A META-ANALYSIS OF REPETITIVE ROOT CAUSE ISSUES REGARDING THE PROVISION OF SERVICES FOR CHILDREN IN CARE

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DECEMBER 2013

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Ombudsman for Children's Office
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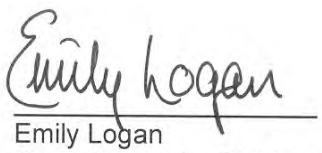
Foreword

This meta-analysis report is designed to highlight many of the flaws of the system in which some of our most vulnerable children find themselves in. However, it is also offers a range of recommendations which aim to account for the systemic root causes of these recurring problems. The Ombudsman for Children's Office has been investigating issues relating to children in care for 10 years and, in light of the re-organisation of children's services, sought to provide an overview of the repetitive issues and their root causes so that the new agency, Tusla could benefit from our systemic recommendations. It was in this spirit that we engaged with Tusla and we are very pleased to present, within this report, their response to our recommendations.

The majority of recommendations have been addressed and Tusla are clearly working toward a positive response in each area. This office recognises that they have committed to implementing a Record Management Policy in this quarter (Q1, 2014), they are to develop a comprehensive strategic plan for residential care which will address purpose, provision, practice and performance and they are creating a policy on Corporate Parenting in 2014 which will have cross departmental support. Each of these promised actions by the newly formed Child and Family Agency will allow the Oireachtas to measure Tusla's progress and provide a baseline for improvements which we all hope to see for this small but extremely vulnerable cohort of children.



Emily Logan
Ombudsman for Children

SECTION 1
INTRODUCTION, AIMS AND OBJECTIVES

Background

The Ombudsman for Children's first special report to the Oireachtas in 2006 related to complaints regarding child protection concerns; the Office's first own-volition, systemic investigation was an examination of the implementation of Ireland's national child protection guidelines across the country. Complaints relating to children in care have accounted for ten per cent of the total number of complaints received by the Ombudsman for Children's Office between 2004 and 2012. As the number of complaints has grown, so too has the complexity of the cases examined. The most recent HSE figures show that there are over 6,000 children being cared for outside their own families and therefore the appropriate care and protection of these children is a major concern for this office.

Notwithstanding the diversity of the investigations carried out by this Office in this area, it is clear that many problems identified are manifestations of recurring and systemic difficulties. Due to the establishment of the new Child and Family Agency, this Office considers it appropriate to submit a meta-analysis of a number of investigations in the area of children in care. By combining and contrasting the findings of different investigations, the analysis highlights common trends that can inform legal and policy developments in this area. This report is being submitted in accordance with section 13(7) of the Ombudsman for Children Act 2002, which provides that the Ombudsman for Children may lay reports before the Oireachtas on the performance of her functions as she thinks fit.

Where systemic problems have been identified with the operation of legislation or provision of services to children, it should not be necessary for quasi-judicial bodies such as the Ombudsman for Children's Office to investigate the same problems repeatedly. It is hoped that the findings of this report and the recommendations it contains will contribute positively to the ongoing reform of Ireland's child and family support services, and that the root causes

identified in the investigations underpinning the report cease to be the subject of examination by this Office save in exceptional circumstances.

Outline of Investigations

Section 8 of the Ombudsman for Children Act 2002 authorises the Ombudsman for Children to undertake an investigation into any action by or on behalf of a public body where, upon having carried out a preliminary examination of the matter, it appears to the Ombudsman for Children that the action has or may have adversely affected a child and the action was or may have been:

i. taken without proper authority
ii. taken on irrelevant grounds
iii. the result of negligence or carelessness
iv. based on erroneous or incomplete information
v. improperly discriminatory
vi. based on an undesirable administrative practice or
vii. otherwise contrary to fair or sound administration

The Ombudsman for Children has a more general duty to promote the rights and welfare of children under s7 (1) of the Ombudsman for Children Act. In particular, under s7(1)(a),the Ombudsman for Children shall advise any Minister of the Government on the development and co-ordination of policy relating to children and under s7(1)(b) shall *encourage public bodies, schools and voluntary hospitals to develop policies, practices and procedures designed to promote the rights and welfare of children.*

The aim of the analysis was to examine a select number of Investigation Statements with a view to assessing the repetition of root cause problems that could be addressed. The 10 Investigation Statements chosen by the Office of the Ombudsman for Children for consideration are set out below. Five complaints were made directly by young people; four were made by relatives and one by a foster parent.

1.1. This complaint was made by a foster mother in relation to a young person who was then aged 15 and had been in her care since she was two years old. The issues with which the investigation was concerned were the transfer of the young person's case between two HSE areas and the implementation of the HSE's Case Transfer Policy, access to Child and Adolescent Mental Health Services (CAMHS), care planning and provision for the young person's education while in temporary foster care and residential care.

1.2. The complaint in this case was made by the mother of a child who died while in the care of the State. The mother and her family had engaged with the HSE Child and Adolescent Mental Health Services (CAMHS) and the Social Work Department of the HSE to deal with the problems her and her husband were having in parenting their son. The mother felt that the response of the staff of both departments was inadequate and contributed to the untimely death of her son.

1.3. This complaint was received directly from a 16 year old girl who was residing in a detention centre. She raised concerns regarding the number and suitability of placements that she has been subject to since being received into the care of the Health Service Executive (HSE) when she was 14. She stated that, before entering the detention centre she had 12 different placements in a one year period and that as a direct result of various placements breaking down she began to self-harm.

1.4. The mother of a young person, aged 16, was unhappy about her care whilst residing in a High Support Unit; she believed that it was not a suitable placement for her, that they were unable to ensure her safety and that she was neglected during her stay. In addition, the parent raised concerns at the level of psychiatric and psychological services available to the young person during her time in the High Support Unit believing them to be insufficient to meet the young person's needs. The young person was subsequently placed in a Special Care Unit. The mother expressed new concerns to the OCO that the young person had not benefited from

the Clinical Team in the Special Care Unit and that she did not receive the therapy she required.

1.5. A young person, aged 17 at the time, submitted a complaint in relation to the actions of the HSE. He was in the care of the HSE at that time and he raised concerns that he had not been allocated an aftercare worker. He also stated that he was having difficulty in contacting his social worker and that a number of important meetings with his social worker were cancelled and that he was not being listened to.

1.6. A young person, aged 16 years, had been in the care of the HSE since the age of 13 years and had given birth to a baby .The young person advised that during her pregnancy she had been placed in a mother and baby unit in the south of the country but stated that this did not work out, as it was too far away from her home in the north west. Following the birth of the baby she and the baby were placed in a foster home together. This placement did not work out. She stated that it was hard getting to know new people and being so far away from the people that she cares about. At the time of contacting the OCO, the young person and baby were in separate placements and she was seeking an opportunity to be placed with her child in an independent placement. She also raised concerns regarding the level of access with her child, and was particularly concerned that the placement and access arrangements in place may affect the bonding between her and her child.

1.7. A complaint was brought by a young person, aged 15, on his own behalf. He was residing in a detention centre having been remanded there in by a District Court. He was of the understanding that he was to be remanded for a four week period for assessment, that this had been completed sometime previously and recommendations made in relation to a future placement. The complaint related to the length of time that he had been in the detention Centre and the alleged delay in a future placement being made available to him by the HSE.

1.8 A young person's grandmother and legal guardian made a complaint regarding the child's care, specifically in relation to planning for his care and the adequacy of services provided to him by the HSE.

The complainant stated her concern that, since entering the care of the HSE, the child's behaviour had deteriorated to the extent that he was now placed in Special Care. She stated that, while she feels the Special Care Unit may now be the most appropriate placement, she has concerns that the child's behaviour had deteriorated to the extent that a Special Care placement was required. Furthermore she raised concerns that the child continued to display increasingly difficult behaviours in the Special Care Unit and did not initially engage well with staff.

1.9. A complaint was submitted by the relative foster carer of a 13 year old girl. She had previously been assessed as having an intellectual disability but was awaiting the completion of a mental health assessment in relation to psychosis and autism. The girl had been in the care of the HSE under a voluntary care arrangement since she was 3 years old. She moved into the foster care of her maternal aunt at age 9. Fifteen months previously she had made allegations of abuse against family members, and others, which had not yet been assessed.

The complaint brought to this Office related to the handling by the HSE of these child protection concerns raised by the child and the care and supports provided to the child by the HSE since these allegations were made. The foster mother stated that the delay in concluding the investigation of the child protection concerns has had a negative impact on the child as she reported that the child was becoming isolated due to access to her family and social activities being curtailed.

1.10. A complaint was made by a young person, aged 16 at the time, who was in the voluntary care of the Health Service Executive (HSE). In her complaint she raised concerns about a delay in provision of an onward placement for her from High Support. She reported that since being placed in High Support she had met all her goals which she had worked

hard to achieve in order that she could leave on the planned discharge date. She explained that the HSE had attempted to source a placement for her but she understood that there was no capacity in the HSE's facilities in the area where she wished to be placed which is close to her family. She reported she visited a private residential placement but this was not progressed. She raised concerns that the issue of an onward placement remained unresolved and stated that this would have an adverse effect on her.

SECTION 2
IRELAND'S DOMESTIC AND INTERNATIONAL LEGAL OBLIGATIONS.

2.1 Introduction

Article 41 of the Constitution expressly recognises the family as 'the natural primary and fundamental unit group of society. This is consistent with Article 8 of the European Convention on Human Rights and the United Nations Convention on the Rights of the Child. The majority of children will have the opportunity to grow and develop; physically, emotionally and intellectually within their family, experiencing positive attachments which will enable their transition into adulthood. Where children cannot be cared for by their families it is important that alternative placements are found which meet their needs and provide safe and secure care.

The admission of a child to care can be a traumatic event for both the child and their families; therefore it is important that this only occurs following a robust assessment of need. The decision making surrounding the process needs to be transparent and should consider if preventative /support packages can be provided to the family which would address safeguarding concerns and promote positive parenting and safe care practices.

