

Child Protection and Welfare Practice Handbook

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Equalities Statement

Throughout the process of ensuring the safety and welfare of a child, professionals should be aware of differing family patterns and lifestyles, not only due to different racial, ethnic and cultural groups but also issues of age, disability, gender, religion, language and sexual orientation.

Disclaimer

The Practice Handbook is not and cannot be a comprehensive procedure for child protection and welfare practice. It is a 'quick reference' document to support skilled practice both within the HSE and between it and partner agencies. It is not a complete or authoritative statement of the law and is not a legal interpretation. Professionals will need to be familiar with *Children First: National Guidance for the Protection and Welfare of Children* (2011), together with other relevant law, policy, procedures and guidelines that govern their practice.

The 'Messages from research', 'Ireland: Serious Case Inquiries – Recommendations' along with the 'Practice Notes' included in the Practice Handbook are, unless otherwise indicated, mainly interpretations of key messages from longer complete documents to support practice. For the more detailed issues raised by the source documents and a thorough understanding, readers should consult the original publications, listed in Section 5.2: References. A separate Bibliography of useful source material is available online at www.hse.ie/go/childrenfirst OR www.worriedaboutachild.ie (North–South Initiative on Child Protection Awareness, currently under development).

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Foreword

Dear Colleague,

Protecting children and promoting their welfare is a collective activity and responsibility, and I am pleased to commend this Practice Handbook as an aide to delivering accountable, consistent and transparent practice in protecting children in Ireland.

Our aspiration for children in Ireland is that they will fulfill their potential and be healthy in every aspect of their lives, physically and mentally. This vision can only be achieved with the cooperation of the relevant professions across departments, support services and communities.

The vital work of social workers and other professionals together with partner agencies in assessing risk and acting to protect vulnerable children is difficult and demanding. This Practice Handbook is designed as a quick reference book to help support front-line practice. It sets out the key issues in the different stages of action – from referral through assessment to intervention. It has taken account of the recommendations of inquiries and case reviews, together with international research and best practice.

The Practice Handbook is designed to be a companion volume and to complement *Children First: National Guidance for the Protection and Welfare of Children* (2011), which is the full reference text for practitioners. It will also support policies, procedures and legislation. The Practice Handbook is a guide to basic and consistent practice, but it cannot and does not cover everything. It will give clear guidance, but additional support and advice should be sought through your peers and your line manager.

The Practice Handbook builds on the skills as well as the resilience and determination of agencies working together to put children first. It is a professional guide to help us be reliable and dependable partners and to ask the same of others. I acknowledge – to all those working directly with and within Social Work teams, those within the Court systems and those working in all agencies – that social work is both demanding and complex. Remember, the population is not made up of customers to whom we sell or colleagues to whom we pander, but of partners on whom we can rely and with whom we can act.

I pay tribute to the dedication, hard work and commitment of the many front-line social workers and other professionals who are challenged on a daily basis to provide a quality service. They deserve the respect and support of the communities whom we serve. They should not be hindered from making the best intervention possible for children and families. The task for all of us who are dedicated to making Ireland safer for children is to use our professional skills, work together and offer an accountable, consistent and transparent child-centred service to protect children.

Gordon Jeyes.

Gordon Jeyes

National Director, Children and Family Services

Health Service Executive

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1.1 How to use the Practice Handbook

Section 1: For everybody whose work brings them into direct or indirect contact with children and their families. It provides a Glossary of Terms frequently used in child protection and welfare practice, as well as the definitions of the four types of child abuse. There is a more detailed chapter on child neglect since this is the most common type of child abuse and is also the most reported concern to the HSE Children and Family Services.

Section 2: For all allied professionals and volunteers whose work brings them into direct or indirect contact with children and their families. It aims to provide advice and guidance on what to do if you are worried about a child, your roles and responsibilities, how to refer your concerns and your involvement after you have made a referral to Children and Family Services. It also provides suggested guidelines on how to respond to a child who discloses abuse.

Section 3: For key Social Work staff of the HSE Children and Family Services. This section aims to provide a practical resource in identifying, assessing and responding to risk. It gives an overview of the child protection process, highlights known risk factors in child protection work and outlines key triggers to consider when carrying out assessments.

Section 4: Provides more information around support and guidance for Social Work staff, including supervision, continuous professional development and training, managing allegations, complaints and how to make a protected disclosure.

Section 5: Resources include national contacts for the HSE Children and Family Services and a list of References used to inform the Practice Handbook.

Appendices: Six appendices provide additional information and resources for practice.

1.2 Key principles of best practice in child protection and welfare

The key principles that should inform best practice in child protection and welfare are:

- (i) The welfare of children is of paramount importance.
- (ii) Early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection. Family support should form the basis of early intervention and preventative interventions.
- (iii) A proper balance must be struck between protecting children and respecting the rights and needs of parents/carers and families. Where there is conflict, the child's welfare must come first.
- (iv) Children have a right to be heard, listened to and taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions that may affect their lives. Where there are concerns about a child's welfare, there should be opportunities provided for their views to be heard independently of their parents/carers.
- (v) Parents/carers have a right to respect and should be consulted and involved in matters that concern their family.
- (vi) Factors such as the child's family circumstances, gender, age, stage of development, religion, culture and race should be considered when taking protective action. Intervention should not deal with the child in isolation; the child's circumstances must be understood within a family context.
- (vii) The criminal dimension of any action must not be ignored.
- (viii) Children should only be separated from parents/carers when alternative means of protecting them have been exhausted. Re-union should be considered in the context of planning for the child's future.
- (ix) The prevention, detection and treatment of child abuse or neglect requires a coordinated multidisciplinary approach, effective management, clarity of responsibility and training of personnel in organisations working with children.

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- (x) Professionals and agencies working with adults who for a range of reasons may have serious difficulties meeting their children's basic needs for safety and security should always consider the impact of their adult client/patient's behaviour on a child and act in the child's best interests.

Children First: National Guidance (2011), Paragraph 1.1.1

1.3 Glossary of Terms

Age of consent

Under the Sexual Offences Act 2006, the legal age of consent is 17. Any sexual relationship where one or both parties are under 17 is illegal, although it might not be regarded as constituting child sexual abuse.

Assessment

'Assessment' is the purposeful gathering and structured analysis of available information to inform evidence-based decision-making. Although assessment is an ongoing process, key junctures in the child protection and welfare process require the recording of formal assessments.

- Initial assessment involves meeting the child, the child's parents and contacting relevant professionals, and is carried out following the receipt of a referral by the HSE Children and Family Services. The focus of the initial assessment is to make a preliminary determination of risk and unmet need.
- Further assessment may be required following initial assessment or at any time in the course of child protection or child welfare/family support planning. The focus of further assessment and the model of assessment used is dependent on the circumstances of the case.
- Core assessment refers to an in-depth Social Work assessment using a standard framework for the purpose of developing a comprehensive overview of the child's circumstances.
- Risk assessment refers to an assessment focused on the risk of harm to a child, carried out using validated actuarial tools to assist professional judgement.

Child

A 'child' is defined under the Child Care Act 1991 as anyone under the age of 18 years who is not married. The child protection and welfare concerns for the unborn may need to be considered during pregnancy.

Child protection

The process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Child protection concern

The term 'child protection concern' is used when there are reasonable grounds for believing that a child may have been, is being or is at risk of being physically, sexually or emotionally abused or neglected.

Child Protection Conference

A Child Protection Conference (CPC) is an interagency and interprofessional meeting, convened by the designated person in the HSE. The purpose of a Child Protection Conference is to facilitate the sharing and evaluation of information between professionals and parents/carers, to consider the evidence as to whether a child has suffered or is likely to suffer significant harm, to decide whether a child should have a formal Child Protection Plan and if so to formulate such a plan.

Child Protection Notification System

The Child Protection Notification System (CPNS) is a HSE Children and Family Services' record of every child about whom there are unresolved child protection issues, resulting in the child being the subject of a Child Protection Plan. The decision to place a child on the CPNS is made at a Child Protection Conference.

Child Protection Plan

A Child Protection Plan is an interagency plan that sets out what changes need to happen to make sure that the child or young person is safe and that their needs are met. Agreed at the Child Protection Conference, the aim of the plan is to reduce or remove the identified risks so that a decision can be made to cease the Child Protection Plan. It will also list the support and help to be given to the family by the different agencies and what the family is expected to do to make the changes happen.

Child Protection Review Conference

Taking place at regular agreed intervals (but no later than 6 months after the initial Child Protection Conference), the primary purpose of the Review Conference is to determine whether the child remains at continuing risk of significant harm and whether the child continues to require safeguarding through a Child Protection Plan.

Child welfare concern

A problem experienced directly by a child, or by the family of a child, that is seen to impact negatively on the child's health, development and welfare, and that warrants assessment and support, but may or may not require a child protection response.

Chronology

A chronology of significant events is a timeline representation of an agency's involvement with a child/family, milestones reached and any known significant events that will impact on the child.

Consent (parental permission)

Permission must be sought from the parent/carer and, where appropriate, from the child or young person too, for any medical examination or interview to take place. In the majority of cases, the parent/carer will be invited to attend any medical examination with the child or young person. The HSE Children and Family Services and An Garda Síochána have a duty to consider the immediate safety of the child or young person.

Core Group

The Core Group is an interagency group jointly responsible for implementing and reviewing the detailed Child Protection Plan following a Child Protection Conference.

Designated Liaison Person

Every organisation, both public and private, that is providing services for children or that is in regular direct contact with children should identify a designated liaison person to act as a liaison with outside agencies and a resource person to any staff member or volunteer who has child protection concerns.

Designated Officer

Specific grades within the HSE and all members of An Garda Síochána designated under the Protection for Persons Reporting Child Abuse Act 1998 are authorised as designated officers to receive reports of alleged child abuse.

Designated Person

Every HSE health area has a designated person* within the HSE with responsibility for coordinating child protection services. These personnel are responsible for:

- receiving all notifications of child abuse;
- taking decisions relating to the holding of child protection conferences;
- promoting interagency cooperation on child protection and welfare;
- promoting interprofessional and interprogramme cooperation on child protection and welfare;
- overseeing staff training programmes;
- negotiating service agreements with non-statutory service providers.

Family Welfare Conference

A Family Welfare Conference is a decision-making meeting convened by an independent coordinator.

Family Welfare Conferencing is a family-led process which offers families the opportunity to make a safe family plan to address their needs in the best interests of the future safety and welfare of their children. The term 'family' is broadly defined to include birth family and extended family members and any significant others.

