development of a culture of critical appraisal. While professionals will always have to carry responsibility for individual children and families, there is a need for a broader service evaluation. In this context, it is possible to under-estimate the pressures which can exist within organisations not to disclose issues of concern. Consequently, monitoring and evaluation will need to be sophisticated and thorough. An element of independence will also need to complement professional participation.

11.25 Vulnerability of Children in Care

The children who are admitted to residential care and their families are not representative of the broader population. The children are drawn disproportionately from the poorer and more disadvantaged sections of society. Their families are frequently educationally disadvantaged and have limited support networks. Many of the parents can be overwhelmed by pressures in their own lives and, consequently, may not be effective advocates for their children. This can add to the vulnerability of their children in care. This was brought home to the Inquiry Team by the fact that of the small number of parents interviewed by the Team, some had themselves experienced varying forms of abuse and had been in care during their own childhood.

11.26 Challenging Behaviour

There is a belief among child care practitioners that the challenging behaviour presented by children currently in care is substantially different to that traditionally experienced. Sexualised behaviour in very young children is just one example of this. There is research evidence in some countries which suggests that the family circumstances of children in the care system has become more problematic. A number of commentators have made specific reference to the fail safe or back-up

role of residential care when used in situations where fostering breakdown occurs (Berridge 1985).

In reviewing the cases of children coming into care in Madonna House in the 1970s, the Inquiry Team found that their history of abusive experience prior to coming into care was as extreme as that of children being admitted in recent times. There is, however, a significant difference today in the knowledge, and the acknowledgement, of these histories and a much greater awareness of the link between history and behaviour. It can be argued that traditional care practices suppressed or controlled the expression or acting out of the pain and hurt of children.

The development of appropriate responses to meet the needs of traumatised children will have considerable implications in terms of resources and expertise. The range of appropriate expertise is not sufficiently available at present to child care practitioners. The core curriculum of basic professional child care training needs to be reviewed. In-service training programmes should be developed so that the gaps in knowledge can be addressed as new issues emerge.

11.27 Reporting and Complaints Procedures

The fact that clear statements of children's rights in care are not commonly in use and written complaints procedures are not generally available adds to the vulnerability of children in care and their families.

There is also a recognition of the inadequacy of the legal system in relation to child abuse. The low prosecution and conviction rate in child sexual abuse cases is associated with issues such as time-lag in disclosure and the reliability of children's statements. This can give rise to hesitation in the involvement of the child victims in a legal process dictated by exacting burdens of proof and exposure to a judicial system which does not take account of their developmental needs and is inadequate to properly address the complexity of the circumstances of a child sexual abuse allegation.

Child abuse may constitute a criminal assault on a child. Children by their nature often lack the capacity to fully understand what is occurring when an assault is abusive and can lack the capacity to prevent the abuse, and may communicate their distress indirectly and in a confused manner.

These communications are always difficult for adults to receive, and the Inquiry Team encountered among the adults interviewed an inappropriate fear of the legal process which, when combined with their inadequate knowledge, disabled them from responding appropriately and effectively.

The Inquiry Team's experience led to a conclusion that the present legal position vis a vis reporting adds to the disabling process evident in adults' response to

children's disclosures. Consequently we consider that legislation should be introduced obliging any person with knowledge of child sexual abuse to report any such concern to an authority.

The Inquiry Team is aware of the concerns that a mandatory reporting law could lead to over-reporting, concentrate scarce resources on investigations, discourage parents from seeking help, inhibit disclosure and admission, and fail to achieve its purpose.

The available research would appear to indicate that as many as 40% of mandated reporters may violate the reporting laws at some time (Finkelhor and Zellman 1991). The failure to report is strongly influenced "by a lack of confidence in the social and legal system to cope with abusive families" (Crenshaw et al 1994) and a belief that children and their families experience only negative consequences from the interventions of the Child Protection System.

Mandatory reporting cannot be viewed in isolation. Mandatory reporting must be accompanied by the development of services, processes, and professional and inter agency practices which ensure that all parties can be confident that the outcome of reporting will be as positive as is possible. In particular, the current options which range from ignoring the problem to family disintegration and imprisonment must be expanded.

Associated with the introduction of mandatory reporting, a number of fundamental actions must be taken.

Clear and comprehensive definitions, as opposed to simple labels, of the various forms of child abuse, must be developed. The absence of definitions in the Irish Guidelines in relation, for example, to physical abuse can result in failure to recognise and to report abusive behaviour.

Relationships of trust must be developed between the Gardaí and other agencies, and procedures negotiated which are clear, yet flexible, and which specify individual responsibility.

The mechanisms for systematic dissemination of guidelines and associated issues must receive attention. Consideration should be given to making the dissemination of guidelines to non-statutory agencies the responsibility of specific officers within the statutory sector. Specific personnel would need to be committed to ensure that guidelines are reviewed regularly and that staff of all agencies receive regular and appropriate training in association with the dissemination of guidelines.

Fear of the consequences of reporting suspicions of abuse also exists in our culture. This is particularly obvious when disclosures are made in a cautious and ambivalent manner or when the behaviour witnessed is open to different interpretations. Professionals and other persons reporting child protection concerns in good faith to an appropriate authority should have the benefit of a statutory

defence of qualified privilege in any subsequent legal proceedings. The existence of such statutory privilege should be widely and regularly communicated. Effective reporting procedures demand a high level of interdisciplinary and interagency co-operation. This must be addressed in educational and in-service training programmes.

The vulnerability to abuse of children in care is difficult for people to absorb and there are strong incentives to minimise or deny the nature and extent of the problem. Inquiry reports from other countries demonstrate that abuse of children in care, in some instances, continued despite attempts by children and staff to disclose or report the matter. The child care system and individual services must be managed so that the vulnerability of children to abuse in care is made explicit and procedures must be developed to facilitate disclosure and appropriate management of concerns.