It is important that for every child who requires to be looked after there is a choice of placements which meets their assessed needs. This process should be managed in a sensitive manner, ensuring that the child is consulted meaningfully about where they will be placed.

The child's views are central to the decision making process having regard to the new Constitutional dispensation in Article 42.A.1 and the process in relation to admitting a child to care needs to ensure that:

– The child's views are central to the decision-making process (as per Article 12 of UNCRC – "child shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child").The goal in

- the National Children's Strategy,[1] which states that "Children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity", is very relevant in this regard.
- Decisions are based on robust assessment of need
- The placement identified meets the needs of the child promoting stability and permanence

The principles of Participation, Non-discrimination and Best Interests accord with the obligations assumed by Ireland as a signatory to the UN Convention on the Rights of the Child (UNCRC) and with other standards relating to the area of child welfare and protection, such as the UN Guidelines on the Alternative Care of Children. Specific obligations under the UNCRC include the following:

- Article 2 of the UNCRC prohibits discrimination in the enjoyment of UNCRC rights.
- Article 3 of the UNCRC requires that the best interests of the child be a primary consideration in all actions taken concerning the child. Article 3 further requires states to ensure to the child such protection and care as is necessary for his or her well-being. In the context of alternative care, the UN Committee on the Rights of the Child has clarified that Article 3 requires an individualised approach to providing for the alternative care of children, meaning more tailored solutions based on the actual situation of the child, including her/his personal, family and social situation[2].
- Article 12 requires States parties to ensure that children have the right to express their views freely in all matters affecting them, with due weight given to those views in accordance with their age and maturity. The UN Committee on the Rights of the Child has emphasised that this right is central to ensuring a decision-making process that is rights-compliant and that operates in the best interests of children.[3] In the context of alternative care, the Committee on the Rights of the Child has recommended that children should be heard throughout the protection measure process, before making the decision, while it is implemented and also after its implementation.[4] Ensuring that young people have access to all necessary information is also an important element of ensuring respect for this right.
- Article 20 of the UN Convention on the Rights of the Child provides that a child temporarily or permanently deprived of his/her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. The Committee on the Rights of the Child recommends that states ensure that the placement of children in alternative care is based on a carefully conducted assessment of the needs and best interests of the child by a competent and multidisciplinary group of experts and that a short- and long-term plan, including the goals of the placement and the measures to achieve these, is available at the time of the placement and is regularly adapted to the development of the child.[5]

The UN Guidelines on the Alternative Care of Children, endorsed by the General Assembly of the United Nations in 2009,[6] include a wide range of recommendations and standards relevant to alternative care, including the following:

- All decisions concerning alternative care should take full account of the desirability, in principle, of maintaining the child as close as possible to his/her habitual place of residence, in order to

1 National Children's Strategy – Our Children Their Lives. Department of Health and Children 2000 -http://dcya.gov.ie/documents/Aboutus/stratSummenglishversion.pdf(6Dec13)

2 UN Committee on the Rights of the Child, *General Day of Discussion on Children with Parental Care,* (2005), para. 667 - http://webcache.googleusercontent.com/search?q=cache:y7HVnagx6n8J:www2.ohchr.org/english/bodies/crc/docs/discussion/recommendations2005.doc+&cd=1&hl=en&ct=clnk&gl=ie (6Dec13)

3 UN Committee on the Rights of the Child, *General Comment no. 12*, CRC/C/GC/12, section B1 - http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf (6Dec13)

4 UN Committee on the Rights of the Child, *General Day of Discussion on Children with Parental Care*, para 664.

5 Ibid., para. 654

6 United Nations General Assembly, *Guidelines for the Alternative Care of Children,* A/RES/64/142 (2009) - http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf (6Dec13)

facilitate contact and potential reintegration with his/her family and to minimize disruption of his/her educational, cultural and social life.[7]

- Attention must be paid to promoting and safeguarding all other rights of special pertinence to the situation of children without parental care, including, but not limited to, access to education, health and other basic services, the right to identity, freedom of religion or belief, language and protection of property and inheritance rights.[8]
- Regular and appropriate contact between the child and his/her family specifically for the purpose of reintegration should be developed, supported and monitored by the competent body.[9]
- Once decided, reintegration of the child in his/her family should be designed as a gradual and supervised process, accompanied by follow-up and support measures that take account of the child's age, needs and evolving capacities, as well as the cause of the separation.[10]
- Decision-making on alternative care in the best interests of the child should take place through a judicial, administrative or other adequate and recognized procedure, with legal safeguards, including, where appropriate, legal representation on behalf of children in any legal proceedings. It should be based on rigorous assessment, planning and review, through established structures and mechanisms, and carried out on a case-by-case basis, by suitably qualified professionals in a multidisciplinary team, wherever possible. It should involve full consultation at all stages with the child, according to his/her evolving capacities, and with his/her parents or legal guardians. To this end, all concerned should be provided with the necessary information on which to base their opinion. States should make every effort to provide adequate resources and channels for the training and recognition of the professionals responsible for determining the best form of care so as to facilitate compliance with these provisions.[11]
- Assessment should be carried out expeditiously, thoroughly and carefully. It should take into account the child's immediate safety and well-being, as well as his/her longer term care and development, and should cover the child's personal and developmental characteristics, ethnic, cultural, linguistic and religious background, family and social environment, medical history and any special needs.[12]
- The resulting initial and review reports should be used as essential tools for planning decisions from the time of their acceptance by the competent authorities onwards, with a view to, inter alia, avoiding undue disruption and contradictory decisions.[13]
- Planning for care provision and permanency should be based on, notably, the nature and quality of the child's attachment to his/her family; the family's capacity to safeguard the child's well-being and harmonious development; the child's need or desire to feel part of a family; the desirability of the child remaining within his/her community and country; his/her cultural, linguistic and religious background; and relationships with siblings, with a view to avoiding their separation.[14]
- States should ensure that any child who has been placed in alternative care by a properly constituted court, tribunal or administrative or other competent body, as well as his/her parents or others with parental responsibility, are given the opportunity to make representations on the placement decision before a court, are informed of their rights to make such representations and are assisted in doing so.[15]

7 Ibid., para. 10

8 Ibid., para. 15

9 Ibid., para. 50

10 Ibid., para. 51

11 Ibid., para. 56

12 Ibid., para. 57

13 Ibid., para. 58

14 Ibid., para. 61

15 Ibid., para. 65

- States should ensure the right of any child who has been placed in temporary care to regular and thorough review - preferably at least every three months - of the appropriateness of his/her care and treatment, taking into account notably his/her personal development and any changing needs, developments in his/her family environment, and the adequacy and necessity of the current placement in these lights. The review should be carried out by duly qualified and authorized persons, and fully involve the child and all relevant persons in the child's life.[16]
- The child should be prepared for all changes of care settings resulting from the planning and review processes.[17]
- All State entities involved in the referral of, and assistance to, children without parental care, in cooperation with civil society, should adopt policies and procedures which favour information-sharing and networking between agencies and individuals in order to ensure effective care, aftercare and protection for these children. The location and/or design of the agency responsible for the oversight of alternative care should be established so as to maximize its accessibility to those who require the services provided.[18]
- When a child is placed in alternative care, contact with his/her family, as well as with other persons close to him or her, such as friends, neighbours and previous carers, should be encouraged and facilitated, in keeping with the child's protection and best interests. The child should have access to information on the situation of his/her family members in the absence of contact with them.[19]

Children in the care of the State live in a range of accommodation types, including foster care with relatives or others; children's homes; high support units and special care units. They may move in and out of the different units and on occasion will be subject to juvenile justice measures and detained in appropriate juvenile detention centres.

16 Ibid., para. 66

17 Ibid., para. 67

18 Ibid., para. 69

19 Ibid., para. 80

SECTION 3
KEY ISSUES RAISED THROUGH A REVIEW OF THE INVESTIGATIONS

This Report provides analysis of ten complaints as these were representative of the type of issues brought to the attention of the OCO. These complaints were received during the period June 2007 and January 2012.

These investigations concerned children and young people with significant problems and complex needs and it is important to acknowledge that in many cases the staff of the social work department, the staff of residential services and the staff of the Child and Adolescent Mental Health Services made considerable efforts to support the young people. This was especially so when they were engaging in very high risk behaviours and on some occasions they were beyond the control and influence of foster parents, the wider family and the professional staff who were attempting to support and care for them.

A number of repetitive themes regarding the Health Services Executive's care of children are outlined in this report. These are:

- Assessment and Care Planning
- Record Keeping
- Provision of Residential Care
- Child Protection for Children in Care
- Social Work Practice and Supervision
- Inter - professional and Multi Agency Collaboration
- Governance arrangements

These themes are now addressed in more detail.

3.1. Assessment and Care Planning

Effective intervention for each individual child depends upon a clear assessment and understanding of her/his needs. Good assessment and comprehensive care planning will enable the delivery of positive outcomes for children and young people by effectively matching resources to children and young people's needs. The important and central role of good assessment and care planning in decisions about when and where to place children in care, and their involvement in this should not be underestimated.

Assessment

Among the 10 investigations included in this analysis it was evident that there were significant shortcomings in the assessment of children's needs and the subsequent plans developed as a result of these assessments. In some cases there were assessments carried out by professionals outside of the social work department but these were not fully taken into account when reviews were being undertaken. There was also information which indicated that the integration of Care Plans, Placement Plans and Individual Crisis Management Plans was inadequate and did not meet the required standards.

An initial assessment provides a structured, in-depth assessment of a child or young person's needs where their circumstances are complex. The record of the assessment provides a structured framework for social workers to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning. This should then be used to develop the plan for the child or young person. It is important that social work practitioners take time to plan how they will complete the assessment. This should include:

- The timescale for completing the record;
- The order in which the various components of the assessment will be completed;
- How the child or young person, parents or carers will be involved in the process;
- How information will be obtained from other family members, agencies and professionals; and
- Who will have access to the completed record?