Harm

Harm can be defined as the ill-treatment or the impairment of the health or development of a child. For further details, please see Chapter 2 of *Children First: National Guidance* (2011). Whether it is *significant* is determined by the child's health and development as compared to that which could reasonably be expected of a child of similar age.

The *threshold of significant harm* is reached when the child's needs are neglected to the extent that his or her well-being and/or development is severely affected.

* The HSE is reviewing existing management structures for Children and Family Services. The designated person for Children and Family Services will remain the role and function of the Child Care Manager until the structures are reconfigured.

Informal consultation

If any person has misgivings about the safety or welfare of a child, they may consult the Children and Family Services' Duty Social Worker to seek an informal consultation. This provides an opportunity to discuss the query in general about the child and to decide whether a formal referral to Children and Family Services is warranted.

Preliminary enquiry

Following a referral to Children and Family Services, and following 'screening' (see *below*), preliminary enquiries involve clarifying the details provided by the reporter and checking the Children and Family Services' records, and where appropriate other internal HSE records.

Referral

Where Children and Family Services are made aware, by whatever means, about a concern regarding a child and where the eligibility criteria are met, a new referral is launched by the Social Work Service through the completion of the standard Intake Record.

Screening

The first step taken when a Duty Social Worker receives a new referral is to ensure that the following eligibility criteria are met:

- the subject of the referral is a child or an adult who has experienced abuse as a child;
- the concern is about the child's welfare.

Serious Incident Review

A Serious Incident Review is a review of the response, manner and quality of services provided to children and families. The purpose of the review is to learn lessons from the handling of specific cases so that deficits in the system can be addressed.

Significant harm (see Harm)

Standard Report Form

The Standard Report Form for referring child welfare and protection concerns to the HSE should be used by professionals, staff and volunteers in organisations working with or in contact with children, or providing services to children, when reporting child protection and welfare concerns to the HSE Children and Family Services (see *Children First* (2011), Appendix 3).

Strategy Meeting

At any point during a child protection enquiry, but particularly at the outset, the HSE Social Work Service team may call a Strategy Meeting at short notice. This is a professional forum and parents/carers do not have to be involved in the process. The purpose of the meeting is to address any urgent child protection concerns, agree an initial plan and next steps in the enquiry and prepare for any urgent intervention required. It is important that the attendance of a Garda Síochána representative is secured at this meeting where appropriate, especially if a formal notification has been made.

Other professionals should be invited to the strategy meeting as appropriate, for example, a paediatrician in cases of physical and/or sexual abuse where a child protection medical and health assessment has taken place/is required.

Welfare concern (see child welfare concern)

1.4 Definitions of the four categories of child abuse

Child abuse can be categorised into four different types: emotional abuse, sexual abuse, physical abuse and neglect. A child may be subjected to one or more forms of abuse at any given time.

For detailed guidance and signs and symptoms on each type of abuse, please refer to *Children First: National Guidance* (2011).

1.4.1 Definition of 'emotional abuse'

Emotional abuse is normally to be found in the *relationship* between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's developmental need for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms.

Emotional abuse can be manifested in terms of the child's behavioural, cognitive, affective or physical functioning. Examples of these include insecure attachment, unhappiness, low self-esteem, educational and developmental underachievement, and oppositional behaviour. The *threshold of significant harm* is reached when abusive interactions dominate and become *typical* of the relationship between the child and the parent/carer.

1.4.2 Definition of 'sexual abuse'

Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. It should be noted that the definition of child sexual abuse presented in this section is not a legal definition and is not intended to be a description of the criminal offence of sexual assault.



Practice Note: Online Safety and Online Child Sexual Exploitation

Online safety is becoming an increasingly significant issue to consider in safeguarding children and young people. Below are some common signs that are shown by children and young people if they find themselves in a situation where they are not comfortable. If a child or young person shows signs similar to those below, it does not necessarily mean that the child is being groomed – these are just some of the signs to look out for if you are concerned:

- excessive texting or use of the computer, e.g. social networking sites;
- aggressive behaviour regarding Internet usage;
- secretive behaviour;
- change in use of sexual language.

Sexual exploitation of children involves situations where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

Online child sexual exploitation can occur through the use of technology without the child’s immediate recognition, for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain.

In all cases, those exploiting the child or young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common. Involvement in exploitative relationships are characterised in the main by the child’s limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Children and young people engaged in prostitution and other forms of sexual exploitation are also victims of abuse and are usually hidden from public view.

- Practitioners should bear in mind the possibility of the abuse having been recorded (e.g. photographed or recorded on video) and transmitted by phone, Internet, etc.
- Practitioners should consider whether use of a phone/camera or other device is part of the alleged abuse and may contain important evidence.

1.4.3 Definition of 'physical abuse'

Physical abuse of a child is that which results in actual or potential physical harm from an interaction, or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.

Fabricated/Induced Illness

This is a form of physical abuse and occurs where parents, usually the mother, fabricate stories of illness about their child or cause physical signs of illness, e.g. through secretly administering dangerous drugs or other substances to the child or by smothering. The symptoms that alert to the possibility of fabricated/induced illness include:

- symptoms that cannot be explained by any medical tests; symptoms never observed by anyone other than the parent/carer; symptoms reported to occur only at home or when a parent/carer visits a child in hospital;
- high level of demand for investigation of symptoms without any documented physical signs;
- unexplained problems with medical treatment, such as drips coming out or lines being interfered with; presence of unprescribed medication or poisons in the blood or urine.



Practice Note: Indicators of non-accidental injury

Munro (2010) highlights indicators of non-accidental injury (NAI):

- A delay in seeking help (or none sought).
- The story of the 'accident' is vague and may vary with repeated telling.
- The account is not compatible with the injury observed.
- The parents' response is abnormal – normal parents are full of creative anxiety for their child; abusive parents tend to be more preoccupied with their own problems, such as how soon they can return home.
- The parents' behaviour gives rise for concern – for example, they become hostile, rebut accusations that have not been made and avoid seeing the consultant.
- The child's appearance and his/her interaction with parents are abnormal – sad, withdrawn or frightened. Full-blown 'frozen

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watchfulness' is a late stage; its absence does not exclude non-accidental injury.

- The child may say something. Where possible, always interview the child (if old enough) in privacy. If an outpatient, the child may be reluctant to open up as he/she is expecting to be returned to the abusing parents.



Practice Note: Injuries in infants under 12 months

Physical injuries in infants can be very difficult to identify and may be life-threatening or cause permanent neurological damage. Any suspicious injury in a pre-mobile or non-mobile child must be regarded with extreme concern, including:

- minor injuries with an inconsistent explanation;
- significant bruising;
- low birth weight;
- any fractures;
- any major injury.

Any injury and its explanation must be assessed in relation to the infant's developmental abilities and the likelihood of the occurrence. Infants are highly vulnerable and may have a serious injury without obvious physical signs, e.g. shaking injuries may result in internal head injuries. Nevertheless, significant internal injuries may be caused and result in:

- lethargy, poor feeding, apnoea or irregular breathing;
- fits;
- variable consciousness;
- intra-cranial bleeding and retinal haemorrhages;
- skull and rib fractures;
- failure to thrive/faltering growth;
- death.

See Appendix 4: Flowchart – Response when an infant under 12 months presents with injuries.

1.4.4 Definition of 'neglect'

Neglect can be defined in terms of an *omission*, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care.

Neglect generally becomes apparent in different ways *over a period of time* rather than at one specific point. For example, a child who suffers a series of minor injuries may not be having his or her needs met in terms of necessary supervision and safety. A child whose height or weight is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived of intellectual stimulation. For more details on 'child neglect', see Section 1.5 below.

1.5 Child Neglect – the most common type of abuse



Messages from research

- On reviewing the number of cases referred to Children and Family Services in Ireland, child neglect is the most common type of abuse. Unfortunately, neglect frequently goes unreported and, historically, has not been acknowledged or talked about as much as child abuse.
- A study undertaken in one Irish Health Board area (Horwath and Bishop, 2001) found that although neglect accounted for more than half of the cases reported, there was still a lack of understanding among staff as to its precise meaning. Many professional respondents believed that social workers accepted lower standards of parenting than other professionals.
- In the United Kingdom, Farmer and Owen (1995) found that in one-third of cases where neglect was the main concern, there were also physical abuse concerns; in one-fifth of physical abuse cases there were neglect concerns; and in one-quarter of sexual abuse cases there were neglect concerns.
- There are more cases of neglect than abuse and maltreatment in child protection.

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- Multiple factors contribute to child abuse and neglect. We should consider not only the parent's role, but also the societal and environmental factors contributing to the parent's inability to provide for the basic needs of the child, such as social isolation, poor housing, low levels of employment and poverty.
- Child neglect often co-exists with other interrelated concerns, such as domestic violence, parental mental health issues, parental substance misuse issues and parental intellectual disability.

Instances of neglect

Instances of neglect can be measured under the following:

- **Mild neglect** usually does not warrant a report to the Child Protection Notification System (CPNS), but might necessitate a community-based intervention (e.g. a parent failing to put the child in a car safety seat).
- **Moderate neglect** occurs when less intrusive measures, such as community interventions, have failed or some moderate harm to the child has occurred (e.g. a child consistently is inappropriately dressed for the weather, such as being in shorts and sandals in the middle of winter). For moderate neglect, the Social Work Service may be involved in working in partnership with community support.
- **Severe neglect** occurs when severe or long-term harm has been done to the child (e.g. a child with asthma who has not received appropriate medications over a long period of time and is frequently admitted to hospital). In these cases, the Social Work Service will undertake an investigation, which may involve legal proceedings.
- **Chronic neglect** can be defined as '*patterns of the same acts or omissions that extend over time or recur over time*'. An example of chronic neglect would be parents with substance abuse problems who do not provide for the basic needs of their children on an ongoing basis. Because some behaviours are considered as neglect only if they occur on a frequent basis, it is important to look at the history of behaviour rather than focusing on one particular incident.

Types of neglect

A distinction can be made between 'wilful' neglect and 'circumstantial' neglect. 'Wilful' neglect would generally incorporate a direct and deliberate deprivation by a parent/carer of a child's most basic needs, e.g. withdrawal of food, shelter, warmth, clothing, contact with others. 'Circumstantial' neglect more often may be due to stress/inability to cope by parents or carers.

Regardless of whether a concern is about circumstantial or wilful neglect, there is a need for a response where there are concerns that a child is experiencing neglect.