No effective standardised protocol exists regarding the handling of allegations or concerns of abuse in residential care. The processing of complaints based on accounts of children who have, for example, a degree of disability, or who have complicated previous histories, creates special difficulties for the Gardaí and the legal system. Equally, normal industrial relations procedures may not be suitable in all circumstances. Where there are complaints against staff, there is a need to develop policies and procedures to guide the investigation of complaints and concerns in relation to children in care, especially when those complaints relate to professional carers.

11.28 Individual Professional Responsibility

The Inquiry Team encountered a reluctance and hesitation among care staff to raise serious concerns with professionals and agencies outside Madonna House. It must be anticipated that even well developed systems will sometimes fail, in which case it will be the personal and individual responsibility of well trained and well supported child care professionals that will represent the ultimate safeguard for children.

Children making disclosures of abuse within a residential service can find themselves scapegoated by perpetrators, by management or by staff. This process can be mirrored when staff draw attention to concerns. Systems need to be put in place to facilitate raising of concerns. Cultural ambivalence in this regard should be addressed.

Child care workers and others must accept that employment in a professional capacity brings certain responsibilities. If internal systems are insufficient to ensure that children receive appropriate care, then they must report concerns to the appropriate Health Board, and if necessary, to the Gardaí. It is worth noting that the discovery of the abusive practices in Madonna House was the direct result of the action of one foster parent in the community following disclosure by a girl in foster care.

11.29 Internal Factors

Madonna House was committed to an open and relatively non-discriminating admissions policy, resulting in high in-take and activity levels. It accepted emergency admissions, large sibling groups and children of both sexes within a broad age range. The task which it set itself was an extraordinarily demanding one. Many staff were dedicated individuals committed to the care of children. They made a positive contribution to the children's lives despite working in what was, in the view of the Inquiry Team, a dysfunctional organisation. The Inquiry Team attempted to identify some of the key characteristics of this organisation.

11.30 Inability to Learn

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11.31 Management Style

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11.32 How Children were Viewed

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11.33 Distortion

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11.34 Psycho-Social Isolation

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11.35 Power and Powerlessness

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CHAPTER 12

Recommendations

12.1 Introduction

Madonna House can only be viewed in the broader context in which it operated. The various components which contributed to the service provided were inter-related and inter-dependent. A comprehensive and wide-ranging approach, addressing all elements of residential care, is needed to ensure the provision of such care in the safest possible manner for both children and staff. Specific personnel will need to be assigned by the Department of Health and Health Boards if substantial development is to occur.

The Inquiry Team's recommendations as a contribution towards the current debate on the future development of childrens' residential services are set out under the following headings:—

(1) Statement of Children's Rights,

(2) National Child Care Policy Statement,

(3) Regulations — Child Care Act 1991,

(4) Family Support Services,

(5) Regional Child Care Policy Statement,

(6) Service Contracts,

(7) Boards of Management,

(8) Resident Manager,

(9) Garda Reports,

(10) Personnel,

(11) Information for Children and Parents,

(12) Care Planning and Review,

(13) Services to Children in Care,

(14) Education,

(15) Health,

(16) Records,

(17) Child Protection,

(18) Complaints Procedure,

(19) After Care,

(20) Inspection,

(21) Children's Rights Officer,

(22) Evaluation and Research,

(23) Offender Response,

(24) Training in Child Care,

(25) Professional Associations.

12.2 Statement of Children's Rights

In the context of Ireland's ratification of the United Nations Convention on the Rights of the Child, a statement of children's rights in care should be developed. This should include:

- recognition of children's rights to personalised and fair care;
- to education and opportunities to develop their potential;
- to involvement in decision making;
- to knowledge of their own and their families' history and circumstances;
- to make contact with their families;
- to the maintenance of their interests and culture;
- to privacy and to freedom from all forms of abuse;
- to access to complaints procedures.

The Department of Health and the relevant professional bodies should initiate a process leading to the development of a comprehensive statement of children's rights in care. This process should include representation from current and former residents and their families.

The process of producing statements is a primary and fundamental step in ensuring that children receive safe and appropriate care. It lays the foundation for the development of child centred policies and practices and of a framework for the development of a positive culture within child care organisations.

12.3 National Child Care Policy Statement

A national child care policy statement should be drawn up by the Department of Health, in partnership with the relevant service providers and consumers of the child care services. Based on the needs and rights of children, this policy statement should identify the principles on which services should be developed and managed.

This statement should explicitly address the respective roles of foster and residential care and ensure that these services are viewed as complementary parts of the care continuum.

Particular regard should be given to the following:

- Deficits exist in service provision for older children and adolescents.
- Children in care are especially vulnerable to abuse.
- Continued contact between children in care and their families is strongly associated with positive outcomes.
- Considerable barriers exist which inhibit families' contact and relationships with their children in care.
- Most children return to live with their families or relatives.
- Adolescents and young adults in aftercare are especially vulnerable and isolated.

A framework should be developed which outlines the different types of residential facilities which exist or should exist.

12.4 Regulations – Child Care Act 1991

Regulations dealing with residential child care services, as provided for in the Child Care Act, 1991, should be brought into effect at the earliest possible date.

The Inquiry Team recommends caution regarding over-reliance on the effectiveness of regulation unless a range of other determining measures regarding the quality of care are put in place.

12.5 Family Support Services

Comprehensive family support services should be developed to promote good parenting and to reduce as far as possible the need for reception of children into care. Substitute care services should have a family support orientation and form an integral part of the family support services in the local community.

Family support services for vulnerable families should be developed in consultation with local communities and should involve consumers in the management and operation of services in a non-stigmatising manner.

Section 41 of the Child Care Act, 1991, which requires the Minister for Health to make regulations in relation to the placement by Health Boards of children with relatives, should be brought into operation at the earliest possible date. Every possible support should be provided by Health Boards and other agencies to facilitate the extended family in caring for children who cannot live with their own parent/parents.