Analysis of the information gathered is the key stage in the assessment process. Research, the findings of Inquiries and inspections have frequently highlighted weaknesses in the area of assessment. Analysis takes the assessment process beyond surface considerations and explores why issues are present and the relationship between what is happening and the implications for the child or young person.[20]

The lack of assessment can be illustrated with reference to an investigation of a complaint in respect of a young person in care who had a baby. In this case there was a lack of clarity in relation to the assessment process. The HSE advised that there was no agreed formal assessment framework. In this particular case, there were different opinions by the professionals involved as to whether the assessment in this case had been concluded or remained ongoing. Further concerns related to the lack of a defined assessment timeframe and written report following the conclusion of the assessment. The delay in completing the assessment led to a delay in resolving the baby's legal status. Whilst regular Care Planning did take place there was significant information not included in these records, namely, the time frame for the assessment and clarity regarding the circumstances in which the baby would be returned to the young person's care.

In another investigation there were a number of psychiatric and psychological assessments carried out on the young person. Some of these were before her admission to care and some during her time in a high support unit and special care. There does not appear to have been any attempt to analyse these assessments and ensure that the appropriate strategies were built into the care plans, placement plans and individual crisis management plans which were developed. For example, the consultant psychiatrist from the Child and Adolescent Mental Health Services who assessed the young person prior to her admission to care produced a very comprehensive report and expressed the view that it would be unlikely that she would return to live with her parents during the course of her adolescence. Despite this well informed view 'return home' was part of the young person's care plan during her stay in special care. Another example is that during her stay in special care she was referred to a Principal Clinical Psychologist. He was of the opinion that she needed to develop skills for controlling sudden

20 www.writeenough.org.uk/introduction.htm (6Dec13)

surges of anger, and for negotiating with others. He concluded his report with a 10 point Behaviour Support Plan. There is no indication that this was reflected in her Placement Plan or Individual Crisis Management Plan.

Integrated and holistic assessment is the key to identifying the needs of individual children and young people. All assessments should be multi-professional, child centred, proportionate and timely. Children and young people's views and aspirations must be taken seriously at every stage and, where possible, support and advocacy provided. Young people should be given a copy of their plan prior to admission as well as copies of subsequent review documents. While there were some indications that children and young people were invited to express their views for their 'Child in Care' reviews this was not carried out on a systematic basis and their participation in reviews was irregular.

Care Planning

The primary responsibility for convening a statutory Care Plan meeting and for writing a statutory care plan lies with the young person's social worker and the Social Work Team Leader. The primary purpose of the Care Plan is to outline the care arrangement for the young person and the aims and objectives of a placement. Among other things, it also details the action plan for meeting the aims and objectives of the placement i.e. the action required; the name of the person responsible and the time frame for completion of the agreed action. In nine out of the ten complaints there were significant shortcomings in the development and implementation of care plans.

In an investigation that was prompted by the breakdown of a foster care placement it was reported that there was a lack of clarity in relation to care planning that has occurred since the breakdown of the foster placement and the current planning in relation to the young person's care. From the Office's review of the social work files for a four year period, there was no evidence that a Care Plan was in place for three of those years. Therefore the Office concluded that there was no Care Plan in place when the foster placement broke down. In another case a child who was placed with a relative foster carer had no care plan or placement plan and was in an un-assessed foster placement (in which the foster parents had limited training and guidance) for a period of approximately 5 years. It was of particular concern to this Office that the young person had no Care Plan for periods during which she was undergoing significant transitions between foster placements and residential care centres and that her current Care Plan had not been reviewed despite the young person having moved from the residential care centre back to her foster placement.

In a third case a central issue arising through the investigation related to the length of time involved in putting in place an after care plan and allocation of an aftercare worker. It took six months for the first clear package of support to be agreed. This represented a significant time period in a young person's life particularly as this young person was due to reach the age of 18 less than three months after the agreed plan.

Placement Plan

A Placement Plan outlines the actions that the staff of a centre or foster carers will undertake with the young person for the duration of the young person's placement. The plan is based on the needs identified and recorded in the young person's care plan. Primarily the Placement Plan outlines the actions that the centre/carers will undertake with the young person for the duration of the young person's placement. It is also designed to inform and be informed by the young person's daily routine and the Individual Crisis Management Plan and Risk Management Plan. Placement Plans should be reviewed to reflect developments in the young person's life. They should also ensure that the guidelines and recommendations of the statutory care plan are reflected in the plan.

In a number of investigations it was evident that despite the fact that the young persons' behaviour

was problematic for their management there was no systematic Placement Planning undertaken and no oversight of these by the social work department. This situation was commented upon by the Social Services Inspectorate in an inspection of a high support unit in which one of the complainants was residing.

Individual Crisis Management Plan

Each young person should have an Individual Crisis Management Plan completed on admission into care and thereafter updated regularly. The plan is to assist staff in providing the best response to the young person while they are in crisis. The plan should include an analysis of the young person's behaviour while they are in crisis and a strategy for intervening with the young person while they are in care. This should cover the use of positive and minimal intrusive intervention techniques and specify the circumstances under which physical restraint may or may not be appropriate. It should also include information on how staff should support the young person in developing internal control and reflect the development of the young person's newly learned coping skills. A copy of the plan should be sent to the young person's social worker.

A number of young people had multiple placements and it was evident that Individual Crisis Management Plans were not developed for the young people on a systematic basis in their placements and there did not appear to be any transfer of knowledge about their behaviours and how to manage them effectively .There is no indication that this was reviewed by social workers and no indication that those that were developed by residential units were supplied to the social workers for consideration in respect of the next placement.

Ongoing care planning, assessment and review are crucial in meeting the changing needs of children and young people in care. Pressure within the system often means that placement is resource-led rather than needs-led.

All children and young people who require integrated support from more than one service should experience a seamless and effective service. It was evident from the cases investigated that there was a systemic shortcoming in the integration of care plans, placement plans, individual crisis management plans and the activity of social workers in relation to these plans. This points to the need for the Social Worker role to be revised to ensure that services are coordinated, coherent and achieve their intended outcome.

3.2 Record Keeping

Closely linked to the assessment of needs and good care planning is the availability of high quality records. In addition to being central to sound public administration and accountability, accurate quality recording is central to good practice within children's services. Good recording helps to focus the work undertaken with children and families and assists with continuity when workers are unavailable or change. It is an essential monitoring tool for managers and provides evidence for investigations and enquiries. Clear and accurate records are vital in providing documented evidence of social work involvement with children and their families.

Recording refers to all the written material contained in the social work file of people using social work services. Social work files may be wholly or partly electronic or they may be hard copy.

Recording is used effectively by social workers and managers to:

- Plan work with service users
- Aid assessment and decision making processes
- Monitor staff's involvement with service users
- Monitor and review progress of set objectives and goals
- Monitor and review plans for children

– Provide an accurate account to a child as to the decisions made in relation to them and why.[21]

There are a number of pitfalls for practitioners and managers in respect of recording. Some of the most important are that practitioners do not distinguish between facts and professional judgements; there is no assessment on file; the record is not used as a tool for analysis and the size of the record makes it difficult to manage. The pitfalls for managers are that there is no management action to support policies and procedures; policies and procedures are insufficiently detailed to support practitioners and recording is not an integral part of performance monitoring.

In a number of cases the case records maintained did not support the assessment of need, planning to meet these needs and reflection on what was in the child's best interest. In one investigation it was noted that the information received from the HSE about a young person's care was contained in numerous files from different groups within the HSE. While it is appropriate for different services to maintain files and records for their own purposes there was no comprehensive social work file on the young person and her family and this did not facilitate the Social Work Department undertaking full assessments and re-assessments of her care at appropriate times.

In another investigation, the Office requested a copy of all social work and fostering case files in relation to a child. Four large lever arch files were received from HSE social work (children in care and fostering team). The purpose of each file and its authors were not always immediately clear. Some files contained pieces of information that were not in other files while some other pieces of information were in duplicate and triplicate. The fact that there were several social work teams, across several offices involved in this child's case appear to have impacted on the consistency of the record keeping. The social worker, who was allocated the file, following child protection allegations being made, raised concerns to her colleagues and team leaders about the state of the files she received and the length of time it took for her to get all the files pertaining to child from her HSE colleagues. She received the last piece of information regarding the allegations some five weeks after being allocated the case. The HSE response team, which was originally tasked with organising the safeguarding visit and care plans following a HIQA audit ,also raised concerns of being informed by the social work team that the files 'were not to be found' until the response team went to look for these files themselves. The response team explained that once found 'the conditions of these files where (sic) 'not pleasant'. The OCO found the files were very difficult to follow.

In another complaint there were concerns about an inconsistent approach and the accuracy of some of the entries on the files. This referred to a placement in which three separate records contained three different dates for the same placement. In addition there was contradictory information in relation to concerns raised regarding a baby's safety while in foster care. One record referred to the mother threatening to kill the baby while in two placements. However, records pertaining to the second placement including social work reports relating to this period did not contain this information. This is a serious concern as the accuracy of such information directly impacted on the planning for both mother and baby and was a key consideration in the decisions made.

In another case the use of the "present tense" when describing a behaviour that was no longer happening led to the delay in resolving a residential placement for one young person who had hoped to move from a High Support setting. In the same case an error regarding the young person's initials (mixed up with another young person with same initials) created confusion as to the actions and behaviour of the young person seeking the move. As a result of this poor record keeping there were implications in regard to placement planning and provision for the young person. High quality accurate records

21 DHSSPSNI. Administrative Systems Recording Policy, Standards, and Criteria September 2010 -http://www.dhsspsni.gov.uk/admin_policyfinalmay2011.pdf (6Dec13)

facilitate communication with colleagues, decision making, information sharing and ensure that the needs of the child or young person continue to be prioritised and their value should not be underestimated.

