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Audit of compliance with the implementation of recommendations arising from the "Roscommon child care case - Report of the inquiry team to the HSE" in HSE West

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

QUALITY & PATIENT SAFETY AUDIT
FINAL AUDIT REPORT – EXECUTIVE SUMMARY

Audit Title:	Audit of compliance with the implementation of recommendations arising from the “Roscommon child care case - Report of the inquiry team to the HSE" in HSE West		
Audit Number:	QPSA0142012		
Audit Timeframe:	August 2012 – February 2013		
Audit Requester:	John Hennessy, Regional Director of Operations, HSE West John Smyth, Regional Director of Children & Family Services, West		
Audit Team Members:	Anne Keane, (Lead) Quality and Patient Safety Auditor		
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	Lia Evans, Quality and Patient Safety Auditor		
Audit Sponsor:	Ms. Edwina Dunne, Director of Quality & Patient Safety Audit		
Source of Evidence	**Type**	**Location**	**Date**
	Questionnaires	National offices, Integrated Service Directorate (ISD) and Children & Family Services (C&FS)	14 Sept 2012
		HSE West regional offices, ISD and C&FS	4 Oct 2012
		HSE West local offices, ISD and C&FS	14 Oct 2012
	Site Visits	Donegal Town, Co Donegal	22 Oct 2012
		Tubbercurry, Co Sligo	13 Nov 2012
		Nenagh, Co. Tipperary	15 Nov 2012
		Limerick City, Co Limerick Ennis, Co. Clare	21 Nov 2012 21 Nov 2012
		Castlebar, Co Mayo	27 Nov 2012
		Roscommon, Co Roscommon Loughrea, Co Galway	29 Nov 2012 29 Nov 2012
Date of Issue of Final Report:	2nd April 2013		

1. AUDIT BACKGROUND/RATIONALE

The ***Roscommon Child Care Case - Report of the Inquiry to the Health Service Executive (RCCC)*** (HSE 2010) identified clear service failures by the Western Health Board (later merged into the HSE) between 1998 and 2004. The Report found that important child protection concerns were not addressed adequately over a number of years, precipitating the ongoing harm and neglect of the children at the centre of the inquiry.

The Report made 58 recommendations both in the context of the wider agenda for vulnerable children and families, as well as the particular case that was the subject of the inquiry. Many of the recommendations made are concerned with improving the systems, services and practices that are dedicated to protecting children and young people. The recommendations are organised into the following five key areas: Organisational Change, Policy Change, Practice, Development of Services, and Management.

The HSE West Regional Director of Operations (RDO) and the Regional Director of Children and Family Services (RD C&FS) requested Quality and Patient Safety Audit (QPSA) to undertake an audit to provide assurance to HSE senior management regarding the extent to which recommendations arising from the RCCC Report have been implemented in the HSE West region.

This audit is considered timely with the forthcoming transfer of child care services from the HSE to the new Child and Family Support Agency. It is envisaged that audit findings will complement and inform the necessary due diligence exercise that is required to support the transfer of HSE services to the new Agency.

2. AUDIT OBJECTIVES

The objectives of this audit were twofold:

- Identify if recommendations arising from the RCCC Report relating to service delivery have been implemented and to what extent.
- Support the due diligence exercise that is required as part of the transfer of child care services from the HSE to the new Child and Family Support Agency.

RCCC Report recommendations relating to human resource and/or finance issues were not included in the scope of this audit.

3. SIGNIFICANT FINDINGS

The audit team found sufficient evidence that the following RCCC recommendations have been implemented:

- Organisation change, including establishment of a national management team
- Court processes
- Staff roles, particularly in respect to contact with children
- Observations made on home visits
- Working with fathers
- Child Protection plans
- Follow-up on, and feedback in relation to, third party concerns
- Key designated worker role
- Targeted family support service developed for Roscommon, and review of the effectiveness of the Home Management Service
- *Children First* Guidelines implemented locally

The audit team found partial evidence that the following recommendations have been implemented, and most are works in progress:

- Policies and procedures for all stages in the child welfare and protection system
- Practice audits and quality assurance
- Reporting up of escalating risks and cases of public importance
- Implementation of a common assessment framework
- Alternative plans
- Working with parents who seek to distract workers
- Involvement of Speech and Language (S&L) Department, and review of Public Health Nursing (PHN) records
- Specialised Child Sexual Abuse Unit or Team in place
- Staff management, including supervision and caseload management
- Child protection case conferences processes and chairpersons
- Standardised file recording and file management systems
- Appropriate staff training

The audit team found insufficient evidence that the following recommendations have been implemented:

- Victim impact statements
- Documenting frequency and purpose of home visits
- Outcomes measurement
- Staff alert to Attachment theory, and testing assumptions in supervision.

4. RECOMMENDATIONS

1. Regional C&FS must ensure that PPPGs are updated regularly, and are standardised wherever possible to reflect best practice.
2. Regional C&FS must develop a clear framework to guide QA practice for the overall child protection and welfare system, and to ensure synchronicity across local, regional and national processes.
3. Regional C&FS should ensure that documentation in respect of home visits follows a structured approach, to include topics and recommendations outlined in the RCCC Inquiry i.e. stating the purpose of home visits. The appropriate frequency of home visits by SWs should be discussed at supervision and carried through; this should be captured in the supervision template.
4. Regional C&FS must focus on an outcomes approach with clearly defined targets and milestones to indicate whether progress has been achieved. Existing documentation should be revised to support this, in line with the HIQA Standards for CP (2012).
5. Regional ISA management must ensure that staff who provide services to children in the home receive supervision / training in respect of parents and carers who consistently try to divert attention away from the welfare of children.
6. Regional C&FS and ISA services must collaborate to agree processes and clear communications in respect of services provided to children and families. RCCC Inquiry recommendations and relevant HIQA Standards for CP (2012) in respect of multidisciplinary working must be considered at this forum, as well as formalising linkages with Primary Care Teams.
7. Regional C&FS should ensure standardised guidance issues in respect of supervision which incorporates the related recommendations from the RCCC inquiry and HIQA Standards for CP (2012). This should include a template for recording supervision sessions in respect of individual cases, signed by both the SW and TL, to demonstrate an outcomes approach and continuum of care.
8. Regional C&FS must standardise CPC processes to ensure a consistent approach in terms of administrative support, distribution of minutes, sign off of minutes/plans, and follow-up with non-attendees. This should incorporate RCCC Inquiry recommendations and statutory requirements in line with HIQA Standards for CP (2012).

9. Regional C&FS must ensure that CPC chairpersons receive appropriate training in the chairing of CPCs, as per both the RCCC recommendation and HIQA Standards for CP (2012).
10. Regional C&FS must ensure a standardised recording and management system, in line with RCCC recommendations, relevant HIQA Standards for CP (2012), and guided by the HSE Standards for Healthcare Records Management (2011), until such time as the National Child Care Information System is established. In particular, duplication should be minimised, and staff should ensure that cloned information on each child's case file is pertinent to the individual child.
11. Regional C&FS must ensure that relevant training, as identified in the 2013 C&FS Workforce Development Training Plans, is delivered.

5. Conclusion

The findings from this audit indicate that C&FS have put systems in place to facilitate the implementation of recommendations from the RCCC Inquiry. A number of areas of good practice and innovation were identified by the team.

In the majority of variables audited, the audit team found sufficient and/or partial evidence of implementation of the RCCC Inquiry recommendations. Critically, the National Business Processes have addressed a number of recommendations. The audit team did not find sufficient evidence of implementation in relation to variables including: frequency and purpose of home visits, outcomes measurement, attachment training, and addressing victim impact statements. Deficits identified by this audit must be addressed locally, regionally and nationally (where relevant). This QPSA audit report makes a number of recommendations which, when implemented, will contribute to addressing these deficits.

6. Acknowledgement

The audit team would like to acknowledge the co-operation and goodwill afforded to them by the staff in C&FS and ISA who participated in this audit.