Decisions to place children in care should take into account the impact of such a radical intervention on the lives of children and their families. Placement in care may solve or appear to solve some problems but in many cases creates further difficulties for a child and his/her family.

Parents and relatives of children in care should receive special support services to enable them to resume care and/or maintain maximum possible appropriate involvement with their children.

Each Health Board should develop a written policy on the services available to parents and relatives of children in care, and this document should be widely available.

12.6 Regional Child Care Policy Statement

Each Health Board should develop a policy statement in relation to services for children in care.

Regional plans for residential care services should be developed based on an objective assessment of needs. Health Boards should ensure that the required range of care options is available. The regional plans should outline the range of children's residential centres in each Health Board area, their respective purpose and function and the relationships between these centres.

Each Health Board should play a lead role in establishing a regional forum which involves and connects the key providers of care services for children. This forum should create a framework for consultation and participation and should:

- contribute to the development of regional policies and guidelines,
- identify issues of concern regarding the quality and operation of the care services,
- identify inadequacies in service provision, and
- identify regional training needs and develop and implement in-service training strategies.

12.7 Services Contracts

Each residential children's centre should have a time-limited service contract with the Health Board which specifies:

- The services to be provided.
- Standards of care.
- Policy and procedures regarding admission, care planning and discharge.
- Staffing levels.
- Recruitment policy.
- Involvement of Health Board representatives in the operation of the service.
- Training and consultancy budget.
- Services to be provided by the Health Board.
- Funding arrangements.

- Monitoring and evaluation mechanisms.
- Arrangements for review of contract.

The internal audit department of the Health Board should ensure proper finance systems in children's homes supported by public funds.

12.8 Boards of Management

Each children's residential centre should have a Board of Management with defined functions and responsibilities. National guidelines should be developed by the Department of Health with the relevant representative bodies. The respective roles and responsibilities of Trustees, Boards of Management and Resident Manager should be clearly defined.

The composition of Boards of Management should include representatives of owners/trustees, Health Boards/funding agency, professional staff, the local community and a relevant child care professional. Consideration should be given to the involvement of former residents and their families.

The Boards of Management should approve and periodically review the policy and procedures of the centre in relation to issues such as recruitment and promotion of staff, sanctions, restraint, discipline and complaints.

Minutes of meetings of Board of Management should be maintained and available for inspection.

Boards of Management should be responsible for the production and publication of an annual report in a standard format.

12.9 Resident Manager

The post of Resident Manager should be advertised and appointments made by open competition. Candidates should have appropriate professional qualifications.

Resident Managers should receive training in management.

The Resident Manager should be responsible for the implementation of the service contract and the use of all resources available to the centre.

The Resident Manager should have explicit primary responsibility to ensure that a safe environment exists for children and staff, be accountable for care standards, and maintain effective working relationships with relevant agencies.

The Resident Manager should ensure that staff support, care and supervision and training mechanisms exist which enhance and develop staff performance.

The Resident Manager should develop, implement and continuously review appropriate care policies and practices.

12.10 Garda Reports

Residential child care workers are involved with the most vulnerable children in society and residential child care positions are qualitatively different from other positions which involve working with children. Consequently, securing Garda reports on potential staff should be compulsory prior to appointment of all grades of staff in children's residential centres.

Garda reports should not be seen as a substitute for comprehensive recruitment procedures.

Delay has been experienced in other jurisdictions in obtaining police reports. A specified time period for processing of Garda reports should be agreed.

Application forms for all positions in children's residential centres should provide for applicants to list convictions and give permission for the securing of all relevant information from the Gardaí in Ireland and police forces in other countries.

12.11 Personnel

The recruitment of all grades of staff for children's residential centres should be the subject of regulation.

The filling of permanent and promotional posts should be the subject of open competition following advertisement with detailed job specifications available.

The Department of Health should develop a specimen application form.

Detailed records covering the composition of interview boards and arrangements for short-listing of candidates should be maintained.

Interview boards should include a nominee of the funding agency and an appropriately qualified person from outside the children's residential centre.

References should be obtained directly by the Resident Manager from previous employers. Specific inquiries should be made as to whether there is any impediment or concern regarding the applicant's capacity to provide care for vulnerable children.

The educational and employment background of candidates should be checked and verified prior to employment.

All candidates for appointment to permanent positions should undergo a comprehensive medical examination.

Employment of staff without appropriate professional qualification should require the approval of the Board of Management and the specific sanction of the Health

Board. The appointment of unqualified staff should be subject to their acquiring professional qualifications within an agreed period of time.

Programmes of staff induction and standard staff appraisal procedures should be developed.

Staff on appointment should receive the Department of Health Guidelines on Child Abuse and a handbook which includes the following:

- Statements of the centre's ethos, policies and procedure.
- The centre's contract and relationship with the funding agency.
- Safety and health statement.
- Statement of the rights of children in care.
- Guidelines on safe child care practice.
- Induction programme.
- In-service training programme.
- Arrangements for supervision.
- Protocol on child protection within the centre.
- Acceptable and unacceptable discipline.
- Appropriate and inappropriate restraint procedures.
- Complaints procedures.
- Arrangements for care planning and reviews.

12.12 Information for Children and Parents

On placement in residential care children and parents should receive in writing, or have effective steps taken to communicate:

- An explanation of the general organisation of the centre including house rules.
- The name of the child's key worker.
- A statement of the rights of children in care.
- A copy of the complaints procedure.
- Contact name, address and phone number of the child's social worker and social work manager.
- Procedure for parents to contact the residential centre both on a routine basis and in the case of an emergency.
- Details of relevant family support services in the community.
- Arrangements for care planning and reviews.

Each Children's Residential Centre, or Community Care Area, should have a designated "Access" facility, appropriately designed and furnished, in which children in care and their families can meet.