3.3. Provision of Residential Care

A number of children in the care of the State are provided with a stable and a caring home and their families receive expert help. However, others are not receiving the kind of help they need when they need it, with an appropriate degree of assessment, planning and multi – agency co-ordination. Many young people experience multiple placements which may be inappropriate, there may be delays in finding the right placement, and placements may be disrupted. This is not a good basis for helping children to develop strength and resilience. The option of a residential child care placement should be considered on the basis of a careful assessment of need. This should apply irrespective of the age of the child. Careful assessment should identify children who may gain from earlier placement in residential care which would avoid the effects of recurrent failure at home or in foster care. Residential care should be considered as having the potential to offer an effective early intervention and support to and for some young children, young people and their families. While this Office is not advocating residential care for children under twelve, in the context of recurrent failure at home or in foster care for some children, consideration of an appropriate placement should include residential care as an option.

Six young people who made complaints to the office, or had complaints made on their behalf, had multiple placements in residential care. One young person had 12 placements in a one year period and another young person had 6 placements in a period of 17 months. Many of these were unplanned and generally were as a result of breakdown in foster care or another residential placement. In the absence of any choice in provision, the social work staff were managing crises on an ad hoc basis. On occasions this meant that young people were referred to the Out of Hours Service but there was no guarantee that being in the care of the State would ensure a placement through this service.

In one case the professional staff involved with the young person expressed the views that her ability to engage and use helpful coping strategies is highly dependent on securing stable placements with adequate supervision. The inability of the HSE to secure a stable placement may have had a detrimental effect on her and led to episodes of self – harm. In the same case the young person was remanded to a detention centre and was given a 12 months sentence. She appealed this sentence and was granted bail on the condition that she resided in a placement approved by the HSE. Discussion took place with the Alternative Care Manager about the availability of another placement but it was not until two months later that the Alternative Care Manager was made aware formally that the request for another placement was to enable the young person to be discharged from the detention centre. This delay constituted an undesirable administrative practice.

Applications were made to High Support Units on her behalf to enable her to be discharged from the detention centre but it would appear that the information about her sentencing conditions was not included as part of the consideration of her applications. It was not until eight months after her detention that a placement was secured for the young person in a High Support Unit.

Another example of the difficulties in accessing appropriate residential care is illustrated by a complaint made by a young person, aged 16 at the time, who was in the voluntary care of the Health Service Executive (HSE). In her complaint she raised concerns that she was placed in a High Support Unit and given a discharge date for seven months ahead. She reported that since being placed in High Support she had met all her goals which she had worked hard to achieve in order that she could leave on the planned discharge date. She explained that the HSE had attempted to source a placement for her but

that there was no capacity in the HSE's facilities in the area where she wished to be placed which is close to her family. She reported she visited a private residential placement but this was not progressed. She raised concerns that the issue of an onward placement remained unresolved and stated that this would have an adverse effect on her.

The investigation report recorded that in seeking an onward placement the HSE noted the importance of stability and consistency for this young person in her placement, given that she has experienced multiple changes of placement throughout the previous 24 months. Records indicate that in a four month period she had 11 changes of placement with various supported lodgings providers, a number of which were with the same provider. Whilst resolution to the complaint was offered through provision of a placement in a residential unit, difficulties continued in relation to placement provision with a number of placement changes during the course of the investigation. The young person returned home temporarily, was then placed in supported lodgings which was suspended for a short period and then re-commenced, but the placement broke down again some three months later due to concerns about her behaviour. The young person again returned home and was subsequently provided with a placement. However, this was a considerable distance from her school and HSE advised that attempts to locate a placement both through HSE and private provision in the desired locality were not successful. The young person advised that this impacted on her education and that she was not attending school at that time. The HSE then advised that the young person wished to remain in her current placement and that the HSE were seeking a school placement for her in that locality.

It was of serious concern to this Office that this young person had experienced such uncertainty and instability in terms of placement provision. The planned onward placement from High Support was a residential placement. It is noted that the placement subsequently provided was ended as it was not appropriate for the young person to remain there due to allegations of assault against her by another resident which were being assessed. As a result supported lodgings were then provided, which is a significant change to the planned step down placement from High Support agreed by the professionals involved in her care. It is noted that the particular circumstances posed challenges in terms of provision of a placement. The HSE advised that the young person continued to remain in supported lodgings given her expressed satisfaction with it, the social work assessment that it was a good match and the young person subsequently was adamant that she would not return to residential care.

These cases illustrate the inadequacies in the range of residential accommodation for children and young people in terms of their availability and suitability. There was no indication that there was any attempt to match the needs of children and young people to the services being offered by individual units. In many instances it was more a matter of finding a residential unit that would admit the child or young person in a crisis.

Several other issues, relating to residential care, require to be highlighted all of which have adverse effects on young people. The first of these refers to the delays in finding onward placements for young people who are detained for longer than necessary in Youth Justice Facilities or residential units which no longer meet their needs.

The second is the use of the Out of Hours Service for children in the care of the State whose placement has broken down. This is a major shortcoming in the corporate parenting role of the State especially when this service may refuse to accommodate children in its care.

Finally, the operation of the admission process for Special Care Units is not supportive of social workers dealing with children and young people in crisis both in terms of the processes involved and the concept of Special Care as a last resort when all other measures have failed. The issue of the use of the Out of Hours Service and the operation of the admission process for Special Care Units is addressed more fully in the section dealing with Governance Arrangements.

Stability in placements can promote resilience for children in care in two respects: by providing the young person with secure attachments (which can also reduce the likelihood of placement breakdown), and by providing continuity in other areas of the child's life, such as school and their friendship group.

3.4. Child Protection for Children in Care

Children are among the most vulnerable members of society: they are vulnerable to abuse, exploitation and deprivation. The previous life experiences of many children in care have exposed them to increased risk of victimisation. They have the right to expect and receive protection from within the child care system.

Safeguarding children in care is particularly challenging and requires staff to be aware of the need to provide robust protection and to know what action to take if abuse occurs.

The HSE "Child Protection and Welfare Practice Handbook" states that in any situation in which there is reason to suspect that a 'child in care' is suffering or is likely to suffer significant harm, this must be assessed. It acknowledges that children entering the care of the State may have previously been abused or neglected and that any allegation of abuse must be dealt with sensitively and support provided to the child and others who have developed close relationships with the child.

Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings including in an institution by those known to them, or more rarely, a stranger. There are different types of abuse and a child may suffer more than one of them. Abuse may also take place on a single occasion or may occur repeatedly over time.

More than half the children who made complaints, or had complaints made on their behalf, had child protection issues. These were dealt with inadequately in that the National Guidance contained in Children First was not implemented. In part this was due to the fact that some community care areas had not accepted the National Guidance and were relying on out of date guidance from previous authorities (Health Boards). In other cases it was seen that an assessment of their child protection needs would be dealt with by reference to their care plans and any review of these. In a number of cases the child protection concerns were not adequately addressed through the care planning and review process.

An example of this was a young girl who following her admission to care, was referred for a child protection assessment because she was engaging in high risk behaviours in which she was sexually abused by older males. It had also been alleged that she had been sexually abused when she was a very young child. This was considered at a case conference. This did not result in a comprehensive assessment of her situation which would have led to an appropriate Child Protection Plan. Her needs were solely identified as requiring secure residential care.

In another case this Office's investigation of the complaint concluded that two years to investigate an allegation of a child protection nature is too long, especially against a child's parent when any delay has the potential to negatively impact the relationship of the child to that parent and extended family. It appears to this Office that this child's case was marked by lengthy delays, compounded by a lack of oversight from the HSE, poor record keeping and a lack of effective communication and cooperation between HSE staff. The HSE social work team spent a lot of time and energy on this child's case but did so outside the normal procedural, policies or statutory framework for either the handling of child protection allegations or handling of children in care. The delay in handling her child protection concerns and handling her care had a significant impact on the child in terms of her relationship with her family and by denying her due process as laid out in the relevant Statute, procedures and guidelines.

In a third case, a young person had been referred to a Child Protection Management Team on the basis

of notifications of physical abuse. Following her admission to a High Support Unit she engaged in high risk behaviour in which she was sexually abused by adult males and a number of notifications were made to the social work department. Notifications of physical abuse by her father were also made and An Garda Síochána made a number of notifications citing 'neglect' following two of her unauthorised absences from the centre. She also disclosed that prior to her admission she had been sexually abused by a member of her extended family. None of these notifications was considered fully by the Child Protection Management Team and no comprehensive assessment of her situation was undertaken which would have led to an appropriate Child Protection Plan. Social Work Managers said that, as she was in care, her needs would have been considered in the context of her Child in Care Reviews and not Child Protection Arrangements. Given that there was no social worker allocated to the young person and that the Social Work Team Leader was monitoring the case and precluded from visiting the young person in the unit, this was a very poor substitute for dealing with an increasingly dangerous situation.

Investigations by the OCO have consistently found evidence of a lack of clear child protection plans to address the safety and protection of children in care. We have also noted examples of serious delays in such plans and a lack of multi-disciplinary input into those plans. There is also a consistent pattern of care plans and child in care reviews not adequately recording the steps necessary to achieve the safety plan set out in such reviews.

The failure of the HSE to consider appropriately the child protection needs of children in its care was detrimental to their well-being.

3.5 Social Work Practice and Supervision

It is important to recognise that social workers are the lead professional group which assists the State in protecting children from harm through neglect, abuse or exploitation. Many of these responsibilities are set out in legislation, government policies and international conventions. The public expect high quality responsive services delivered by well-trained and competent staff. However, social work is not well understood and public confidence is frequently influenced by the media's handling of individual cases.

Practice

It was evident from the examination of the complaints that some children in the care of the State had no social worker allocated to them for long periods of time or had social workers assigned to them on an irregular basis. In these situations they or their families had to rely on the Duty System to access a social work service. This meant that there was no one to discharge the responsibilities of the HSE in safeguarding children who are living in alternative care arrangements. These responsibilities are set out below.

The National Standards for Children's Residential Centres outlines the Social Work role for children admitted to Residential Centres. These National Standards state that supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate, external to the centre, to whom they confide any difficulties or concerns they have in relation to any aspects of their care. Social work management is required to ensure, among other things, that the supervising social worker:

- Visits the young person in the centre and sees the young person privately;
- Is satisfied that the young person is safe and well cared for in the centre and, from time to time, reads the child's case file and daily dairy;
- Ensures that every visit to a young person by the supervising social worker is entered in the centre's care file, together with any action taken as result of the visit.
- Article 17 of the Child Care (Placement of Children in Foster Care) Regulations, 1995 sets

out the requirements for the supervision and visiting children in Foster Care Placements.