While neglect may be harder to define or to detect than other forms of child abuse, there are common categories of neglect, including:

- physical neglect;
- medical neglect;
- homelessness and neglect;
- inadequate supervision;
- emotional neglect,
- educational neglect;
- newborns addicted or exposed to drugs.

The following sections give detailed information on each of these types of neglect.

Physical neglect

Physical neglect is one of the most widely recognised forms. It includes:

- **Abandonment** – the desertion of a child without arranging for his or her reasonable care or supervision. Usually, a child is considered abandoned when not picked up within 2 days.
- **Expulsion** – the blatant refusal by a parent/caregiver to allow a child access to their home on a permanent basis without adequately arranging for his or her care by others or the refusal to accept custody of a returned runaway.
- **Nutritional neglect** – when a child is undernourished or is repeatedly hungry for long periods of time, which can sometimes be evidenced by poor growth.
- **Clothing neglect** – when a child lacks appropriate clothing, such as not having appropriately warm clothes or shoes in the winter.
- **Other physical neglect** – includes inadequate hygiene and forms of disregard for the child's safety and welfare (e.g. driving with a child while intoxicated, leaving a young child in a car unattended).

Medical neglect

Medical neglect encompasses a parent or guardian's denial of or delay in seeking needed healthcare for a child as described below:

- **Denial of healthcare** – the failure to provide or to allow needed care as recommended by a competent healthcare professional for a physical injury, illness, medical condition or impairment.

- **Delay in healthcare** – the failure to seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognised as needing professional medical attention. Examples of a delay in healthcare include not getting appropriate preventive medical or dental care for a child, not obtaining care for a sick child or not following medical recommendations.

Homelessness and neglect

- Unstable living conditions can have a negative effect on children and homeless children are more at risk for other types of neglect in areas such as health, education and nutrition. Homelessness can be considered neglect when the inability by a parent or carer to provide shelter is the result of not managing their finances appropriately and there is evidence that the money has been spent not on rent but on drugs or alcohol, or the family had been engaged in anti-social behaviour leading to eviction.

Inadequate supervision

Inadequate supervision encompasses a number of behaviours, including:

Lack of appropriate supervision

There is no defined amount of time children at different ages can be left unsupervised and the guidelines for these ages and times vary. In addition, all children are different, so the amount of supervision needed may vary by the child's age, development or situation. It is important to evaluate the maturity of the child, the accessibility of other adults, the duration and frequency of unsupervised time, and the neighborhood or environment when determining if it is acceptable to leave a child unsupervised.

Exposure to hazards

Examples of exposure to in- and out-of-home hazards include:

- **Safety hazards** – poisons, small objects, electrical wires, stairs and drugs.
- **Smoking** – second-hand smoke, especially for children with asthma or other lung problems.
- **Guns and other weapons** – guns that are kept in the house and are not locked up.
- **Unsanitary household conditions** – rotting food, human or animal faeces, insect infestation or lack of running or clean water.
- **Lack of child safety restraints.**

Inappropriate caregivers

Another behaviour that can fall under ‘failure to protect’ is leaving a child in the care of someone who is either unable or should not be trusted to provide care for a child. Examples of inappropriate caregivers include a young child, a known child abuser or someone with a substance abuse problem.

Another common, but complex example is single working parents who are having difficulty arranging for appropriate back-up childcare when their regular childcare providers are unavailable. For example, a mother may leave her child home alone when the childcare provider fails to show up. If the mother does not go to work, she can lose her job and will not be able to take care of her child. However, if she leaves the child alone, she may be guilty of neglect. It is important that parents in situations similar to this receive adequate support so that they are not forced to make these difficult decisions.

Emotional neglect

Typically, emotional neglect is more difficult to assess than other types of neglect, but it is the general opinion that it can have more severe and long-lasting effects than physical neglect. It often occurs with other forms of neglect or abuse, which may be easier to identify, and includes:

- **Inadequate nurturing or affection** – the persistent, marked inattention to the child’s needs for affection, emotional support or attention.
- **Exposure to chronic and/or extreme domestic violence.**
- **Permitted drug or alcohol abuse** – the encouragement or permission by the caregiver of drug or alcohol use by the child.
- **Other permitted maladaptive behaviour** – the encouragement or permission of a maladaptive behaviour (e.g. chronic delinquency, assault) under circumstances where the parent or caregiver has reason to be aware of the existence and seriousness of the problem but does not intervene.
- **Isolation** – denying a child the ability to interact or to communicate with peers or adults outside or inside the home.

Educational neglect

Parents and schools are responsible for meeting certain requirements regarding the education of children. Types of educational neglect include:

- **Permitted, chronic truancy** – permitting habitual absenteeism from school averaging at least 5 days a month if the parent or guardian is informed of the problem and does not attempt to intervene.

- **Failure to enroll or other truancy** – failing to home school, to register or to enroll a child of mandatory school age, causing the child to miss at least one month of school without valid reasons.
- **Inattention to special education needs** – refusing to allow or failing to obtain recommended remedial education services, or neglecting to obtain or follow through with treatment for a child’s diagnosed learning disorder or other special education need without reasonable cause.

Newborns addicted or exposed to drugs

Women who use drugs or alcohol during pregnancy can put their unborn children at risk of mental and physical disabilities. Once a referral is received from other appropriate services identifying an infant born as being affected by illegal substance abuse or withdrawal symptoms, resulting from prenatal drug exposure, a safety plan needs to be developed for the baby. An immediate risk and safety assessment must be conducted following the prompt investigation of such a referral.

Indicators of Neglect

Indicators of neglect in the child

Indicators of neglect are likely to be visible in the appearance or behaviour of the child. Individuals/agencies concerned should consider making a referral to the HSE Children and Family Services if they notice that a child:

- wears soiled clothing or clothing that is significantly too small or large, or is often in need of repair;
- seems inadequately dressed for the weather;
- always seems to be hungry, hoards, steals or begs for food, comes to school with little or no food;
- often appears listless and tired, with little energy;
- frequently reports caring for younger siblings;
- demonstrates poor hygiene, smells of urine or faeces, has dirty or decaying teeth;
- seems emaciated or has a distended stomach (indicative of malnutrition);
- has unattended medical or dental problems, such as infected sores;
- displaying apathy, unresponsive to affection;
- states that there is no one at home to provide care;
- presents with frequent accidents and/or minor injuries;

- growth not within the expected range;
- signs of developmental delays, poor attention/concentration, lack of self-confidence/poor self-esteem, low academic achievement (including erratic or non-school attendance);
- behavioural signs, e.g. overactive, aggressive, poor coping skills, impulsive behaviour, indiscriminate friendliness, withdrawn, poor social skills development, bed-wetting, soiling or destructive behaviours, substance misuse, running away, sexual promiscuity, self-harm, offending behaviours.

Indicators of possible neglect in parental behaviour

It can be difficult to observe a situation and to know for certain whether neglect has occurred. Behaviours and attitudes indicating that a parent or other adult caregiver may be neglectful include if he or she:

- appears to be indifferent to the child;
- seems apathetic or depressed;
- behaves irrationally or in a bizarre manner;
- abuses alcohol or drugs;
- denies the existence of or blames the child for the child's problems in school or at home;
- sees the child as entirely bad, worthless or burdensome;
- looks to the child primarily for care, attention and/or satisfaction of emotional needs.

Indicators of neglect in the home environment

Indicators of neglect in the home include:

- unhygienic and dirty;
- unsafe/hazardous;
- environmental odour;
- inadequate bedding and/or furniture;
- inadequate food;
- inadequate sleeping space;
- inadequate ventilation and/or heating;
- inadequate care of pets.

Indicators of neglect in older children

Neglected children, even when older, may display a variety of emotional, psycho-social and behavioural problems, which may vary depending on the age of the child. Some of these include:

- displaying an inability to control emotions or impulses, usually characterised by frequent outbursts;
- being quiet and submissive;
- having difficulty learning in school and getting along with siblings or classmates;
- experiencing unusual eating or sleeping behaviours;
- attempting to provoke fights or solicit sexual interactions;
- acting socially or emotionally inappropriate for their age;
- being unresponsive to affection;
- displaying apathy;
- being less flexible, persistent and enthusiastic than non-neglected children;
- demonstrating helplessness under stress;
- having fewer interactions with peers than non-neglected children;
- displaying poor coping skills;
- acting highly dependent;
- acting lethargic and lackluster;
- displaying self-abusive behaviour (e.g. suicide attempts or cutting themselves);
- exhibiting panic or dissociative disorders, attention-deficit/hyperactivity disorder or post-traumatic stress disorder;
- suffering from depression, anxiety or low self-esteem;
- exhibiting juvenile delinquent behaviour or engaging in adult criminal activities;
- engaging in sexual activities leading to teen pregnancy or fatherhood;
- having low academic achievement;
- abusing alcohol or drugs.



Practice Note: Uncertainty about neglect

Points to consider if you are uncertain about whether a child is being neglected include:

- Order your concerns in chronological order to identify possible trends/patterns of behaviour from either the child and/or parent.
- Identify any protective factors and strengths within the family or available to them through their extended family/community, etc.
- Check whether your service/organisation has any previous records on the family/related child/parent.
- If appropriate, discuss your concern with the parent/carer of the child to clarify and explain your concern.
- Talk to the child if appropriate.
- Monitor your concerns over time by keeping track of events and relevant issues.
- Remember – neglect usually manifests over time and it is important to connect incidents and events, not to treat them separately. This way a fuller picture can be built up, especially if you share your concerns and relevant information as appropriate with other agencies (see Section 3.9 on 'Use of chronology').
- If you are concerned about a child's safety and/or welfare, contact Children and Family Services for an informal consultation (see Section 2.7).

2

Allied professionals and all others who work with children and their families

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2.1 Roles and Responsibilities in identifying and responding to child protection and welfare concerns

Protecting children and young people is everyone's responsibility.

This section is for all professionals and volunteers whose work brings them into direct or indirect contact with children and their families. It aims to provide advice and guidance on what to do if you are worried about a child, your roles and responsibilities, how to refer your concerns and your involvement after you have made a referral to the HSE Children and Family Services, as well as suggested guidelines in responding to a child who discloses abuse.

2.1.1 HSE staff

The HSE has specific statutory responsibilities regarding the protection and welfare of children. As an employee of the HSE, irrespective of the position you hold, you have a share in this responsibility.

All HSE employees

All HSE personnel and health professionals, irrespective of the position held within the organisation, have a responsibility towards child protection and welfare. They are major contributors to all aspects of the work. They promote the welfare of children through health promotion and health surveillance programmes. They are well placed to identify and refer child protection concerns, participate in assessment, attend child protection conferences and work with the HSE Children and Family Services in planning the ongoing support of the child and family (see *Children First* (2011), Paragraph 4.14.1).