12.13 Care Planning and Review

A written care plan should be devised for each child in residential care, which identifies the child's needs and the tasks to be undertaken by named individuals to meet those needs. The care plan should be developed with the participation of all parties, including the child, and his/her parents and extended family, as appropriate, together with the professionals involved, i.e. social workers, teachers and psychologists.

Regulations should specify the minimum frequency of reviews of the placement and the care plan for each child in care.

Children in care and their families should normally attend review meetings and have the right to seek a special review if they have serious concerns.

Within the framework of the overall care plan, the children's residential centre should have its own care programmes with identified goals in relation to issues such as relationship with their family, health, education, hobbies, friendships, preparation for after care and development of life skills.

Consideration should be given by Health Boards to the appointment of independent reviewing officers of children's residential centres. These officers could carry out annual reviews of children in long-term care and of particularly difficult placements where serious disagreements exist between the parties. Independent reviewing officers should receive appropriate training, and should be drawn from other sections of the Health Board or from other Health Boards. Each Health Board should nominate and train the appropriate number of reviewing officers.

Formal records of care plans and reviews should be maintained indefinitely.

The provision of the necessary administrative personnel will be essential to ensure adequate maintenance of records.

In preparing children for reviews the responsible social worker should seek to establish if the children are suspected of experiencing any form of abusive or unsafe behaviour.

The Resident Manager of a residential centre should appoint a key worker for each child from the care staff, having due regard to the wishes of the child.

The key worker should have lead responsibility within the residential centre for ensuring that the personal needs of the child are met. This arrangement should

not, however, restrict the development by the child of relationships with other staff.

In respect of children in long term residential care, if a situation exists or develops whereby no functioning guardian/parent is available, the Health Board should consider making a guardianship application to the Courts. This application should be for the appointment of a specific individual with established maturity and common sense whose role would be limited to specific purposes. This "children's friend" who would not represent a child care or related discipline, would not act in a professional role, but would take a special interest in the child and be consulted and involved in child care planning. Each Health Board could approve and maintain a panel of suitable people to act as "children's friends".

12.14 Services to Children in Care

Health Boards should ensure that children in care receive all the Health Board services to which they are entitled. Existing arrangements for referral to specialist services should be reviewed and specific written procedures developed.

The relevant Health Board should co-ordinate the involvement of professionals such as teachers, psychologists, speech and language therapists and child guidance personnel with the social work service to ensure that the special needs of children in care are adequately met.

Consideration should be given to the appointment of specialised staff having responsibility for children in long-term care. In addition, social work staff involved with a child in long term care should ensure that such child has regular and confidential access to a social worker who is fully aware of all aspects of the child's welfare and circumstances.

12.15 Education

The Department of Education and Health Boards should immediately review current arrangements for meeting the educational needs of children in care. A commitment from the education authorities to the special needs of children in care is needed.

A co-ordinated approach is necessary to remedy the educational disadvantage of children being admitted to care. Care and education authorities should regularly review such arrangements.

Where possible children in care should be educated with their peers in schools within the community.

Special educational services within children's residential centres should meet all the requirements of schools in the community.

Personal files should contain comprehensive educational histories and assessments of educational needs. The progress of each child's education should be considered at each review meeting.

Each children's residential centre should have an agreed procedure with its Health Board for securing appropriate psycho-educational services.

12.16 Health

The arrangements for identifying and meeting the health needs of children in care should be reviewed by the medical staff of the Health Board in whose area the residential centre is located.

A comprehensive system of health records should be developed nationally and adopted in each children's residential centre.

The Health Promotion Services of the relevant Health Board should be available to every children's residential centre.

12.17 Records

Children's residential centres should have guidelines on recording of information. Information systems should be ethical, accessible and facilitate high standards of practice and management review.

The issues to be dealt with include:

- admission procedures,
- discharge procedures,
- children's files,
- unit logs, and
- complaints and incident reports.

An individual file should be maintained on each child, and should be updated on at least a weekly basis.

Unit logs should be completed at the end of each shift, should be signed clearly, dated and identify the staff on duty.

Unit logs should be reviewed by supervisory staff.

12.18 Child Protection in Residential Centres

A specific statute should be enacted which would designate certain professionals as being legally obliged to report allegations of child abuse. Actual reporting will be substantially influenced by confidence in the outcome of such reports.

The relevant professional associations and the Department of Health should immediately develop comprehensive definitions of all forms of child abuse, and include these in future guidelines.

An officer of each Health Board should have specific responsibility for systematic and on-going dissemination of the national child abuse guidelines throughout the voluntary sector.

Professional and other persons reporting child protection concerns in good faith to an appropriate authority should enjoy the benefit of a statutory defence of qualified privilege in legal proceedings.

Professional and in-service training should address the issues effecting inter-agency and inter-disciplinary co-operation in child protection.

Each children's residential centre should have a written policy on the protection of children in their care from all forms of abuse. This declaration should specify the responsibility of all members of staff to an unambiguous commitment to the centre's child protection policy.

Abuse prevention programmes suitable for children and adolescents in care should be developed and implemented.

Specific protocols and procedures dealing with reporting child care protection concerns or children's disclosures should be prescribed for child care staff. Such protocols and procedures should give specific consideration to the vulnerability of children who have suffered sexual abuse and consequently exhibit sexualised behaviour. In addition, they must address the vulnerability of such children to further abuse by adults, and the possibility of their molesting other children in care.

In-service training and staff appraisal procedures should inform and reinforce the implementation of the centre's child protection policy.

Serious consideration should be given to the formulation of statutory criteria concerning the commencement of an investigation into an allegation of child sexual abuse by An Garda Síochána.

12.19 Complaints Procedure

Health Boards and children's residential centres should develop procedures for the investigation of complaints against child care services and personnel. A senior member of management of the relevant Health Board should have responsibility for the designation of the officer to conduct such investigations and to consider and approve the outcome.

Such procedures should be accessible to children in care and their parents, who should have the opportunity of making a confidential complaint without the immediate involvement of the staff of the centre.