There were also occasions when these duties were not discharged by an allocated social worker. An example of this was when there was a ban on travel outside a community care area. This meant that a child placed in a residential unit a considerable distance away was not seen by her social worker for many months. In this case the young person felt that she was isolated in her placement and had no one to talk to.

In another case a young person had a social worker allocated to him but felt that he did not see her often enough and that he did not have enough time to discuss the matters that were important to him.

In a third case the delay in the transfer of the young person's case from one community care area to another was at the centre of a number of the concerns raised by a foster mother. In the first instance, the level of social work support available to the young person following her move was of concern to this Office. Social work files indicate that the child received the minimum recommended number of social work visits under the Child Care (Placement of Children in Foster Care) Regulations, 1995 for two years and had no allocated social worker for most of a third year. These files also indicate that no home visits were undertaken for seven months prior to the point at which the placement broke down, even though significant concerns had been raised about the difficulties the young person and foster mother were experiencing and the stability of the placement. Given the ongoing difficulties documented in the social work files in relation to the young person and her placement, it is the view of this Office that the minimum number of safeguarding visits was insufficient and did not provide adequate support for the child's welfare. The 1995 Regulations require that a note of each visit to the child and their Care Plan reviews be entered in the case records. Such notes were not included in the social work files for a number of reviews. The delivery of the minimum number of visits to a child in care who is known to be experiencing difficulties and whose placement is noted as being in danger of breakdown, the lack of an allocated social worker for almost a year, and the lack of consistent and required record keeping by the community care area constituted undesirable administrative practice.

In this case the delay by one area in seeking the transfer of the case for four years and the refusal by another area to accept the transfer resulted in the lack of an adequate and accessible social work service to the young person and foster mother. It is not possible to conclude that a locally provided service could have prevented the difficulties they experienced. However, it is the opinion of this Office that a locally provided social work service would have resulted in a more accessible and intensive level of service provision that may have mitigated the eventual temporary breakdown of the placement. In this respect, the failure to transfer the case at an earlier date and the refusal to accept it once requested has had an adverse effect on the young person.

Young people consistently raised the importance of regular contact with their social worker and the impact of multiple changes of social worker. The significance of the social work relationship with the young person cannot be under estimated. Social workers are responsible for planning for young people's future, and are a key mechanism for young people's participation and inclusion in this process. Ensuring that the views of children in care are listened to and that they are able to influence care planning will make it more likely that children's placements meet their emotional needs and is also likely to reduce placement disruption.

If alternative care arrangements (foster care and residential care) are to promote stability and resilience it must promote opportunities for children to develop secure attachments. One of the important relationships that can contribute to children's sense of stability and continuity includes their relationship with social workers.

In 2012 eight Children's Charities in England came together through a shared concern about how the

State is caring for children who cannot live at home. They held a number of consultation sessions with interested parties, including a Parliamentary briefing to gather opinions from interested individuals. They also had a strong social media presence and facilitated a number of sessions with children and young people who had been cared for by the state. In 2013 they published Making Not Breaking [22] which states that *"The weight of evidence, from all quarters, convinces us that the **relationships** with people who care for and about children are the golden thread in children's lives, and that the quality of a child's relationships is the lens through which we should do and plan to do."* [emphasis in original] They have developed a set of recommendations that support this approach and that are consistent with the principles that underpin the United Nations Convention on the Rights of the Child and the Human Rights Act 1998.

In respect of reducing organisational change that disrupts relationships they make the following recommendations.

"Local authorities must reduce the impact of organisational change that militates against sustaining positive relationships for children. The professional system should focus on supporting social workers to remain in post and in children's lives. Enabling this continuity should include:

- *allowing social workers time for high – quality handover periods and endings, when they or children move*
- *introducing a three – month notice period for social workers working with children in care, to provide more effective handovers*
- *avoiding allocating a new social worker to a child in care where it is known that the worker will be leaving shortly*
- *providing opportunities for social worker promotion based on expert practice rather than management skills*
- *rewarding social workers for remaining in post in order to support children long term*
- *having strategies in place to minimise for children the number of changes in social worker and IRO[23], including changing how teams are structured, and*
- *careful planning of any necessary change in carer or support worker.*

These recommendations are worthy of consideration in respect of children in the care of the State in Ireland.

Supervision

The allocation of social workers and their supervision by management staff are closely linked. There was evidence to suggest that supervision of social workers was irregular and did not meet the standards set down by the HSE. These are contained in The Report of the Task Force for Children and Families produced by the HSE in June 2010 and which is based on previously published reports. This report suggests that supervision should take place every four weeks. The standards state that supervision should focus on children and young people's rights, outcomes for children and families, how decisions are made that impact on those outcomes and planning for the future.

An example of inadequate supervision can be found in the case where a social worker was allocated to a young person but she did not receive supervision for ten months after taking on the case. She received one other supervision session during the first year and in the next year there were seven supervision sessions dealing with the young person's situation. Thereafter the frequency of supervision declined. Given the significant developments and challenges in providing suitable care for the young person this fell short of the standards set.

In another example a social worker was allocated to a young person but she did not receive supervision for the first four months after taking on the case. She received another three supervision sessions during

22 The Care Inquiry "Making not Breaking – Building Relationships for our Most Vulnerable Children" 2013 - http://www.nuffieldfoundation.org/sites/default/files/files/Care%20Inquiry%20-%20Full%20Report%20April%202013.pdf (6Dec13)

23 Independent Reviewing Office

the rest of in the first year and in the following year there were only two supervision sessions dealing with the young person's situation – one in January and one in December. Given the significant developments and challenges in providing suitable care for the young person, this fell very far short of the standard set in the HSE's National Policy on Staff Supervision. The supervision sessions appeared to be significant in considering what was happening and in considering the future plans for the young person. However, the supervision notes did not record what the future plan was for her for the incoming period. There was also no indication that the discussions and agreements on the way forward were reflected in the care plans.

It is well recognised that reflective practice together with a good work environment supports improving practice and ongoing professional development to deliver improved outcomes for children. This means that management have to provide effective supervision and employee development systems that link individual performance to service outcomes. They should also ensure that regular audit of the quality of social work practice is carried out. In turn social workers should actively seek, and engage fully with, supervision on a regular basis to reflect on their practice and identify areas for development. They should also undertake regular analysis and assessment of the quality of their practice including reflection on engagement and interventions with children; what is going well and what requires changing.

3.6. Inter–professional and Multi–agency Collaboration

Inter-professional and multi-agency collaboration means continuously working together for the benefit of each and every child. It can and does make a difference.

Effective collaboration among those who plan, manage and work in services for children and young people is essential if the many issues facing alternative care arrangements are to be fully addressed and resolved. There is a huge range of stakeholders with a real investment in the future of these children and young people.

Most children and young people in the care of the State have been known to a variety of agencies for some time before admission and may have received services in the community. All will have used universal services such as health and education and many of them and/or their families will have had specialist help and support. The collaboration of agencies working across the continuum of children's services therefore is critical if we are to deliver all the responsibilities to children in the care of the State under the Child Care Act 1991 and which are a corporate responsibility of the Health Service Executive. So far the statutory bodies with this corporate responsibility for children in the care of the State have failed to fully adopt the role of a corporate parent.

Corporate Parenting

Corporate Parenting means the formal and local partnerships needed between all departments and services, and associated agencies, which are responsible for working together to meet the needs of children and young people who are in the care of the State. Corporate Parenting offers the opportunity to improve the futures of children in the care of the State by all parts of the organisation, into whose care they have been admitted or committed, and partners making their contribution to the well-being of all children in care.

Good nurturing corporate parenting by the State should be seen as the foundation upon which wider care planning and support is laid. Many children will require additional support to address emotional, physical and educational deficits created by adverse early experience.

There were examples in the investigations completed where collaboration between professional groups and services within the HSE was not good. In one case a young person had a history of mental health difficulties, including an early diagnosis of borderline ADHD from a young

age and had attended a number of services while residing in one location. In addition, she attended a number of therapeutic services while residing in another location for three years. The young person was reported by the foster mother and social worker as having difficulty managing her behaviour, particularly her anger, and was also reportedly engaging in self-harm.

Of particular concern to this Office was the refusal of CAMHS in the second location to see the young person due to the fact that she did not have a locally allocated social worker. This decision was made on the basis of previous difficult experiences of treating children whose social worker was not in that location. The CAMHS involved expressed concerns over the quality of the service that could be provided to children in such circumstances, the reluctance of social workers to travel to the second location for meetings and the time spent by them travelling to meetings in other areas.

The Manager of the Mental Health Services in the second location and the consultant in question both advised this Office that following a meeting of the Child and Adolescent Psychiatry Services it was agreed that children in care living there should be able to access services in that area, irrespective of where their social worker is located. They stated that this is a policy which is now implemented in the area concerned. This was also their expectation of CAMHS services in other parts of the country when dealing with children whose social worker is located in the second location.

It appears that, prior to this meeting, there was no agreed policy in CAMHS regarding the treatment of children in care whose social worker was located elsewhere. This lack of local policy reflects the lack of national policy and guidelines for CAMHS in relation to children in care. It further appears that this lack of national policy and oversight has resulted in individual CAMHS operating in various ways across the country. This lack of a coherent national policy and guidance results in inconsistent practice and service delivery to vulnerable children thereby failing to alleviate, or worse, increasing their poor mental health. The Office has recommended that this should be addressed by the HSE at national level.

In a second case two separate issues arose. Firstly, the young person received psychiatric support from a children's Hospital and the CAMHS during her initial period of care. When she was admitted to a Special Care Unit in another city she was refused a psychiatric assessment by the local CAMHS team as she was from outside the catchment area for the team and it was considered that she should receive a service from the team in the area from which she came. This was unrealistic and was detrimental to her overall well-being.