Designated Persons within HSE

Every HSE health area has a designated person within the HSE with responsibility for coordinating child protection services. (The HSE is reviewing existing management structures for Children and Family Services; the designated person for Children and Family Services will remain the role and function of the **Child Care Manager** until the structures are reconfigured.)

These designated persons are responsible for:

- receiving all notifications of child abuse;
- taking decisions relating to the holding of child protection conferences;
- promoting interagency cooperation on child protection and welfare;
- promoting interprofessional and interprogramme cooperation on child protection and welfare;
- overseeing staff training programmes;
- negotiating service agreements with non-statutory service providers.

HSE Designated Officers

If you are employed by the HSE in the following list of grades/functions, you are a designated officer with explicit responsibilities in responding to child protection and welfare under the Protection for Persons Reporting Child Abuse Act 1998. If you receive a report from an external service, it is your responsibility to pass this on to the HSE Children and Family Services.

Access Workers	Inspectors of Children’s Residential Centres and Foster Care Services
Advocacy Workers	Non-Consultant Hospital Doctors
Care Assistants	Nurses (all grades and services)
Child Care Managers	Occupational Therapists
Social Care (all grades)	Pre-School Services Officers
Children First Implementation Officers	Project Workers
Children First Information and Advice Officers	Psychologists
Child-minder Coordinators	Psychiatrists
Community Welfare Officers	Physiotherapists
Counsellors in services for AVPA	Public Health Nurses
Coordinators of Disability Services	Quality Assurance Officers – including Monitoring Officers for Children’s Residential Centres and Foster Care Services
Environmental Health Officers	Radiographers
Family Support Coordinators	Residential Child Care Managers/ Residential Child Care Workers
Family Support Workers	Substance Abuse Counsellors

Hospital Consultant Doctors	Social Workers (all grades and services)
HIV and AIDS Service Workers	Speech and Language Therapists
Health Education and Health Promotion Personnel	Training and Development Officers
HSE Dental and Medical Personnel	

As a HSE Designated Officer, you may receive reports of suspected abuse or you may have concerns about a child’s safety and welfare. It is your responsibility:

- To ensure that you are fully conversant with your organisation’s statutory duties to the protection and welfare of children.
- To ensure that you know your internal child protection and welfare policies and procedures, and that you know what they are and where to find the most up-to-date version.

If a person, including third parties, reports suspected child abuse to you, your responsibility in the first instance is:

- To inform that person that when they report to a person designated under the Protection for Persons Reporting Child Abuse Act 1998, they are protected in law from civil liability or penalisation by their employer, if the report is made reasonably and in good faith. A person who makes a report in good faith and in the child’s best interests to another appropriate person may also be protected under common law by the defence of qualified privilege.
- To establish, in consultation with the individual who has raised the concern, if reasonable grounds for concern exist.
- If you are unsure whether the concern constitutes reasonable grounds for concern, you may consult informally with the Children and Family Services’ Duty Social Worker (*see Section 2.7*).
- Where you decide not to pass on the concern brought to your attention, you must inform the person of this and also tell them they may report directly to Children and Family Services and that the provisions of the Protection for Persons Reporting Child Abuse Act 1998 would pertain.
- The information given to you should be forwarded to the Children and Family Services’ Duty Social Worker if reasonable grounds for concern exist, regardless of whether the source wishes to be identified or not. The source should be made aware that you will be reporting the information.

If you have a concern and discuss it with your line manager and there is disagreement as to whether to share this information with the HSE Children and Family Services or An Garda Síochána, the line manager should inform the worker/volunteer:

- that they are not reporting and their reasons for not doing so;
- that the worker/volunteer can report in their own right;
- that if they do report in good faith, they are protected under the provisions of the Protection for Persons Reporting Child Abuse Act 1998 (protection from civil liability and protection from penalisation by employer).

2.1.2 Designated Liaison Persons – Agencies and services outside the HSE (including voluntary and community sectors)

In accordance with Section 3.3 of *Children First: National Guidance* (2011), every organisation, both public and private, that is providing services for children or that is in regular direct contact with children should:

- Identify a designated liaison person to act as a liaison with outside agencies and a resource person to any staff member or volunteer who has child protection concerns. The designated liaison person should be familiar with *Children First: National Guidance* (2011).
- The designated liaison person is responsible for ensuring that the standard reporting procedure is followed, so that suspected cases of child neglect or abuse are referred promptly to the HSE Children and Family Services' Duty Social Worker. In the event of an emergency where you think a child is in immediate danger and you cannot get in contact with the HSE Children and Family Services' Duty Social Worker, you should contact An Garda Síochána.
- The designated liaison person should ensure that they are knowledgeable about child protection and undertake any training considered necessary to keep themselves updated on new developments.

As a designated liaison person, you may receive reports of suspected abuse or you may have concerns about a child's safety and welfare. It is your responsibility:

- To ensure that you are fully conversant with your organisation's duties to the protection and welfare of children.
- To ensure that you know your organisation's child protection and welfare policies and procedures, and that you know what they are and where to find the most up-to-date version.

If a person, including third parties, reports suspected child abuse to you, your responsibility in the first instance is:

- To establish, in consultation with the individual who has raised the concern, if reasonable grounds for concern exist.
- The information given to you should be forwarded to the HSE Children and Family Services' Duty Social Worker if reasonable grounds for concern exist, regardless of whether the source wishes to be identified or not. The source should be made aware that you will be reporting the information.
- If you are unsure whether the concern constitutes reasonable grounds for concern, you may consult informally with the Duty Social Worker (see Section 2.7).
- Where you decide not to pass on the concern brought to your attention, you must inform the person of this and also tell them that they may report directly to Children and Family Services and that the provisions of the Protection for Persons Reporting Child Abuse Act would pertain.
- Any professional who suspects child abuse or neglect should inform the parents/carers if a report is to be submitted to the HSE Children and Family Services or to An Garda Síochána, unless doing so is likely to endanger the child (see *Children First* (2011), Paragraph 3.2.9).



Practice Note: Staff working in adult services

Many services have contact with adult family members and can pick up signs of problems. The association between parental problems (such as poor mental health, domestic violence and substance misuse) and child abuse and neglect is well established. Adult services are therefore vital in recognising the possible impact that such problems may be having on children and whether these impact negatively on the care, safety and well-being of the child.

While some professionals may not define their core role as a 'child protection' one (e.g. professionals who may be working primarily with adults in the household), their information and involvement may be crucial in ascertaining and managing present and future risks to a child or young person.



See Appendix 2: *Checklist for multi-agency contribution* for how your role can contribute to the protection and welfare of children.

2.2 What constitutes reasonable grounds for a child protection or welfare concern?

- An injury or behaviour that is consistent both with abuse and an innocent explanation, but where there are corroborative indicators supporting the concern that it may be a case of abuse.
- Consistent indication over a period of time that a child is suffering from emotional or physical neglect.
- Admission or indication by someone of an alleged abuse.
- A specific indication from a child that he or she was abused.
- An account from a person who saw the child being abused.
- Evidence (e.g. injury or behaviour) that is consistent with abuse and unlikely to have been caused in any other way.

2.3 What to do if reasonable grounds for concern exist

Examine the report you receive by looking at the information that has been reported to you and asking open-ended, non-leading questions, if necessary, to give further clarity.

It is recommended that a referral to Children and Family Services should always be made in the following circumstances (see Section 2.9):

- any concern about a child at risk of sexual abuse;
- physical injury caused by assault or neglect which may or may not require medical attention;
- incidents of physical abuse that alone are unlikely to constitute significant harm, but taken into consideration with other factors may do so;
- children who suffer from persistent neglect;
- children who live in an environment which is likely to have an adverse impact on their emotional development;
- where parents' own emotional impoverishment affects their ability to meet their child's emotional and/or physical needs, regardless of material/financial circumstances and assistance;
- where parents' circumstances are adversely affecting their capacity to meet the child's needs because of domestic violence, drug and/or alcohol misuse, mental health problems, intellectual disability;

- a child living in a household with, or having significant contact with, a person at risk of sexual offending or with previous convictions for offences against children;
- an abandoned child;
- children left home alone;
- bruising/injury to a pre-mobile baby;
- pregnancy where children have been previously removed;
- suspicion of fabricated or induced illness;
- where a child under one year is present in a home where domestic violence is a concern.

PLEASE NOTE: The above are examples of circumstances that may occur. There are other circumstances under which a referral should be considered. If you are in any doubt, discuss your concern with your line manager (HSE)/ designated liaison person (non-HSE services) or call a member of your local HSE Children and Family Services' Duty Social Work Team for an informal consultation.

2.4 Questions that may help staff when they are concerned about a child's welfare

- Is the child behaving normally for his or her age and stage of development?
- Does the child present a change in behaviour?
- For how long has this behaviour been observed?
- How often does it occur? Where?
- Has something happened that could explain the child's behaviour?
- Is the child showing signs of distress? If so, describe (e.g. behavioural, emotional, physical signs).
- Does the behaviour happen everywhere or just in the school or childcare setting?
- Is the child suffering?
- Does the behaviour restrict the child socially?
- Does the behaviour interfere with the child's development?
- What effect, if any, does it have on others (e.g. other children)?
- What are the child's parents(s) views, if known?

Source: Barnardos (2010)
Barnardo's Ireland Child Protection Information Pack

2.5 Responding to a child who discloses abuse – suggested guidelines

Remember, a child may disclose abuse to you as a trusted adult at any time during your work with them. It is important that you are aware and prepared for this.

- Be as calm and natural as possible.
- Remember that you have been approached because you are trusted and possibly liked. Do not panic.
- Be aware that disclosures can be very difficult for the child.
- Remember, the child may initially be testing your reactions and may only fully open up over a period of time.
- Listen to what the child has to say. Give them the time and opportunity to tell as much as they are able and wish to.
- Do not pressurise the child. Allow him or her to disclose at their own pace and in their own language.
- Conceal any signs of disgust, anger or disbelief.
- Accept what the child has to say – false disclosures are very rare.
- It is important to differentiate between the person who carried out the abuse and the act of abuse itself. The child quite possibly may love or strongly like the alleged abuser while also disliking what was done to them. It is important therefore to avoid expressing any judgement on, or anger towards, the alleged perpetrator while talking with the child.
- It may be necessary to reassure the child that your feelings towards him or her have not been affected in a negative way as a result of what they have disclosed.