The responsibility for maintaining a record of complaints should rest with two named staff members in each children's residential centre, and a named officer of the Health Board.

Complaints made directly by children in care should be notified to their parents immediately, and parents should be formally informed of the outcome of any investigation.

Managers of residential homes should seek to develop a culture which encourages and supports staff in listening to children and acknowledges the difficulties that children may have in disclosing concerns. Staff should be encouraged to question and challenge practices which concern them, and to report their concerns without fear of reprisal. Sensitive and skilled management will be necessary to ensure that a culture of openness is fostered which respects and appreciates the value of the 'whistle blower'.

The learning from this is:

- An investigation of a complaint is complex and time consuming.
- The investigation of such complaints must be conducted by independent and experienced professionals.
- When the complainant is a child who has experienced separation and trauma, inconsistencies and confusion must be anticipated and credibility will be easy to undermine.
- Extensive interviews with other children may be necessary as their understanding of what is normal and acceptable behaviour as opposed to abusive behaviour may be blurred.
- The investigation of one complaint of abusive behaviour may represent an opportunity to uncover and investigate a range of practices and related incidents that would not otherwise come to light.

12.20 After Care

The principles underlying preparation for aftercare should have regard to the lengthy process of transition from childhood to adulthood, and after care planning should incorporate contingency arrangements for the breakdowns which inevitably arise.

Care plans for children should be directed towards their eventual self-sufficiency as adults, and preparation for independent living should be a main focus of work with adolescents.

Children's residential centres should develop specific programmes to prepare children for after care and designated members of staff should be given responsibilities for after care services. Residential centres should have an after care policy which will ensure appropriate contact and follow-up for children, especially for those who have been in residential care for an extended period.

Former care residents should be provided with specific support services in their adult lives by the Health Board, and consideration should be given to developing special services with designated teams.

12.21 Inspections

The Child Care Act, 1991 makes provision for inspection of children's residential centres by an authorised officer of the relevant Health Board or of the Minister of Health.

National standards should be developed to guide the inspection process. Inspections should take the form of an organisational audit and review the quality standards and assess the outcome of the services provided by the residential centre.

The inspection process should be independent, competent, credible and acceptable. The process should include contact with children and staff and inspection of records of the centre and of the relevant Health Board. Care should be taken to ensure that the inspection process supports the staff of the centre without losing its independence and objectivity.

The specific purpose of inspection should be to ensure

- that statutory standards are met,
- that good management and care practices are in place,
- that the care provided is safe, nurturing and appropriate to the needs of the children,
- that the necessary remedial actions are identified and communicated.

Persons carrying out inspections should receive special training, including training in understanding the complex dynamics which may exist in residential centres.

The Department of Health and Health Boards should consider the setting up of an inter-disciplinary panel from which Health Boards and the Department of Health could draw to assist them in this inspection processes.

Such a panel could also be drawn on for advice and consultancy services.

12.22 Children's Rights Officer

Each Health Board should appoint a Children's Rights Officer at senior level whose main focus should be on the systems and procedures of child care services.

The Children's Rights Officer should have a major advocacy function in the context of the statement of children's rights. He/she should ensure that the policies and procedures of the Health Board, child care services and associated agencies are appropriate to the needs and rights of children in care.

The Children's Rights Officer should be advised of all complaints regarding children in care and should maintain records which assist in the identification of pattern of complaints and the co-ordination of information on complaints.

The Children's Rights Officer could have a function in the investigation of complaints on referral by Health Board Management.

The Children's Rights Officer should receive reports of 'exit' reviews for children who have been in long-term care.

The Children's Rights Officer should monitor and review the operation of the review and care planning system.

12.23 Evaluation and Research on Children in Care

A comprehensive review of National Child Care Information Systems should be undertaken. Specific issues to be addressed should include data collection with standardisation and uniform interpretation mechanisms, analysis and dissemination.

On-going service audits should form an integral part of the operation of residential care services.

A minimum data set should be defined nationally and maintained in each residential centre.

Children's residential centres should prepare Annual Reports which should outline and comment on activity levels, staff development and training, staff turnover, finance and should identify key issues of concern.

A systematic procedure should be established for the conduct of 'exit reviews' with children who have been in long term residential care.

Comprehensive research programmes should be developed and should include longitudinal and qualitative studies. These programmes should seek to illuminate the child's experience of care and should include research on:

- relationships of social workers and children in care,
- research into family support services
- role of men in child care.

An important aim of research should be to establish methods of monitoring the quality of care and children's progress.

12.24 Offender Response

Serious and immediate consideration should be given to developing a comprehensive counselling and treatment programme for persons found to have committed abusive behaviour. This programme should have a statutory legal framework and be incorporated as a component part of the sentencing options in the criminal justice system.

12.25 Training in Child Care

Special arrangements should be made to provide basic training for existing permanent untrained child care staff. Specific time limited contracts with educational establishments should be considered whereby such training could be achieved over a specific period.

A comprehensive review of professional and in-service child care training should be undertaken. The current practice of student placements being supervised by unqualified child care staff should be immediately prohibited.

The curriculum of professional training courses should include:

- human sexuality;
- the dynamics of child abuse, and disclosure process;
- the vulnerability of children in care to abuse;
- knowledge and skill in caring for children exhibiting challenging and sexualised behaviour;
- the special needs of children with disabilities;
- appropriate boundaries of professional relationships;
- reporting requirements;
- guidance in relation to drug, alcohol and solvent abuse;
- recognition of dangerous child care practices;
- child care planning.

All staff should be given induction training on recruitment.

Continuing in-service training strategy should give priority to training in management and supervision skills.

Mechanisms should be developed to facilitate the communication of concerns of institutions providing professional training courses to the management of children's residential homes and the relevant Health Boards.

A specific proportion of a centre's budget should be designated for in-service training, including training in child protection and child abuse.