Secondly, following her discharge from her special care placement, the young person continued to access the children's hospital and the CAMHS until her placement in a residential unit. There was no contact between the young person and the clinical psychologist in CAMHS for seven months at which time the clinical psychologist wrote to the social worker asking for an update. There had been no significant effort on behalf of the CAMHS to maintain contact and keep up – to - date on her health status. Reliance had been placed on the social worker and residential staff to contact CAMHS if necessary. The action by CAMHS in not directly monitoring developments closely constituted an undesirable administrative practice.

In a third case securing a mental health assessment was very problematic. In this case a child protection assessment appears to have been dependent on a mental health assessment being secured. The handling of the mental health referrals by HSE CAMHS was a cause for concern. The referrals made on behalf of the child were reviewed seven times by HSE CAMHS and refused on the basis that CAMHS did not work with children with intellectual disability. The HSE social worker did advocate for the child through several letters and phone calls. For a period of six months, the child's referral was bouncing between Disability and CAMHS services as *'CAMHS do not work with children with intellectual disability and Disability Services do not work with children with mild intellectual disability'.* On foot of

the new assessment of her Intellectual Disability being in the average range, CAMHS accepted the referral and placed her on a routine waiting list.

However, once the referral was accepted, there was poor communication between the social work department and the CAMHS team. For a period of 10 months there did not appear to have been any proactive communication from the social work department to CAMHS to seek updates on the referral, organise a professional meeting or give an update on the child, her needs or the actions taken by social work to progress her mental health assessment beyond the three telephone calls made (and only one of them substantively discussing the case with CAMHS). While CAMHS did give the child an appointment they did not inform the Social Work Department of this for a period of 2 months, which was after the child had been seen. Subsequently CAMHS made over 10 attempts to contact the social work department (both in writing and by phone), but it appears that, in reality, the foster carer was the main conduit of information between the two teams during this time. Once again the fact that the social work team and the CAMHS team were not in the same area appears to have had an impact on the quality of the communication. As a result the first meeting between HSE social work and HSE CAMHS in relation to this child occurred 16 months after the allegations of child protection were first made, 13 months after a mental health functioning assessment was required. This was far too long.

This was a significant failure by the HSE and HSE CAMHS in providing for the needs of this child in a timely fashion.

In These Are Our Bairns: A Guide for Community Planning Partnerships (2008)[24] on being a good corporate parent, the Scottish Government has summarised the three key elements of corporate parenting as:

– "The statutory duty on all parts of a local authority to co-operate in promoting the welfare of children and young people who are looked after by them, and a duty on other agencies to co-operate with councils in fulfilling that duty.
– Co-coordinating the activities of the many different professionals and carers who are involved in a child or young person's life, and taking a strategic, child-centred approach to service delivery.
– Shifting the emphasis from 'corporate' to 'parenting', taking all actions necessary to promote and support the physical, emotional, social and cognitive development of a child from infancy to adulthood."

It went on to state "we believe that corporate parenting is not just a responsibility. It is also a real opportunity to improve the futures of looked after children and young people. Success relies on many different organisations - including local authorities, health boards, the police and schools - recognising they have a critical contribution to make.

Good corporate parents will want the same outcomes for their looked after children as any good parent would want for their own children. They will accept responsibility for them and make their needs a priority."

3.7. Governance Arrangements

Governance in family and child care services refers to a framework within which organisations are accountable for continuously improving the quality of their services and taking corporate responsibility for performance and providing the highest possible standard of care. It provides a means to learn from and improve services. It supports organisations and individual workers to be accountable for the quality of services, and to take responsibility for maintaining and improving service provision and practice.

The key principles fundamental to good governance are:[25]

– **A clear focus on the organisation's purpose and**

24 http://www.scotland.gov.uk/Resource/Doc/236882/0064989.pdf (6Dec13)

25 http://www.dhsspsni.gov.uk/governance-guidance (6Dec13)

outcomes for service users
- **Clarity about roles and functions**
- **Managing risk and transparent decision making**
- **Engaging with key stakeholders**
- **Ensuring accountability.**

In a number of investigations it was clear that there were significant shortcomings in the governance arrangements which affected the delivery of care to children and young people.

An example of this is the delay in the transfer of a young person's case from the one community care area to another, the HSE management of the application of the transfer policy and the impact of this delay on the allocation of a social worker in the receiving area. In this case the family moved from one area to another in 2006 but no application was made to transfer the case for some four years, with the first request for transfer being made in 2010. Although the HSE Case Transfer Policy was not in operation at the time of the family move, it came into being in 2007. A further three years elapsed between this policy and the first request for transfer of the young person's case. No explanation was provided by the HSE for this delay. There is a clear emphasis in this policy on the timely transfer of cases when a family moves from one administrative area to another. The transfer of the case should be initiated immediately upon the family's move and all transfers involving children in care should be affected within 12 months. The delay in seeking to transfer this case and the refusal to accept it constitute undesirable administrative practice and is also contrary to the HSE's own policy. The delay by the HSE in seeking the transfer of the case between 2006 and 2010 and the refusal to accept the transfer resulted in the lack of an adequate and accessible social work service to the young person and foster mother. In this respect, the failure of HSE to transfer the case at an earlier

date and the refusal to accept it once requested has had an adverse effect on the young person.

The operation of the admissions process to Special Care featured in a number of investigations. In one case, following a case conference an application was made for a special care placement for a young person. This was rejected by the National Special Care Admissions and Discharge Committee two weeks later on the basis that she did not meet the criteria for a special care placement. No reason was given. The social worker appealed this decision and the Committee considered it again two weeks later. This time they informed the social worker that the criterion for placement in a special care unit was that such placement is a matter of last resort when all other options have been tried. The application was again rejected. It was not until another meeting held four weeks later that the Committee agreed that the young person now met the criteria for special care and the social worker was advised a week after this decision was made. The rigid approach taken to this application by the Committee did not facilitate the social work department in managing what was becoming a more difficult situation. The failure to initially provide reasons for the decision represented an undesirable administrative practice.

The young person was admitted to a special care unit but because of her behaviour only remained there for six days and was then transferred to another special unit. One of the reasons for seeking a transfer was that there were a number of other young people from the Out of Hours Service and this had caused a lot of problems and it was not in her best interests to be involved with them. This could have been identified prior to admission and obviated the need for such a rapid transfer to another placement. Consequently, it reflected insufficient planning of the young person's care and was contrary to sound administration.

In another investigation following the breakdown of the young person's placement in a residential unit, when he was aged 13, he was placed in a Crisis Intervention Service the following day. On the same date an application was made for a special care placement for the young person. Despite the requests by the social work department the National Special Care Admissions and Discharge Committee did not meet on an emergency basis. The committee

was of the view that he was in a placement and that the application could be considered at the next scheduled meeting. This was due to take place two weeks later but at the meeting the Committee decided it would not consider the application again until it was in receipt of a confirmed onward placement. This was despite the fact the requirement to identify an onward placement was no longer part of the criteria for admission to Special Care. This had been replaced by "a commitment on the part of the social work management to the provision and implementation of an appropriate discharge plan." The social worker was not allowed to appeal this rejection of the application on the basis the Committee had not refused the application. The Committee stated that the application had not contained information on a step - down placement. The information was supplied by the social worker and two days later the Committee decided that the young person would meet the criteria for Special Care. The rigid approach taken to this application by the Committee did not facilitate the social work department in managing what was becoming a more difficult situation. In accordance with the Ombudsman for Children Act, 2002, this represented an undesirable administrative practice.

In yet another investigation the criteria for admission to special care came under some scrutiny. This young person presented with complex difficulties and there was serious concern in relation to his behaviour and possible risks to self and others. From the information provided it appears that all agencies involved were of the view that this young person's needs were primarily welfare based and not criminal. The information provided by HSE indicated that the Judge in the Juvenile Court did not wish to criminalise the young person and that remands in custody had been made on welfare grounds.

It was of grave concern to this Office that a 15 year old with identified welfare needs remained in the criminal justice system for a seven (7) month period whilst the most appropriate way to meet those needs was identified. The delay in providing an onward placement related to the divergent views as to the most appropriate placement for him and the length of time involved in making a decision in this regard, specifically the Special Care application.

The intertwining of the welfare and justice court systems appears to be inevitable for some children who present with a complex and simultaneous mix of welfare and justice problems. The needs of such vulnerable children cross different court jurisdictions as well as court systems. There has been an absence of legislation which provides for the High Court to have statutory jurisdiction to hear applications for Special Care and that addresses the particular difficulties that have arisen in this regard. As a consequence children in respect of whom there are criminal matters ongoing could not access Special Care, even where this may have been recommended, until these proceedings were concluded. This was reflected in the revision of the Special Care Criteria in 2008. This issue is addressed in the Child Care (Amendment) Act 2011which is enacted but has not yet been commenced. However, the criteria for special care have been revised since 2012 and removed this exclusion. It is hoped that the relevant legislative provisions will be commenced as soon as possible.

In another case social work decision-making appears to have occurred outside the normal framework, procedures and policies in place with regards to handling child protection allegations (such as Children First, the National Standard for Foster Care and/or handling decisions regarding children in care). Between February 2010 and end of 2011, only three strategy/formal professional meetings took place. During this same time period, there were however, in excess of 18 meetings between social workers and their line managements regarding this case and many more emails and discussions. At these meetings, a large number of decisions were made (such as seeking care orders for the children, the appointment of a child care worker, etc.). These decisions were often not implemented and no reason recorded for their non-implementation. This appears to indicate that there were difficulties in implementing decisions made and lack of governance on these decisions.

An example of this is where the HSE social work department carried out a prompt initial assessment on the allegations made by the child against sports volunteers and held meetings with all concerned parties within a few days. At a professional meeting to deal with these concerns, the HSE decided to make a referral for a child care worker and to identify support services in the local area of the foster carer. There is no record of any steps taken by the HSE to implement these decisions. The HSE found the concerns to be unfounded. The subsequent management of the notifications to the accused was inconsistent.