When asking questions

- Questions should be supportive and for the purpose of clarification only.
- Avoid leading questions, such as asking whether a specific person carried out the abuse. Also, avoid asking about intimate details or suggesting that something else may have happened other than what you have been told. Such questions and suggestions could complicate the official investigation.

Confidentiality – Do not promise to keep secrets

At the earliest opportunity, tell the child that:

- You acknowledge that they have come to you because they trust you.
- You will be sharing this information only with people who understand this area and who can help. There are secrets, which are not helpful and should not be kept because they make matters worse. Such secrets hide things that need to be known if people are to be helped and protected from further ongoing hurt. By refusing to make a commitment to secrecy to the child, you do run the risk that they may not tell you everything (or, indeed, anything) there and then. However, it is better to do this than to tell a lie and ruin the child's confidence in yet another adult. By being honest, it is more likely that the child will return to you at another time.

Think before you promise anything – Do not make promises you cannot keep

At the earliest possible opportunity:

- Record in writing, in factual manner, what the child has said, including, as far as possible, the exact words used by the child.
- Inform your supervisor/manager immediately and agree measures to protect the child, i.e. report the matter directly to the HSE.
- Maintain appropriate confidentiality.

Follow your organisation's procedures for child protection issues. Further support regarding concerns is available from the HSE.

Ongoing support

Following a disclosure by a child, it is important that the staff member continues in a supportive relationship with the child. Disclosure is a huge step for a child. Staff should continue to offer support, particularly through:

- maintaining a positive relationship with the child;
- keeping lines of communication open by listening carefully to the child;
- continuing to include the child in the usual activities.

Any further disclosure should be treated as a first disclosure and responded to as indicated above. Where necessary, immediate action should be taken to ensure the child's safety.

2.6 What to do if you are concerned about a child's safety and/or welfare

Protecting children should not be seen as a separate response from promoting their welfare. Those with protection concerns must be mindful of the welfare and needs of a child in the same way that those with child welfare concerns must be alert to potential abuse and neglect.

2.7 Informal consultation

If any person has misgivings about the safety or welfare of a child, they may consult the HSE Children and Family Services' Duty Social Worker to seek advice through initiating an informal consultation. This could be just a telephone call and provides an opportunity to discuss the query in general and to decide whether a formal referral is warranted.

The consulting party needs to state explicitly that they are not making a report – that they are giving details of a concern, but no identifying information in relation to a child or family.

Remember – if in doubt, check it out. If you are concerned about the safety of a child and are unsure what to do, talk to your line manager or a HSE social worker.

2.8 Out-of-hours services/In case of an emergency

Ensure that you are aware of your local area Emergency Services arrangements since different arrangements are in place across HSE health areas.

In the event of an emergency where you think a child is in immediate danger and you cannot get in contact with the HSE Children and Family Services' Duty Social Worker, you should contact the Gardaí.

Under no circumstances should a child be left in a situation that exposes him or her to harm.

2.9 How to make a formal referral to the HSE Children and Family Services

If you identify a child as being at risk of harm – you must act. Paragraph 3.7.3 of *Children First: National Guidance (2011)* states that *'It is the responsibility of all agencies working with children and for the public to recognise child protection concerns and share those with the agencies responsible for assessing or investigating them, not to determine whether the child protection concerns are evidenced or not'*. In the first instance, if possible, make telephone contact with the Duty Social Worker, or if out-of hours or in an emergency with the Gardaí.

The following procedure should be followed:

- The line manager (HSE)/designated liaison person (non-HSE services) should make a referral to the HSE Children and Family Services' Social Work Service by using the Standard Report Form.
- The Standard Report Form can be accessed:
 - directly from Children and Family Services at www.hse.ie/eng/services/Find_a_Service/Children_and_Family_Services/childrenfirst/
 - downloaded from www.hse.ie/go/childrenfirst OR www.worriedaboutachild.ie

If you believe the concern is urgent and that there is imminent risk to a child, make the report by telephone and then follow it up with the completed form. The quality of the information you provide will influence the ability of the Social Work Service to respond.

The completed Standard Report Form must contain as much of the following as possible:

- **Accurate identifying information** – including all known full names and surnames, addresses, date of birth, age, disability if applicable, ethnicity, first language (need for interpreter, if known) of the child **and** all the known members of his or her family and other adults living in the household. In cases of suspected abuse and neglect, family members should not be used as interpreters.

- **Details of the concern, allegation or incident** – outline exact nature of concern; include dates, times and names of persons present. It is important to describe any observed injuries or behaviours that may be linked to the incident. In cases where neglect or abuse is indicated over time, the reporter should be encouraged to provide a chronology of the evidence or symptoms in the child that give rise to the concern.
- **Views of the parent/carer and views of the child (where age-appropriate)** – the reporter must provide any accounts of the parents' or child's views about the concern that are known to them.
- **Keep a copy for your own records** and send original to Social Work Service.

2.10 Anonymous and Malicious Referrals

Anonymous referrals

A designated officer of the HSE has statutory responsibility and therefore cannot report anonymously or request anonymity. Designated liaison persons of external services, where reporting in their professional capacity, should be complying with their organisation's Child Protection Policy and should not report anonymously. Under the Freedom of Information Act, anonymity should never be promised since it cannot be guaranteed (*see Children First (2011)*, Sections 3.9-3.11 and 5.15).

Malicious referrals

Malicious reporting is not a common occurrence, but creates a significant impact on the innocent person. The Protection for Persons Reporting Child Abuse Act 1998 includes the creation of an offence of false reporting of child abuse, where a person makes a referral of child abuse to the appropriate authorities 'knowing that statement to be false'. In the event that any staff member is concerned that a report is malicious, this should be discussed with their line manager with immediate effect (*see Children First (2011)*, Appendix 9).

2.11 Third-party referrals

In the event of any member of staff or volunteer of the HSE or any other service or organisation working with children and their families receiving information in respect of a suspicion of child abuse/welfare from a third party, this must be reported, regardless of any consideration in respect of

confidentiality, to the local Children and Family Services' Social Work Service, which will then investigate the concerns.

If you believe that reasonable grounds for concern exist, the information should be forwarded to the Duty Social Worker regardless of whether the source wishes to be identified or not. The source must be made aware that you will be reporting the information and it will be acted upon in the usual manner.

Third parties who express concerns should be interviewed as part of assessment of the family.

2.12 The position of parents

Any **professional** who suspects child abuse or neglect should inform the parents/carers if a report is to be submitted to the HSE Children and Family Services or to An Garda Síochána, unless doing so is likely to endanger the child (see *Children First* (2011), Paragraph 3.2.9). Discuss this with your line manager, designated liaison person or the HSE Children and Family Services' Social Work Service if you are unsure.

2.13 What happens after a referral is made to Children and Family Services

There are two steps once the Duty Social Worker receives the referral:

- screening;
- preliminary enquiry.

Both of these are defined in the Glossary of Terms (see p. 8).

The Duty Social Worker will screen the referral to see if it meets the relevant threshold for acceptance and complete an Intake Record. The case will then either proceed to an initial assessment or no further action will be taken and the case will be closed.

At any stage of the process, including after closure, the social worker can seek the assistance of outside agencies for support/intervention (e.g. ISPCC, Barnardos, community projects).

After the initial assessment, the case may be classified as:

- suspected child abuse, requiring a Child Protection response incorporating as appropriate the involvement of An Garda Síochána, or a Welfare case, requiring a Family Support response.
- closed, with no further action required.

2.14 Feedback to Referrer

Persons who refer child protection and welfare concerns to the Duty Social Worker should have their reports acknowledged within 24 hours and be informed of what will most likely happen next. Due to the circumstances of individual cases, it will not always be feasible for this timescale to be met.

If, having made a report to the HSE Children and Family Services' Social Work Service, you remain concerned about the safety or welfare of a child, your line manager/designated liaison person should contact the Social Work Team where the initial report was made. It may be necessary to make subsequent reports where there are ongoing concerns or fresh concerns arise. **Do not assume that the child is safe because a report has been made.** You are entitled to contact the Duty Social Worker to request information in relation to what action may be taken in response to your referral. However, there may be some limits as to what can be discussed with you due to the rights of children and families to confidentiality.

2.15 Your role after making a referral to Children and Family Services

If the referral is accepted as meeting relevant thresholds, the Social Work Team will assume overall responsibility for the management of the case. The Social Work assessment will look at three key areas:

- the child's safety and developmental needs;
- the parent's capacity to meet their child's needs;
- family and environmental factors.

After you or your designated liaison person make a referral to Children and Family Services, you may, depending on your professional role, setting and dealings with the child/family, be requested to:

- provide further information;
- co-work the assessment of the case;

- attend subsequent HSE convened meetings to discuss the concern and the response to it (e.g. Child Protection Conference, Core Group meetings, interprofessional planning meetings);
- be called to provide evidence should Court proceedings follow.

Should you be requested to attend a Child Protection Conference (CPC), it is important that you attend because:

- professionals involved come together and pool information to develop a clear picture of the risks to the child in question;
- pooled information may be used in legal proceedings;
- key actions to be taken are decided at CPCs.

There is a need to have appropriate and systematic input into decision-making regarding children at risk.

All professionals who have had previous dealings with the child/family should bring their records and a written summary of the case history to any CPC they are invited to attend.

2.16 What if you do not agree with the outcome of the referral to Children and Family Services

- Discuss with your line manager/supervisor/designated liaison person.
- Make a clear record on the child's file about your concerns.
- Put concerns formally in writing to Children and Family Services, outlining why you do not agree with the decided course of action.

2.17 Key practice points in dealing with child protection and welfare concerns

- **Do not assume** if other professionals are involved that they will make a report to the Social Work Service of Children and Family Services. If you have concerns, you must act by making a referral.
- **Do not assume** if social workers are already involved that they know or are aware of everything. If you have concerns, contact the Social Work Service and discuss the issues with them. You may provide a vital piece of information.