12.26 Professional Associations

The Irish Association of Care Workers and the Resident Managers' Association should appoint a panel of officers from their associations, with whom individuals could consult if they have concerns regarding child care standards and practices. The panel should consist of at least two officers.

This process of consultation should not be a substitute for proper management reporting.

APPENDICES

APPENDIX I

Sisters of Charity Policies and Code of Ethics of Child Care Services

"Permit the little children to come to Me and forbid them not;
For of such is the Kingdom of Heaven"

The Religious Sisters of Charity in their Service of Caring for Children are driven by the love of Christ. Out of this motivation they offer a service which takes into account the rights of the child as outlined in the United Nations' Convention on the Rights of the Child.

The child has a right to: affection, love and understanding; to adequate nutrition and recreation; to a name and nationality; to special care if handicapped; to be among the first to receive relief in times of disaster; to learn to be a useful member of society and to develop individual abilities; to be brought up in a spirit of universal sister and brotherhood; to enjoy these rights regardless of race, colour, sex, religion or social origin.

Vision/Policy Statement for Child Care Personnel

Vision

We are called in the spirit of Mary Aikenhead our Foundress, and in the tradition of the Religious Sisters of Charity, to be daily attentive in listening to the cry of the poor and marginalized; to break the shells of prejudice and fear that protect our security and limit our vision, to truly die and rise in a Paschal rhythm that is celebrated in our daily Eucharist.

We are people who practice hospitality, cherish equally the children given to our care; provide safety from exploitation; respect them and their families; carry them in our hearts, assuring them that they will always be our children; lead them to develop their full potential and become good citizens, care for them with fidelity, love and understanding and lead them to enjoy these rights irrespective of sex, race, colour or religion.

Policy

It is the policy of the Religious Sisters of Charity Child Care Services to be Catholic both in name and in fact. This characteristic places on us the obligation to observe and defend Gospel principles, the social laws of the Church and norms regarding human rights.

Within our Child Care Service the rights of the child are upheld. These are based on the presupposition and recognition of the fact that children are individuals with inalienable rights, rather than the "property" of their parents or guardians. When the family unit disintegrates, or when it becomes impossible for a child to realise his/her basic rights, then the child has a right to alternative care and society has an obligation to provide it.

The Sisters of Charity Child Care Service is directed towards the rights of the child:–

(a) to be cared for in a stimulating environment where he/she may be enabled to develop his/her potential – emotionally, socially, spiritually and intellectually;

(b) to continuity of care by professionally selected and skilled adults who are capable of working as members of a caring team;

(c) to be loved and valued as a person with individual needs, regardless of presenting behaviour;

(d) to a sense of security and acceptance, where he/she is enabled to become an integrated person with a good personal identity and sense of self-worth;

(e) to be given a sense of personal history; to be assisted to integrate it into a more positive approach to life;

(f) to know why he/she is in care and to be informed of developments in his/her family related to his/her being in care;

(g) to have his/her family treated with respect and dignity and to be himself/herself and treated at all times as a member of that family, especially in situations where alternative care is being planned;

(h) to confidentiality regarding himself/herself personally and his/her family to privacy regarding his/her personal belongings;

(i) to have his/her family and friends to visit him/her as often as possible, having due regard to the agreed plan of treatment for him/her and the rights of the other children in the group;

(j) to experience relationships which will enable him/her to communicate with other children and adults and to form lasting relationships;

(k) to be involved in decision making regarding himself/herself and his/her family in an environment where his/her feelings are made known and his/her initiative encouraged, having due regard to his/her age and understanding;

(l) to the protection of the law and to the benefits provided by legislation;

(m) to an education which is best equipped to meet his/her needs academically and socially;

(n) to full religious education and formation according to the tradition into which he/she has been born;

(o) to live in a milieu where the Christian maxim of 'Love one another' may be experienced and shared with other children and staff;

(p) to support from the agency responsible for placing him/her in care and to expect that his/her family will be helped to prepare for his/her return if possible;

(q) to be prepared for departure from care as fully as possible, secure in the knowledge that he/she will be welcome to visit and receive suitable support until he/she has achieved a mature level of independence.

(r) to provide an After-Care Service for those who have a need for such service.

The Sisters of Charity acknowledge that, through fostering a deeper understanding of each other's roles, the Sisters and Caring Team will work in partnership to develop a true sense of care which respects the dignity of the individual and promotes his/her self esteem.

APPENDIX II

Standard Format for Interview of Staff by Team Members

Checklist and Queries

1. **Introduction**
   - Briefly outline the Inquiry Team's assurance that it is not a "witch hunt"
   - Team's concern for them, realisation that they were being taken away from work etc,
   - Are they aware of allegations?

2. **Work**
   - Career path, when started in Madonna House, whether moved to various Units,
   - Job description,
   - Induction, in-service training, access to courses/seminars, written policy documents, guide-lines/current literature,
   - Staff appraisal,
   - If carried out, by whom?
   - Job satisfaction, support in work if a mistake occurs,
   - Progress reports, do care staff compile reports?

3. **Management**
   - How he/she perceives role of management,
   - How well services operate – health, education etc.,
   - Responsibility for finances,
   - Line of authority in house, planning processes in place, do staff contribute to plans/policy-making?
   - Reporting relationships,
   - Cover at night,
   - Concerns i.e. if concerned about another staff member, were they in a position to report it, was there a climate to allow this to happen?
   - Was there an appeals system?

- Staff discipline,
- What procedures in place?
- Complaints procedures – staff/children
- Formal/informal management processes,

4. Child Care

- What he/she sees as philosophy of Home – Child care planning,
- Who is responsible for reports on day-to-day activities?
- Any inappropriate placements of children?
- Staff observations on transfers,
- Explore area of 'pets', 'treats', rewards system,
- Discipline/sanctions including constraints, deprivation, physical restraint, any occasion when breached?
- Material necessities, clothes, pocket money etc. who decides and processes? Who is responsible for them?
- Rules – do's and don'ts for children,
- Procedures/guide-lines for children going out,
- Policy on children's activities – who decided/where decided? i.e. Team meetings,

5. Other

- What is atmosphere in relation to Social Workers coming in?
- Attitude to Health Board,
- How outside agencies are perceived,
- Staff/residents: sensitivity/vulnerability,
- Any untoward approaches – harassment of staff,
- Special knowledge/suspicions? Aware of anything about Phase I and Phase II.