This Office requested the files from the Child Care Manager on several occasions. The notifications sent by the Child Care Manager to the Gardaí were provided by the HSE but nothing else. According to the HSE social work team, there was no Child Care manager's file or documentation in relation to this child. It is unclear whether/where letters sent to the Child Care Manager about this child were kept, especially when these letters are not in the social work files. Moreover, it appears that no oversight on the child protection allegations was exercised by the Child Care Manager and/or the Child Protection Notification Management (CPNM) Meeting. The social work department stated at the investigation meeting that Children First Guidelines were operational at the time of the allegations and that no local procedures were in place. However, when asked to provide minutes of any CPNM's meeting(s) where the allegations regarding this case may have been discussed, the social work team did not provide anything. They later explained in a phone conversation to this Office, in November 2012, following several requests that no such meetings occurred and that Children First Guidelines (the national policy for handling child protection concerns) are currently being implemented in the area for the first time. Implementation occurred between November 2012 and May 2013. It is of serious concern to this Office that Children First Guidelines were not implemented. It is equally concerning that the process governing the local child protection practices, in lieu of Children First, appears to have been unwritten and did not allow for external governance or oversight (from the child care manager or CPNM team) of the handling of the allegations beyond the Principal Social Worker already actively involved in the case.

Finally, in another case following the breakdown of a placement a young person was placed with her mother for a few days and when this was no longer viable presented to a Garda station and was refused a bed in the Out of Hours Service. The young person had been advised by the Social Work Department that she should present there if required, as there was no alternative accommodation available for her. The Crisis Intervention Service (CIS) informed the social work department that she was not provided with a service due to her behaviour while accessing the CIS in the previous year. This was in contravention of an internal HSE contract of service and was contrary to fair and sound administration.

SECTION 4
RECOMMENDATIONS

Children and young people who live in the care of the State have a right to, and must have, the same life chances as all children and young people in Ireland. They have faced difficult childhoods. Most have experienced periods of instability and insecurity, many have had their education disrupted and their health needs neglected. For these reasons, children in State care require the full support of services to enable them to achieve where possible, a good education, emotional stability and security in their placement. They are entitled to the right to prepare for a successful adult life. Governments and agencies working with and for children have a duty to ensure this right is realised.

Article 20 of the UN Convention on the Rights of the Child (UNCRC) places a specific duty on Governments to provide special care and protection for all children unable to live with their families. The Child Care Act, 1991 which governs most of the areas of the Health Services Executive's duties, powers and responsibilities in relation to children in the care of the State and care leavers, states that children are the responsibility of the whole Executive and not just the social work department. Taking responsibility for children in the care of the State, listening to them and working together are essential elements of the corporate parenting responsibilities of the HSE. This refers to the contribution the Board members and all departments of the HSE can make to improve the lives of children looked after by the State.

This report has highlighted a number of particular difficulties for children in the care of the State, either on a voluntary basis or through court orders, and their families in securing a suitable pattern of care to meet their needs.

Following the examination of the recurring concerns regarding the Health Service Executive's services for children in care the key recommendations arising from this special report are set out below. It is acknowledged that it is planned that the Child and Family Services currently provided by the Health Services Executive will be transferred to the Child and Family Agency when this is established

and the full implementation of some of these recommendations will fall to that new body.

4.1 Assessment and Care Planning

Effective assessment and care planning led by social workers, promotes permanence and reduces the need for emergency placements and placement changes. Good care planning supports the quality of the relationship between the child or young person and a carer by minimising disruption, increasing attachment and providing greater placement stability, which also helps to promote a stable education.

As part of the transition from the HSE to the establishment of the Child and Family Agency, **it is recommended that the Health Service Executive Child and Family Agency:**

- **Recognises that research, the findings of Inquiries and Inspections have frequently highlighted weaknesses in the area of assessment**
- **Issues guidance on the assessment of children entering the care of the State. This would include the areas listed earlier i.e.**
- **The timescale for completing the assessment record;**
  - **The order in which the various components of the assessment will be completed;**
  - **How the child or young person, parents or carers will be involved in the process;**
  - **How information will be obtained from other family members, agencies and professionals; and**
  - **Who will have access to the completed record?**
  - **Analysis of the information and conclusions about children's needs.**
- **Children in care have a right in Irish statute to participate in the decisions made about their individual care. This is closely linked to their rights for care and protection.**

It is also recommended that the Health Service Executive/Child and Family Agency ensures that the views of the child or young person is heard at every stage in the care planning process, as appropriate, with particular concern for the choice, quality and continuity of the placement. They should ensure that clear mechanisms exist to promote the views of children and young people in decision making. This may include independent support, advice and advocacy, as well as effective complaints processes. Independent support, advice and advocacy can come from a variety of sources including EPIC, Guardians ad Litem and independent representatives.

Earlier it was noted that there were systemic shortcomings in the integration of care plans, placement plans and individual crisis management plans and the role of the social worker in relation to these plans.

It is recommended that the Health Service Executive/ Child and Family Agency ensures that all children in the care of the State have an up-to-date care plan and placement plan and that the relationship of these is clearly stated.

It is also recommended that the social worker allocated to children in care undertakes a set of core functions to help deliver effective, integrated support by:

- **acting as a single point of contact for the child or family**
- **coordinating the delivery of the actions agreed by the practitioners involved**
- **reducing overlap and inconsistency in the services offered to families.**

4.2 Record Keeping

At an individual level case recording supports good practice, facilitates reflection and planning and gives evidence that the practitioner and the organisation is meeting the expected standards of care. It has been described as the 'most important tool available to social workers and their managers when making

decisions.'[26] Recording is a vital part of the social work task and inquiries into service failures and the investigations of complaints by the Ombudsman for Children's Office have identified it as a significant area of concern.

In addition the HIQA Standards (July 2012) – No. 6.3.2 states that
"Each child's record is:

- Factual, accurate, and legible
- Maintained and filed in chronological order
- Dated and signed after each entry
- Regularly updated
- Accessible at all times during periods of leave
- Compliant with all information requirements as outlined in Children First, national standards and relevant legislation
- Standard 6.3.4 states that "Regular audits evaluate the record-keeping and file-management and practices"[27]

The Health Service Executive have stated in response to investigation statements that it is committed to a systematic and planned approach to the management of client records, controlling both the quality and quantity of information generated and that it is the manager's responsibility to ensure that staff are fully aware of what is good practice and appropriate with regards to records management. It reported that a draft Children and Families Records Management Policy was completed in May 2012 and work is in progress regarding a final document being issued.

It is recommended that the Health Service Executive/Child and Family Agency finalise the new policy on records management and ensure that it is fully implemented prior to the establishment of the new agency

It is also recommended that a training programme for social workers and their managers is provided and that an annual audit of records is undertaken.

4.3 Provision of Residential Care

There is a need to place residential care of children and young people in a well thought out strategic role in relation to all other children's services. This should be done at both planning and individual levels. Residential care is generally now seen as the option that is taken when family placement looks inappropriate, is unavailable or has failed. There are those young people with complex and often deep rooted problems, such as those in this sample, who may need the security of having a group of adults who can share the tasks of providing consistent care and attention.

There is a pressing need to identify the place that residential child care should occupy in the range of services for children in the care of the State, in order to open up its potential for a more creative and effective role in responding to the needs of children and young people.

Addressing the needs and improving the outcomes for children and young people in residential care requires collaboration between agencies in the provision of relevant universal and specialist services. Virtually all children in residential care need additional help beyond basic care and safety. It is also important that the location, design and work of residential services supports continuity of children's' key relationships with family, friends, professionals, school and community except when this is contrary to the child's best interests.

The Office understands from a previous examination and proposed investigation into HSE Homelessness service provision that the HSE had initiated a Review of Alternative Care Services in 2011.

It is recommended that the Health Service Executive/Child and Family Agency urgently develops a strategic development plan for residential child care services which would

26 Walker, Steve, David Shemmings and Hedy Cleaver: WriteEnough www.writeenough.org.uk/introduction.htm (6Dec13)

27 "National Standards for the Protection and Welfare of Children-For the Health Service Executive Children and Family Services." Health Information and Quality Authority July 2012 -http://webcache.googleusercontent.com/search?q=cache:9xCDr59ZxWEJ:www.hiqa.ie/system/files/Child-Protection-Welfare-Standards.pdf+&cd=1&hl=en&ct=clnk&gl=ie (6Dec13)

shape the future direction of services, plan for the provision of sufficient services in locations throughout the country and ensure that the needs of children and young people are met.

There are children and young people with very serious challenging or self-harming behaviours and those with a range of mental health disorders, disabilities and conditions, including those requiring secure accommodation. These children and young people are currently placed in services outside the state and are far removed from their families and communities.

It is recommended that the Department of Children and Youth Affairs establishes a national expert commissioning group to plan and promote the development of the highly specialised services which are required to meet the needs of children and young people with a combination of complex needs. This group should include representatives from other Government Departments or their agents e.g. Department of Health, Department of Justice and Equality and Department of Education and Skills.

4.4 Child Protection for Children in Care

All adults who work with and on behalf of children are accountable for the way in which they exercise their authority, manage risk, use resources, and safeguard children. These adults have a duty to keep children safe and to protect them from sexual, physical, emotional abuse and neglect.

Some children and young people place themselves at risk of significant harm from their own behaviour. Concerns about these children and young people can be just as significant as concerns relating to children who are at risk because of their care environment. The main difference is the source of the risk, though it should be recognised that at least some of the negative behaviour may stem from earlier experiences of abuse. Where such risk is identified, as with other child protection concerns, it is important that a multi-agency response is mobilised and a support plan identified to minimise future risk. The key test for triggering these processes should always be the level of risk to the individual child or young person and whether the risk is being addressed, not the source of the risk.

Among the different types of concern that may arise are:

- Self-harm and /or suicide attempts
- Alcohol and/or drug misuse
- Inappropriate sexual behaviour or relationships
- Sexual exploitation
- Violent behaviour
- Running away/going missing

A number of children who made complaints to this office displayed some of the behaviours mentioned above and placed themselves at considerable risk of harm. These child protection concerns were considered within the context of care planning and review requirements as set out in the regulations of 1995. These regulations pre-date the Children First Guidelines and are insufficient to consider fully the needs of children in care who are placing themselves at risk.