(continued)

- **Do not assume** that this information is only for professionals working with children and families. If you are working in the adult sector, you could be involved with vulnerable adults who are parents/carers of children. Their difficulties or vulnerabilities could be impacting on children.
- **The severity of a sign does not necessarily equate with the severity of the abuse.** Severe and potentially fatal injuries are not always visible. Emotional and/or psychological abuse tends to be cumulative and effects may only be observable in the longer term.
- **Neglect is as potentially fatal as physical abuse.** It can cause delayed physical, psychological and emotional development, chronic ill health and significant long-term damage. It may also precede, or co-exist with, other forms of abuse and must be acted upon.
- **Child abuse is not restricted to any socio-economic group, gender or culture.** All signs must be considered in the wider social and family context. However, serious deficits in child safety and welfare transcend cultural, social and ethnic norms, and must elicit a response.
- **Challenging behaviour by a child or young person should not render them liable to abuse.** Children in certain circumstances may present management problems. This should not leave them vulnerable to harsh disciplinary measures or neglect of care.
- **It is sometimes difficult to distinguish between indicators of child abuse and other adversities suffered by children and families.** Deprivation, stress or mental health problems should not be used as a justification for omissions of care or commissions of harm by parents/carers. The child's welfare must be the primary consideration.
- **The aim of child protection services is to promote positive and enduring change in the lives of children and families.** All action taken with respect to children and young people must reflect the principles and objectives of the Child Care Act 1991. In particular, the welfare of the child must always be the first and paramount consideration, and thereafter priority must be given to the safety and well-being of the child.

(continued)

- **Society has a duty of care towards children.** Parents/carers are primarily responsible for the safety and welfare of the children in their care. The HSE is the statutory body responsible for child protection and welfare, and must intervene when children are harmed or fail to receive adequate care and protection.
- **You must act.** By not sharing your concerns, you may be potentially putting a child at further risk of harm.

3



Social Work Procedures and Practice

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3.1 Child Protection and Welfare Process – Overview

At all stages of the child protection and welfare process, the key professionals must:

- consider the need for immediate action to ensure the safety of the child;
- consider the protection and welfare of the child as a priority;
- avoid actions that cause the child or family unnecessary distress;
- respect the rights of parents/carers to have their views heard and to be fully informed of any steps taken;
- respect the rights of children to have their views heard.

3.1.1 Referral

The first consideration when receiving a referral is the immediate safety of the child. All referrals to the Social Work Service of Children and Family Services are screened on the day they are received irrespective of the source. Upon receipt of a referral, the Duty Social Worker carries out preliminary enquiries to clarify the nature of the concern, records the personal details of the child and family, and checks the Social Work records for previous contact. Members of the Duty Social Work team will endeavour to provide feedback to the referrer within 24 hours as to the outcome of the referral, although responding within this timescale may not always be possible depending on the individual case.



Practice Note: Engaging with families

It is often very difficult for professionals to discuss child protection concerns with parents. It is important that a decision following an investigation of a child welfare concern is communicated to an individual or a family, taking into consideration the circumstances of the case and the outcome of the investigation. For example, it may be more appropriate that communication in the first instance is in person rather than communication by telephone or letter. It is recognised that each individual case may require a different approach, but one-to-one personal discussions, where everything can be explained in an unhurried fashion, can give reassurances and support to families.

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In developing a professional and supportive working relationship with a family, the following points may assist you in practice:

- be honest about the concerns and issues, and ensure that they are understood by the family;
- check the parents' understanding of what has been said to them. This is especially important where, for example, a parent may have an intellectual disability;
- do not use jargon. Use clear language in a respectful and sensitive manner;
- be clear as to what needs to change and what will be expected from them as a family;
- be clear as to what you will do after you have shared your concerns with them and be as clear as possible about what they can expect from you;
- be punctual and responsive, for example, in returning telephone calls and attending appointments on time;
- get to know the children and family, and build up a rapport with them if possible;
- ensure that the family is aware if/how you will be sharing information with other professionals/agencies;
- if it is not possible to engage the parents/family in a meaningful discussion about the concerns/issues raised, discuss further appropriate action with your line manager/supervisor.

3.1.2 Initial Assessment

Unless the concern is resolved in the course of the referral process, an initial assessment is undertaken. This will include meeting the child and meeting the child's parents, as well as contacting professionals involved in order to develop an understanding of the child and their circumstances. The purpose of the assessment is to reach a preliminary conclusion about unmet need and risk of harm in order to plan and provide an appropriate response. The timescale for completing an initial assessment is 20 working days. Note that this timescale might not be met at times due to circumstances specific to an individual case.

A multidisciplinary approach underpins the assessment process and a number of key tasks are involved when Children and Family Services carry out an assessment of a child protection and/or welfare concern. These include:

- establishing with the child (if age-appropriate) and his or her parents/ carers whether grounds for concern exist;
- if necessary, arranging for a medical examination, assessment for child sexual abuse and medical treatment (this, of course, requires parental consent);
- communicating with any professionals involved with the child and family, and eliciting their views on the report of abuse;
- identifying the nature and severity of any risks;
- identifying any strengths and protective factors that appear to lessen the risk, such as protective care, support of extended family member or friend, or existing family support service;
- deciding on initial protective action pending, or prior to, further action, such as investigation, Child Protection Conference or further assessment;
- if necessary, arrange for a joint HSE/Garda Specialist Interview (see 'Practice Note' below).



Practice Note: Joint HSE/Garda Specialist Interviewing

As part of the initial assessment, a joint HSE/Garda Specialist Interview may need to take place. Discuss with your line manager as appropriate.

The Criminal Evidence Act 1992 allows for a video recording of any statement made by a person under 14 years of age (being a person in respect of whom an offence is alleged to have been committed) during an interview with a member of An Garda Síochána or any other person who is competent for the purpose. This legislation was enacted in October 2008.

Special facilities for the holding of (child abuse) interviews have been developed, together with training for social workers and Gardaí undertaking such interviews.

The protocol between An Garda Síochána and the HSE relates to electronic recording of children being interviewed for suspected child abuse cases. The purpose of the protocol is to facilitate and to assist both organisations in their joint approach to making a video recording of an interview with a complainant where it is intended to submit the recording as evidence in Court.

3.1.3 Further Assessment

Where, following initial assessment or at any other juncture in the child protection and welfare process, it is necessary to carry out a more specific or comprehensive analysis of a child's circumstances, a further assessment will be undertaken. Further assessment may be in the form of a core social work assessment or may be based on specialist assessment by an allied service – e.g. addiction services, child psychology or adult mental health. In planning a further assessment, it is essential to articulate a clear focus for enquiry at the outset.

3.1.4 Child Welfare

When an initial assessment concludes that a child has unmet needs requiring Social Work intervention but the child is not at ongoing risk of significant harm, a Family Support Plan is agreed with the family and reviewed at intervals not exceeding 6 months. The Family Support Plan may be developed at a formal meeting or by informal contacts with the child, family and professionals involved.

3.1.5 Child Protection

Where, following initial assessment, the primary concern is physical abuse, sexual abuse, emotional abuse or neglect, and it is determined that a child is at *ongoing risk of significant harm*, the child protection process outlines the pathway that must be followed.

Formal oversight of the safeguarding of this cohort of children by the Principal Social Worker for Children and Family Services is a crucial feature of the child protection process.

3.1.6 Strategy Meeting

At any point during the child protection process, or if necessary during the initial assessment, a Strategy Meeting may be called to secure the safety of the child. It is the responsibility of the Social Work Team Leader or Principal Social Work Manager to convene a Strategy Meeting.

The purpose of a Strategy Meeting is to facilitate the sharing and evaluation of information between professionals and to prepare a plan of action for the protection of a child, and their siblings if necessary. A Strategy Meeting may involve any or all of the professionals involved at either management or case assessment level, depending on the circumstances. It is important that the attendance of a Garda Síochána representative is secured at this meeting where appropriate, especially if a formal notification has been made.

The objectives of the Strategy Meeting are:

- to share available information;
- to consider whether immediate action should be taken to protect the child and other children in the same situation;
- to decide in consultation with the Gardaí if Section 16(1)(b) Criminal Evidence Act 1992 interviews should take place;
- to consider available legal options;
- to plan early intervention;
- to identify possible sources of protection and support for the child;
- to identify sources of further information;
- to allocate responsibility;
- to agree, where possible, with An Garda Síochána how the remainder of the enquiry will be conducted;
- to identify if other children may be at risk and take action.

3.1.7 Child Protection Conference

A Child Protection Conference is an interagency and interprofessional meeting and is convened by the Child Care Manager for Children and Family Services following a request from the Social Work Service as an outcome of initial assessment, child welfare, further assessment or children in care processes.

The purpose of a Child Protection Conference is:

- to establish whether the child has suffered or is at risk of suffering significant harm;
- to facilitate the sharing and evaluation of information between professionals and parents/carers;
- to formulate a Child Protection Plan;
- to identify tasks to be carried out as part of, or pending, a Child Protection Plan;
- to specify the appropriate service to carry out the tasks;
- to appoint a key worker for the purpose of coordinating the Child Protection Plan.

The child’s parents/carers and the child should be included at the meeting unless doing so would not be in the child’s best interests. The child may be involved depending on his or her age and level of understanding.

In cases where there is a language barrier, or a disability or sensory impairment, those with particular expertise (e.g. interpreters) must be included.

Pre-birth risks and concerns can lead to a pre-birth Child Protection Conference

On occasion, the likelihood of significant harm to an unborn child may be indicated by the parent's background or current behaviour. Examples of circumstances where this may be the case include:

- where parents have a criminal conviction for harming another child;
- where another child has been removed from the care of one of the parents through civil proceedings although no criminal conviction was achieved;
- where a parent's lifestyle is such that there is considered likelihood of significant harm to the child, such as severe emotional, behavioural or mental health difficulties or dependencies on drugs, alcohol or other substances.



Practice Note: Guidance on written reports for a Child Protection Conference

- As with all report writing, a report for a Child Protection Conference should be accurate, concise and clear.
- All reports, either now or in the future, may become available to be read by clients and should be written accordingly.
- A written report is a professional document which may some time in the future be required in Court.
- The written report must be factual and accurate, and not contain gossip or unfounded opinion.
- Identify all sources of information.
- It is preferable to use descriptive language rather than a label, e.g. 'On four of my last six visits, Mr B had been drinking excessively and was incoherent' rather than 'Mr B is an habitual drunk'.
- Use plain, non-technical language and avoid professional jargon where possible.
- It is acceptable, and often desirable, to include professional judgement in a report. In this case:
 - separate between the professional judgements and facts in the report;
 - clearly identify statements, where relevant, as the judgements of the writer;
 - base judgements on fact and establish this link in the report.

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- If the report concerns a particular assessment of a child, summarise the assessment findings, analysis and conclusions rather than providing a verbatim report.
- The report should include any relevant information on children in the household who may not be subject to the Child Protection Conference.
- Reports should be signed and dated, and submitted to the Chair prior to the Child Protection Conference.