6. Conclusion

- Team may have to come back to them to clarify some points and any other matters,
- They are free to contact the Team – give name etc.

APPENDIX III

Job Description for Resident Manager (Department of Health)

1. Introduction

Description will vary from Home to Home depending on consultation between the individual Home, or the Homes Management Committee, and the respective Health Board, but should include:–

(i) the role the Home is to play in the context of the Board's overall policy for child care services in its area;

(ii) the agreed objectives for the Home;

(iii) a general description of the type of service to be provided by the Home;

(iv) the number and types of children to be catered for;

(v) the legal position of the Home;

(vi) its relationship with the Health Board.

2. Purpose of the job

(i) to provide a stable and secure environment for the children in the Home;

(ii) the direct government of the Home in accordance with policy guidelines agreed from time to time with the Health Board and with regulations made by the Minister for Health under the Children's Acts;

(iii) to ensure that specified programmes of care for each child placed in the Home are agreed with the placing Health Board and that these programmes are implemented and the child's progress monitored regularly.

3. Function of Resident Manager

3.1 Responsibility for the day-to-day activities of the Home and its component units, general leadership and decision making in the Home.

3.2 Co-ordination and implementation of programmes of care designed in conjunction with the statutory authorities to meet the specific needs of each child.

3.3 Liaison with the local Health Board, or the Home's Management Committee, where appropriate, in the recruitment, selection, and appointment of staff and active participation in the process.

3.4 Maintenance of records on staff with regard to sick leave etc., and ensuring that conditions of service and pay are within guidelines laid down by the Department of Health and the local Health Board.

3.5 Deployment, development and training of staff including directing them and assisting them in the performance of their duties, and monitoring them in probation.

3.6 Advising Health Board, or Management Committee where appropriate, on - going planning for the Home and use of its resources and on the monitoring and evaluating of the Home's performance, particularly in regard to agreed policy objectives.

3.7 Maintenance and upkeep of the premises, furniture and equipment and adherence to local authority fire safety and other standards specified by regulation.

3.8 Financial management and control of the Home in accordance with approved budgetary procedures including maintenance of:

(a) such records as are required by statement, or direction from the Health Board or the Minister for Health and to ensure that such records are kept up-to-date and at all times available for inspection by a duly authorised person;

(b) full and proper accounts of monies disbursed in accordance with requirements agreed with the Health Board.

3.9 Provision of reports, statistics and information as the Health Board or Minister for Health may require from time to time.

4. Qualifications

4.1 Each candidate must be of good character,

4.2 Have a recognised qualification in or with direct relevance to Child Care and at least 5 years post-qualification experience in the practice of child care, preferably in a residential setting.

4.3 Produce evidence that he/she can relate well with both children and staff.

4.4 Possess sufficient administrative capacity to discharge the function and perform the duties of the post.

4.5 Have knowledge of budgetary and book-keeping procedures.

4.6 Be free from any defect or disease which would render him/her unsuitable to hold the post and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.

5. Particulars

5.1 The employer(s) ..... confirm that subject to (5.3) the post (which has been approved by the Minister for Health) is permanent.

5.2 The person appointed will, on reaching the age of 65, cease to hold office.

5.3 The person appointed shall hold office for a probationary period of 1 year. Thereafter the post shall be held on the basis set out at (5.1) provided the employer has not issued notice to the post holder prior to the 330th day of the probation period indicating that the contract of employment will cease on the day before the anniversary of the date on which the post holder commenced employment.

5.4 A 40 hour working week applies. Attendance during unsociable hours (8.00pm to 8.00am) will be as required in the carrying through of the programme of the Home.

5.5 Annual leave entitlement will be 25 working days.

5.6 The salary for the post is .....

5.7 Deductions will be made from remuneration in respect of the statutory deduction (e.g. P.A.Y.E., P.R.S.I. etc).

5.8 The post holder will be required to reside in the Home.

APPENDIX IV

Job Descriptions for Second Tier Management Group (Madonna House)

(1)

Title of job: Assistant Resident Manager
Works to: Resident Manager
Supervises: 16 Assistant/House Parents Grade IV
4 Assistant House Parents Grade III
1 Trainee

the Assistant Resident Manager's duties fall into four main categories:

1. Deputises for the Resident Manager in her absence.
2. Schedules work rota for staff and supervises day-time services.
3. Assists Resident Manager with staff recruitment, development and training. Monitors staff performance with children.
4. Organises hospital visits, Court attendances, external schooling, recreational activities etc. for children.

Main Tasks:

The Assistant Resident Manager is responsible for the provision of all day-time services which include emergency admissions, planned admissions, liaison with Social Workers, parents, foster or adoptive parents, arranging medical/psychological assessments, preparing case histories of children and attending case conferences, consulting staff in planning children's future placement, supervision of prescribed medicine.

Also involved is the supervision of the staff members and the up-dating of records on staff performance.

The Assistant Resident Manager organises appointments for children outside the Home. These include those listed above and the daily attendance of several children who attend a number of national schools in the locality.

Organising or attending fund-raising functions arising from time to time where communication with several hundred members of the general public is required.

(a) Decisions

Decision-making by the Assistant Resident Manager is non-routine with wide clearly defined limits. His/her contribution to decisions is of major proportions and in the most complex category.

(b) Supervision

A staff of 21 is assigned to 5 houses on the day-time rota, ensuring that the children in their care are receiving full benefit of the available resources. It is also necessary to supervise visits to children by parents and/or families without intruding on personal relationships.