It is recommended that the Health Service Executive/ Child and Family Agency ensures that there is a multi-agency policy, procedure and system in place for identifying, referring and responding to situations where young people in care place themselves at risk through their own behaviour.

It is also recommended that Children First should be fully applied in respect of children in care when there are child protection concerns including the use of the CPNS in situations where there is ongoing risk for these children.

4.5 Social Work Practice and Supervision

There is no doubt that social workers work with some of the most vulnerable people in our society promoting their rights and independence and working to improve and safeguard their social well-being. They are at the forefront in protecting children. Our experience is that many social workers display enormous commitment to the children in their care and may and do find themselves in very upsetting situations.

There are a number of important challenges facing the profession. These include:

- Major changes in the health and child care system
- Growth and changes in the need and demand for services
- Resource pressures and the drive for more efficiency
- Expectations about social work which at times may be too high and unrealistic.

In these circumstances it is important that this resource is valued and developed in line with the considerable expectations placed upon it.

It is recommended that since Social workers are required to discharge explicit statutory duties, in relation to children in the care of the State, the Health Service Executive/Child and Family Agency ensures that there are sufficient resources to discharge these duties placed upon it in relation to children in care.

The Health Service Executive has now produced a revised Staff Supervision Policy for the Child and Family Services.

It is recommended that this policy is implemented quickly to ensure that social workers receive high-quality supervision with a particular focus on the management of care plans and corrective action to ensure that interventions are acted upon as agreed to ensure that children receive the care and treatment that they need.

It is also recommended that the Health Service Executive/ Child and Family Agency ensure that all staff providing supervision are trained for the task.

4.6 Inter-professional and Multi-Agency Collaboration

For effective care to be provided, professionals need to collaborate closely and share relevant and sensitive information. It is also clear that when multi-agency teams are supported and encouraged to address their way of working, they are better able to collaborate when handling difficult and complex situations, and more readily adopt a non- defensive approach that focuses on best outcomes.

It is evident from the complaints reviewed here that collaboration between professionals and services within the Health Service Executive has been problematic. This has impacted significantly on the ability of the HSE to fulfil its' role as corporate parent for children in the care of the State. This responsibility will transfer to the Child and Family Agency which will not have the same range of services under its direct control. It is evident that there are many professional staff and agencies who will not be directly under the control of the Child and Family Agency but who, nevertheless, will make a huge contribution to the overall system of care for children. These include, Child and Adolescent Mental Health Services; Public Health Nursing and Youth Justice Services. Therefore, the goal must be for the State to become a competent, caring and confident parent to all children in the care of the State and thus:

It is recommended that the Department of Children and Youth Affairs addresses how the Child and Family Agency, and those organisations providing a service on its behalf, will discharge the role of corporate parent and ensure that all relevant government departments, state agencies and relevant elements of the HSE accept their responsibilities for children and are committed to playing a full role in collaborating with the new Agency in the parenting of children in the care of the State.

It is understood that section 13 of the Child and Family Agency Bill provides that the Board of the Child and Family Agency prepare an annual report.

It is recommended that this should include reporting on the discharge of its corporate parenting functions, including inter-professional and multi-agency activities.

4.7 Governance Arrangements

Good governance is important because children and families, carers and the public deserve good quality and safe services and the Child and Family Agency has a statutory duty to provide these.

All staff have a responsibility to ensure good standards of care are maintained and organisations need to have internal systems to monitor child care governance arrangements.

There were a number of examples in the cases investigated which highlighted shortcomings in governance arrangements that did not meet the best interests of children. These included:

1. The arrangements for accessing Special Care
2. Poor supervision of social workers
3. Case transfers
4. Record maintenance

Ensuring effective professional governance requires:[28]

- Clear professional accountability arrangements to oversee the discharge of statutory functions;
- Robust professional governance arrangements from frontline practice to the most senior levels in the organisation to ensure safe, high standards of practice and management of risk and to enable employers to discharge their duty of care;
- Effective information gathering and reporting mechanisms;
- Evidence based risk assessment, including positive risk assessment (this means identifying those activities that people can undertake fully or partially without the assistance of others) and management tools and training for staff in their application; and
- Clarity about professional roles and responsibilities for social care governance within organisations.

It is recommended that the Health Service Executive/Child and Family Agency undertakes a review of the governance arrangements in family and child care services with particular reference to the four shortcomings identified above. They should prepare guidance on this and ensure its implementation on the establishment of the new Agency.

28 http://www.dhsspsni.gov.uk/print/index/swstrategy/issw-section3g.htm (6dec13)

An Ghníomhaireacht um Leanaí agus an Teaghlach
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Ombudsman for Children Office
Millennium House
52-56 Great Strand Street
Dublin 1

14th February 2014

Re: Meta analysis of Repetitive Root Cause Issues Regarding the Provision of Services – December 2013 - Response from Tusla – Child & Family Support Agency.

Dear Dr Muldoon

Tusla welcomes this report from the Office of the Ombudsman for Children as an opportunity for learning and is grateful for the opportunity to comment on it. Please find attached a detailed response to the Meta Analysis.

The Child and Family Agency is determined to provide quality services to all children and families, particularly children in care who are among Ireland's most vulnerable.

Thank you again for the opportunity to comment on this report and please do not hesitate to contact me if you require further information.

Yours sincerely

Fred McBride
Chief Operating Officer

Enc:

- Tusla – Child & Family Support Agency Response to the Meta Analysis of Repetitive Root Cause Issues Regarding the Provision of Services – December 2013.

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TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Tusla – Child & Family Support Agency Response to the Meta Analysis of Repetitive Root Cause Issues Regarding the Provision of Services – December 2013.

The report is based on ten cases over an eight year period, while there are approximately 6,500 children in care on any given day. The report acknowledges that the ten cases highlighted are complex and we are pleased that it also acknowledges the dedication of staff in seeking to alleviate the difficulties described in each case.

In terms of regulatory compliance the Tusla - Child and Family Agency is committed to adhere to, and exceed where possible, the conditions set out in the Child Care Regulations 1995, the National Standards for Children's Residential Standards and the National Foster Care Standards 2003. In addition the Agency has developed a comprehensive Alternative Care Practice Handbook which we are committed to introduce in the first quarter of the year. This Handbook covers the vast majority of issues raised in the Ombudsman's report and includes chapters on legislation, children and young person's rights, social work roles and responsibilities, access, contact and re-unification, foster, residential care, leaving care and after care, children out of home, missing or absences from care, separated children and child trafficking, managing risk , promoting safe practice and child protection in alternative care, direct work with children, education, personal development, health and well-being, diversity and equality, record and case management, monitoring and inspections.

Assessment and Care Planning

The Agency is well aware of the benefits of research in informing practice. In the last number of months a series of seminars have been held for practitioners on the learning from serious case reviews and a comprehensive training plan is in place for 2014. As a matter of course a needs assessment on children entering the care system is undertaken in accordance with National Standards and the process is further addressed in the Practice Handbook. Children are participants in decision making within the care system as a matter of routine. The Agency is placing a strong emphasis on participation generally and will soon be issuing a Participation Strategy. Systems are already in place to consult representative groups of children in care and this will be further advanced in 2014.

In relation to care planning compliance with Regulation requirements has consistently exceeded 90% in the past twelve months. The role of social workers for children in care is clearly set out in the Practice Handbook. Guidelines will be issued in the first quarter of 2014 covering the pointes highlighted in the report on page 47:

- The timescale of completing the assessment record.
- The order in which the various components of the assessments will be completed.

- How to involve the child or young person, parents and carers in the assessment.
- A protocol on how to obtain information from other family members, agencies and professionals and who has access to records.
- Guidelines on analysing the information about children's needs.

Record Keeping
The record management policy referred to in the report has been finalised and will be implemented in the first quarter of this year. It should also be noted that the Child Care Information System, providing standardised business processes, is in the implementation phase. The Agency has a comprehensive training programme on Social Work record keeping and this is a key component in the training programme for 2014.

Residential Care
In 2013 a working group was established under the Chief Operations Officer to devise a comprehensive strategic plan for residential care. This will address purpose, provision, practice and performance.

Child Protection
Risk management systems are currently in place to manage protection issues, including young people placing themselves at risk. This process includes an escalation to the Chief Operations Officer as required. In addition, Children First is unequivocally applied to children in residential care. Guidance was issued to all staff in January 2014 in relation to the Child Protection Notification System and the conferencing process. An implementation plan is in place and briefings are currently taking place across the country for the Social Work teams.

Supervision
The Supervision policy referred to in the report has been implemented uniformly in 2013. An implementation plan is in place, staff briefings have been held, a verification process has been put in place to ensure compliance and ongoing supervision training is scheduled for this year.

Collaboration
The Agency is strongly committed inter-professional and multi-agency collaboration. A new Service Delivery Framework, which seeks to maximise collaboration, has been designed and is currently being implemented. This includes guidance to staff and community partners on an area-based approach to prevention, partnership and family support.

Governance
In relation to specific issues raised in the report, access to special care has been revised since the Ombudsman's individual reports were published and new arrangements are in place. As mentioned above a supervision policy has been consistently implemented and a national records management policy is about to be. In addition a renewed case transfer policy was issued in 2013. Overall accountability has been improved with a new management structure. Under the management of the Chief Operations Officer, four regional directors manage 17 Area Managers who are accountable of all aspects of service delivery. A National Director for residential care

has been appointed, reporting to the Chief Operations Officer. In addition senior managers at regional level are now responsible for quality assurance and risk management.

The Agency will be developing a Policy on Corporate Parenting in 2014 and would intend to get cross departmental support.

In relation to a number of points highlighted in the report the Agency would like to highlight:

> Page 51, paragraph 2 - The Agency is not able to comment on the work of the Department of Children & Youth Affairs and recommendations directly related to the Department should be followed up with the Department.

Fred McBride
Chief Operating Officer

ombudsman
for children • do leanaí