Ireland: Serious Case Inquiries – Recommendations for Child Protection Conference practice

Abbreviations: KF = Kelly Fitzgerald (1996); KI = Kilkenny Incest (1993); RO = Roscommon (2010); WI = West of Ireland Farmer (1998).

Parents/guardians should attend case conferences unless there are substantial grounds for their exclusion.	KI
Contact with children should appear on the agenda for every professional supervision meeting and form part of every report for a case conference. Where there is more than one child in a family, the needs, wishes and feelings of each child must be considered and reported on, as well as the totality of the family situation.	Ro 5.3.1
Case conferences should be arranged to facilitate the implementation of planned intervention or to review its continuing appropriateness or effectiveness.	KF
A key worker to be appointed to each case. All those involved in each case are to be aware of the key worker's identity and should share information with him or her.	KF
Personnel attending a case conference should, as far as practicable, be consistent over the duration of the Board's involvement with a child or family. The designated officer for conveying a case conference should have access to all previous information on contacts with the child or children's family, especially previous case conferences notes. This will require adequate secretarial and data retrieval facilities being readily available.	WI
In convening a case conference, arrangements should be made to have a chronological record of all community and hospital contacts between the Board and the child who is the subject of a case conference provided to all the participants at such a conference. Where a case conference is not called, the reasons should be recorded and circulated to appropriate personnel.	WI

(continued)

<p>The Director of Community Care (DCC) takes all reasonable steps to facilitate the attendance of relevant persons at the case conference. There must be an equal obligation on those required to attend to facilitate the DCC in arranging the case conference.</p>	<p>KI</p>
<p>There is a need to have appropriate and systematic medical input into decision-making regarding children at risk. The General Practitioner (GP) has a key role and if his or her attendance at a case conference is not possible, alternative methods of consultation with the GP must be found to ensure comprehensive assessment, monitoring and plan of action.</p>	<p>WI</p>

3.1.8 Child Protection Plan

A Child Protection Plan is an interagency plan formulated and agreed at a Child Protection Conference where the Conference confirms that the child is at ongoing risk of significant harm. It outlines the actions that professionals and agencies directly involved with the family need to take in order to ensure the child’s continued protection and well-being.

When a Child Protection Plan has been agreed, it is the responsibility of all identified professionals and agencies to implement those parts of the plan that relate to them and to communicate with the key worker.

The successful implementation of a Child Protection Plan will depend on a number of functions: interagency and interprofessional cooperation; ongoing consultation with the child and with his or her parents/carers; ongoing monitoring of the implementation of short- and long-term goals; and supervision and support.

Child Protection Plans need to separately identify risks and unmet needs. It is the identification of risk that informs the decision to construct a plan, just as it is a judgement that those risks have diminished or disappeared that informs the decision to cease the plan.

The Child Protection Plan must identify:

- who is at risk and from whom;
- what are the risk factors;
- how risk will be reduced, including specific actions;
- how agencies can measure reduction in risk;
- within what timescale are these changes to be made;
- protective aspects of the child’s situation, which may need to be strengthened and developed;

- what resources are needed to increase or strengthen protective factors and sustain change;
- identified roles and responsibilities of all professionals;
- identified roles and responsibilities of family members;
- provision, supports and interventions to be put in place, with specific detail about what they should achieve;
- contingency planning and what this will mean for the individual child;
- timescales for review;
- explicit timeframes for each stage;
- the name of the professional (social worker) who will be responsible for overseeing and coordinating the work;
- details (including membership) of the Core Group.

3.1.9 Core Group

Core Groups are recommended as good practice in many jurisdictions and supported as good practice by official Inquiries. They are currently not a required action under the *Children First: National Guidance* (2011). They are included here as a way of ensuring good information sharing, continued interagency involvement and shared monitoring of risks, plans and progress.

The Core Group is an interagency group jointly responsible for implementing and reviewing the detailed Child Protection Plan following a Child Protection Conference.

Membership

Membership of the Core Group should be identified at the Child Protection Conference and should include:

- social worker (key worker), who leads/chairs the Core Group;
- parents and relevant family members;
- child/young person if appropriate;
- professionals involved with the child/parent, e.g. public health nurse, teacher, parent's social worker or support worker, education social worker;
- foster carers or residential care staff if involved with family;
- other members identified as appropriate.

Roles and responsibilities of Core Group members

All members of the Core Group are jointly responsible for:

- collecting and sharing information to assist the social worker in carrying out further assessment;

- participating in the compilation of assessment;
- formulation and implementation of the detailed Child Protection Plan, refining it as necessary;
- carrying out their part of the Child Protection Plan;
- monitoring progress against specified outcomes of the detailed Child Protection Plan;
- making recommendations to subsequent Review Conferences about future protection plans and needs;
- attending Core Group meetings at the scheduled intervals and ensuring there is no drift in planning and intervention.

Core groups are an important forum for working with parents, wider family members and children of sufficient age and understanding. Where there are conflicts of interest between family members in the work of the Core Group, the child's best interests should always take precedence.

3.1.10 Child Protection Notification System (CPNS)

The Child Protection Notification System (CPNS) is a HSE Children and Family Services' record of every child about whom there are unresolved child protection issues, resulting in the child being the subject of a Child Protection Plan. The decision to place a child on the CPNS is made at a Child Protection Conference.

- Following notification from a Child Protection Conference, a child's name is placed on the CPNS by the Child Care Manager/HSE designated person.
- Removal of a child from the CPNS can only occur following a Child Protection Review Conference at which a decision is made that the child need no longer be the subject of a Child Protection Plan.
- The parent/carer, other relevant agencies and, where appropriate, the child should be informed in writing by the Child Care Manager/HSE designated person when his or her name is listed on the CPNS.
- The CPNS is the specific responsibility of the Child Care Manager/HSE designated person. It is held securely and separately from other records. Information about how to access the CPNS is available to all agencies with agreed rights to access.
- The system records all enquiries, whether the child is on the list or not. If a CPNS enquiry is repeated, a report will be made by the Child Care Manager/HSE designated person to Children and Family Services.

- Details of any changes in information relating to a child whose name is recorded on the CPNS must be provided immediately by the allocated key worker to the designated person with responsibility for the CPNS.

3.1.11 Child Protection Review Conference

Child Protection Review Conferences must be held at intervals not exceeding 6 months where a child is the subject of a Child Protection Plan.

It is the responsibility of the Child Care Manager/HSE designated person within the HSE to arrange Child Protection Review Conferences. Where applicable, Review Conferences should be attended by the Core Group of professionals involved with the case.

The purpose of the Child Protection Review Conference is:

- to build up a picture of the child's current situation;
- to coordinate the views of professionals;
- to consider the views of the child and parents/carers;
- to review the progress of any legal action or prosecution if relevant;
- to decide on the need for an ongoing formal Child Protection Plan and the ongoing listing of the child's details on the CPNS;
- to review and amend the Child Protection Plan where necessary;
- to assess the availability of resources needed to carry out the Child Protection Plan.

The child's parents/carers and the child should be included at the meeting unless doing so would not be in the child's best interests. The child may be involved depending on his or her age and level of understanding.

In cases where there is a language barrier, or a disability or sensory impairment, those with particular expertise (e.g. interpreters) must be included.

3.1.12 Joint HSE/Garda Action

The HSE and An Garda Síochána are the key agencies empowered by law to carry out assessments and investigations, respectively, of suspected child abuse and neglect. Each agency manages the responsibility within its brief and their joint efforts are designed to ensure that the protection of vulnerable children receives priority attention. Their separate and complementary roles require careful understanding if the shared objectives of child protection are to be realised. An Garda Síochána has the additional responsibility of bringing allegations of abuse to the attention of the Director of Public Prosecutions (DPP), who decides on and carries out prosecutions.

Where the HSE suspects that a child has been or is being physically or sexually abused or wilfully neglected, An Garda Síochána must be formally notified in accordance with the procedure set out in Paragraph 7.4.5 of the *Children First: National Guidance* (2011).

Where An Garda Síochána suspects that a child has been or is being the victim of emotional, physical or sexual abuse or neglect (whether wilful or unintentional), the HSE must be formally notified in accordance with the procedure set out in Paragraph 7.7.4 of the *Children First: National Guidance* (2011). It is not necessary for An Garda Síochána to have sufficient evidence to support a criminal prosecution before notifying the HSE.

An Garda Síochána is vested with the power to remove a child to safety under Section 12 of the Child Care Act 1991. Where a member of the Gardaí has reasonable grounds for believing that there is an immediate and serious risk to the health or welfare of a child and it would not be sufficient for the protection of that child from such immediate and serious risk to await the making of an application for an Emergency Care Order by the HSE under Section 13 of the Child Care Act 1991, the Garda may remove the child. Where a child has been removed by An Garda Síochána under Section 12, the child shall be delivered into the custody of the HSE as soon as possible.

Relationship between HSE and An Garda Síochána

The functions and roles of HSE personnel and An Garda Síochána are different. It is important that all personnel in both services work closely and collaboratively to ensure the protection and welfare of children, which is of paramount importance. It is critical that close working relationships are maintained to facilitate the clear roles and functions of both organisations and that all criminal investigations are supported, not impeded.

An allegation of extra-familial abuse will inevitably involve allegations of criminal activity. Thus, the need for close liaison between the HSE and An Garda Síochána is crucial. In relation to this, Section 7.10 of *Children First: National Guidance* (2011) specifies the following:

7.10 Assessment and investigation of cases

7.10.1 It is essential that enquiries by the HSE and An Garda Síochána should be coordinated to ensure that:

- (i) the welfare of the child is protected;
- (ii) everything possible is done to assist the criminal investigation and protect the available evidence;

- (iii) there is an effective flow of relevant information between both agencies;
- (iv) decisions and actions follow consultation within and between both agencies.

This reinforces the need for close strategic cooperation between the HSE and An Garda Síochána, not least to ensure effective child protection but also that evidence is not contaminated.

3.1.13 Communication and information sharing between agencies



Practice Note: Communication and information sharing between agencies

Always check that what you said is understood in the way you intended it.

Always check that you understand information in the way it was intended.

Do not make any assumptions.

Fit for discharge? Yes or No?

Victoria [Climbié] was prematurely discharged from one hospital, having been admitted with suspected non-accidental injuries. Sources of the confusion were multiple, but included a nurse's fax that Victoria was 'fit for discharge' being interpreted by the social worker as meaning the ward staff had no concerns at all.