(c) Accountability

An error in dispensing prescribed medicine to even one child could leave the home open to legal proceedings and serious liability.

Abduction of a child from the Home could lead to legal action and major loss.

Neglect of an injury could have considerable impact on the Home.

An error in compiling a confidential report on a child needing special treatment could cause irreparable damage.

(d) Communications

Contact with social workers, parents, foster/adoptive parents, external school teachers, hospital staffs as well as the internal staff occupies a major portion of every single day. Motivating the staff and having contact with the children themselves gives rise to a wide variety and frequency of reasons for such exchanges.

Explaining the Home's activities to organised groups or occasionally to the media.

(e) Knowledge and Skills

A very thorough understanding of the relevant procedures and the Home's general policy is essential. A high level of expertise is required and a Leaving Certificate is required.

(2)

Title of Job: Secretary/Administrator
Works to: Resident Manager
Supervises: 1 Teacher, Grade IV
1 Cook, Grade IV, 1 Assistant Teacher, Grade III
1 Chef, Grade III
1 Maintenance Worker, Grade III
1 Playgroup Leader, Grade III
1 Assistant Leader, Grade III
2 Kitchen Assistants, Grade II
Part-time Maintenance, Grade II

The Secretary/Administrator has responsibility for four main areas:

1. All secretarial duties.
2. Financial – all income and expenditure, pay-roll, banking, purchases and stock control.
3. Maintenance and upkeep of school, dwellings, kitchen and grounds.
4. Supervision of non-child care staff and assisting with supervision of child care staff.

Main Tasks

The Secretary/Administrator spends a considerable amount of his/her time ensuring that the physical needs of the children in care are available to them. Organising the provision of food, clothing, medicine, heat, light and shelter for up to 60 children on 365 days of the year requires daily contacts with suppliers by means of correspondence, phone-calls, and personal callers as well as consultations with school and kitchen staffs.

Submitting weekly and monthly returns and accounts to the Health Board; preparing the weekly pay roll; reconciling bank statements and maintaining all income and expenditure accounts to audit standard.

Contact with Health Board officials/Social Workers/Parents/Adoptive Parents.

Fire precautions and security arrangements.

The Secretary/Administrator spends many hours each week on secretarial work – taking dictation from the Resident Manager and the Assistant Resident Manager. Typing all their correspondence and all confidential reports on children for case conferences with Health Board staff.

Operating the telephone switchboard in addition to ensuring that incoming post is attended to and outgoing mail is despatched. No other secretarial staff is employed.

(a) Decisions:

Decision-making by the Secretary/Administrator falls into the involved and wide clearly defined limits of operation. The contribution made to the very involved decisions that have to be made in the running of a Child Care Home is major and on a regular basis.

(b) Supervision:

The supervision of 10 persons doing diverse jobs in the non-child care area requires constant attention. It goes hand-in-hand with overall supervision of all staff which becomes a team effort in the Home.

(c) Accountability:

An error in the standard of food/dietary supplies could lead to serious illness among the children which could result in legal proceedings.

An error in compiling the confidential records relating to the children could result in him/her being treated incorrectly. An error in wage calculation could cost the Home a financial loss.

Neglect of maintenance of the grounds or buildings could result in injury to children and/or staff with subsequent financial penalty.

An indiscretion in dealing with external contacts could lead to adverse publicity and/or Official Inquiry resulting in a major loss which would be very difficult to rectify.

(d) Communications:

The job holder's communications responsibilities are set out in the description of main tasks above.

(e) Knowledge and Skills:

This post requires someone with the administrative skills to deal with an annual budget of over £0.75 million. The ability to communicate on all levels, to work with and supervise a large staff requires a maturity and experience unlikely to be found in a junior.

Familiarity with Health Board standards and requirements in child care is essential. A minimum of Intermediate Certificate plus shorthand and typing is required. Experience in book-keeping, pay-roll and accounts to audit standard is an absolute must.

The ability to research, collect and collate reasonably complex material for reports and submissions is also necessary.

(3)

Title of Job: Senior House Parent
Works to: Resident Manager
Supervises: 15 Assistant House Parents Grade IV
2 Assistant House Parents Grade III

The Senior House Parent's responsibilities fall into three main areas:

1. Scheduling work rota for staff and supervises night-time services.
2. Providing emergency admission service.
3. Monitoring staff performance to ensure children receive maximum benefit. Monitoring child performance for confidential records.

Main Tasks

The Senior House Parent is the person-in-charge at night. He/she maintains all necessary services and also provides the emergency admission service.

Supervision of dispensing prescribed medicine, of visits to children by parents and/or families who cannot attend during the day and organising medical attention for any child needing same at night.

(a) Decisions:

Decision-making in this job is within wide clearly defined limits and of a very routine nature. His/her contribution to decisions would be of major significance in an involved situation.

(b) Supervision:

Supervision of 17 staff in 5 houses on the night-time rota, requires a person who can motivate people to motivate children. Coping with visiting parents/families before bed-time can be distressing. Direction and organisation of staff is crucial at such times if considerable disruption is to be avoided in the house concerned.

(c) Accountability:

An error in dispensing prescribed medicine to even one child could leave the Home open to legal proceedings and serious liability.

Abduction of a child from the Home could lead to legal action and major loss.

Neglect of an injury could have considerable impact on the Home.

An error in compiling a confidential report on a child needing special treatment could cause irreparable damage.

(d) Communications:

Contact with Social Workers, parents, foster/adoptive parents etc. is kept to a minimum. Dealings with the night staff are pretty constant and of a routine nature. The same would apply to involvement with the children. Attending case conferences as required.

(e) Knowledge and Skills:

The job holder would need to have a high level of expertise in child care and a thorough understanding of the relevant procedures and the general policy of the Home. The person would require Intermediate Certificate or equivalent plus several years' experience in child care.

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