At the time, Ms A. (social worker) says she understood the phrase 'fit for discharge' to mean that the hospital no longer had any concerns about Victoria in the general sense. By contrast, several hospital staff in their evidence to the Inquiry said that 'fit for discharge' meant that Victoria was medically fit to leave and they assumed the social workers would make the necessary inquiries of her home and family before that actually happened.

Source: Laming, H. (2003) The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming, p. 148.

3.1.14 Family Welfare Conference

The Family Welfare Conference is a family-led decision-making meeting involving family members and professionals, which is convened by the HSE or designated partner agency, when decisions need to be made about the welfare, care or protection of a child/young person. The purpose of the meeting is to develop a safe plan to meet the needs of the child or young person.

The Family Welfare Conferencing Service was established under the Children Act 2001. Part 2 (Sections 7-15), Part 3 (Sections 16 (IVA) and 27) and Part 8 (Section 77) of the Act sets out, on a statutory basis, the role, purpose and format to be adopted by the HSE in convening and operating a Family Welfare Conference.

A Family Welfare Conference is convened when:

- the HSE is directed to do so by order of the Court;
- the HSE is of the view that a child requires a Special Care Order or protection which he or she is unlikely to receive unless a Special Care Order is made;
- the HSE is concerned for the welfare/care/protection of a child/young person and wishes the family to devise a safe family plan to address their concerns.

3.1.15 Intra-familial and Extra-familial Mistreatment

Following consideration of Section 3 of the Child Care Act 1991, the High Court did not limit this to suspected abuse within families and found that the HSE had a duty to all children who may be at risk. In the revised *Children First: National Guidance* (2011), Paragraph 7.11.6 contains a specific reference to extra-familial abuse, as follows:

Extra-familial abuse: Where a concern is made known to the HSE or An Garda Síochána that a child is at risk or has been abused by a person outside the family, the HSE shall:

- (i) undertake an assessment of need on the child and provide support as required;
- (ii) endeavour to undertake a risk assessment of the alleged perpetrator, where known, in accordance with HSE policy.

Further information is provided in Appendix 1: Summary of Key Legislation.

3.1.16 Retrospective Disclosures

In relation to retrospective disclosures, it is imperative that all child protection concerns are examined and addressed. Section 3.6 of *Children First: National Guidance* (2011) outlines the requirements to establish whether there are current risks, as follows:

3.6 Retrospective disclosures by adults

- 3.6.1 An increasing number of adults are disclosing abuse that took place during their childhoods. Such disclosures often come to light when adults attend counselling. **It is essential to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures.**
- 3.6.2 If any risk is deemed to exist to a child who may be in contact with an alleged abuser, the counsellor/health professional should report the allegation to the HSE Children and Family Services without delay.
- 3.6.3 The HSE National Counselling Service is in place to listen to, value and understand those who have been abused in childhood. The service is a professional, confidential counselling and psychotherapy service and is available free of charge in all regions of the country (see www.hse-ncs.ie/en). The service can be accessed either through healthcare professionals or by way of self-referral (Freephone 1800 477477).

Furthermore, Paragraphs 7.16.7-7.16.8 of *Children First: National Guidance* (2011) specify the requirements for the statutory authorities to establish whether there is any current risk to any child who may be in contact with the alleged abuser, as follows:

Retrospective disclosure by adults

- 7.16.7 When a disclosure is made by an adult of abuse suffered during their childhood and it comes to the attention of either the HSE or An Garda Síochána or other service, it is essential to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in the adult's disclosure. If any risk is deemed to exist, this information must be shared between both agencies, following the notification procedures (see *Paragraphs 7.4.5 and 7.7.4*). It is essential that all relevant information in relation to any of the above eventualities is carefully collated and that each agency informs the other of any such concerns during an investigation.
- 7.16.8 The need to refer an adult for counselling, treatment and/or other support services for victims of assaults should also be considered.

3.2 Risk factors in child protection

Alongside the signs and symptoms of the four types of abuse (physical abuse, sexual abuse, emotional abuse and neglect), there are a number of known risk factors that need to be considered when identifying, responding to and assessing child protection concerns.

Risk factors are features of the child's circumstances that are known to be associated with heightened risk to health, development and welfare.

Risk factors associated with child abuse and maltreatment can broadly be grouped in four domains:

- parent or caregiver factors;
- family factors;
- child factors;
- environmental factors.

In addition, risk factors that need to be considered are (*see detailed discussion below*):

- age of the child;
- domestic and sexual violence;
- parental mental health problems;
- parental substance misuse;
- parental intellectual disability;
- childhood disability;
- unknown male partners;
- families who are 'uncooperative' or 'hard to engage';
- poverty and social exclusion.

Many families often experience more than one of these risk factors or a combination of a number of them. This is not an exhaustive list.

Individually, parental mental health problems, substance misuse and domestic violence represent significant risk factors for child abuse and neglect. But the reality is that parenting problems rarely occur in isolation. Instead, they tend to be part of a complex and interrelated group of problems.

3.2.1 Age of the child

Risk factors and early years – the vulnerabilities of infants

- The majority of child deaths from abuse and neglect are of children under the age of 4, when children are most vulnerable to physical attacks and to dangers created by lack of supervision and severe neglect, and are isolated from professionals, such as teachers, who might intervene to protect them.
- This age group is more at risk of being maltreated when they are growing up in families affected by parental substance misuse, domestic violence and mental ill health.
- Experiences of abuse and neglect can cause distress, emotional and physical pain, and overwhelming fear or terror in response to sudden separations, experiencing neglect, being assaulted or witnessing violence.
- Exposure to trauma affects every dimension of an infant’s psychological functioning (e.g. emotional regulation, behaviour, response to stress and interaction with others). Very young infants may be overwhelmed with intense negative emotions, manifesting in incessant crying, inability to be soothed, feeding problems, sleep disturbances, hyper-arousal and hyper-vigilance, and intense distress during transitions. Toddlers may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, and constricted affect and play. They are likely to have reduced tolerance of frustration and problems with emotional regulation, evident in intractable tantrums, non-compliance and negativism, aggression and controlling behaviour.

Risk factors and adolescents

Risks factors specific to adolescents and young people include:

- adolescent mental health problems;
- self-harm and/or suicide;
- involvement with, or fear of, gang-related violence;
- sexual exploitation;
- teenage domestic violence.

The neglect of older children and adolescents is difficult to recognise and too often goes unnoticed (*see p. 21, 'Indicators of neglect in older children'*).

3.2.2 Domestic and Sexual Violence

Domestic violence occurs across society regardless of age, gender, race, sexuality, wealth and geography. Domestic violence is generally underreported, but the 2005 study *Domestic Abuse of Women and Men in Ireland: Report on the National Study of Domestic Abuse* shows that 1 in 7 women and 1 in 17 men surveyed experienced severely abusive behaviour from an intimate partner at some time in their lives (National Crime Council and ESRI, 2005).



Messages from research

Even though men are also victims of domestic violence, the majority of victims are women. A major study of police reports and crime surveys in the UK, USA and Canada found that between 90% and 97% of perpetrators of violence in intimate relationships are men.

The Women's Aid report *Annual Statistics 2010* finds:

- 1,658 specific incidents of child abuse disclosed by callers to the Helpline in the preceding year. These are incidents where the perpetrator was directly abusing the children of the relationship, as well as the mother.
- The kinds of abusive tactics used directly against children living in domestic violence situations disclosed to the National Freephone Helpline in 2010 include: the abuser smacking and hitting children including with household items; the abuser physically and sexually abusing children; and abusers constantly shouting in children's faces.
- In addition to the 1,658 specific incidents of child abuse reported in 2010, in another 2,946 calls it was directly disclosed that children were living in situations where their mother was experiencing domestic violence. In the majority of these incidents, it is likely that children will have witnessed or heard the abuse of their mother as a form of emotional abuse of children.
- 97% of callers were female, while 297 callers to the Helpline were identified as minority callers, 81% of whom were migrant women.
- Women who experience domestic abuse have, on average, experienced it 35 times before they ask for help and then make between 5 and 12 different contacts in an effort to end the violence.

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Other research findings show:

- Prolonged and/or regular exposure to domestic abuse can have a serious impact on a child's development and emotional well-being despite the efforts of the victim parent to protect the child (Cleaver *et al*, 1999).
- The most dangerous time for a victim of violence is when she is on the verge of leaving and for 6 months afterwards. 76% of homicides occur after separation.
- Women in Black Minority Ethnic (BME) communities are more vulnerable due to the additional barrier of reporting and receiving help, for example, uncertain immigration status; no recourse to public funds; language/literacy barriers; housing issues; community/faith honour; cultural issues (e.g. female genital mutilation, forced marriage).
- Women experiencing violence may also respond to the trauma of violence in ways that damage their own health. These responses can include substance use, depression, anxiety and social withdrawal, and all can affect women's physical and mental well-being. This may impact on their ability to care safely for children they may have.
- The majority of high-risk victims have children. Some international studies into domestic violence have found that 1 in 4 young people have witnessed violence against their mother or stepmother.
- During the vast majority of incidents of domestic violence, children are in the same or the next room.
- The link between child physical abuse cases and domestic violence is high, with estimates ranging between 30% to 66% depending on the country in question.
- Studies show that adult partners who are violent toward each other are also at increased risk of abusing their children.
- Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life.
- It is important to always consider the implications of any domestic abuse for unborn children since pregnancy and after the birth of a new baby are some of the highest risk periods for women.
- Pregnancy is a time of increased risk of domestic violence since 30% of domestic violence begins or escalates during pregnancy.

Margolin and Gordis (2000) in their study *The effects of family and community violence on children* state: 'Violence affects children's views of the world and of themselves, their ideas about the meaning and purpose of life, their happiness and their moral development. This disrupts children's progression through age-appropriate developmental tasks.'

Definition of domestic violence

The HSE (2010d) *Policy on Domestic, Sexual and Gender-based Violence* defines domestic violence as 'the use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships. It can also involve emotional abuse; the destruction of property, isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone' (HSE, 2010d).

The HSE 2010 policy makes reference to the 3 Rs to assist practitioners:

- **Recognise:** know the signs, indications and sequence of abuse
- **Respond:** know how to deal with the issue of abuse
- **Refer:** make a good, appropriate referral

Points for practitioners to consider:

- Are you familiar with the HSE's 2010 *Policy on Domestic, Sexual and Gender-based Violence*?
- Are you familiar with your local area's policy and procedures around domestic violence?
- Do you know the emergency contact information for domestic violence victims?
- Do you know how to refer a domestic violence victim for help?
- Do you know how to complete a safety plan with a domestic violence victim?
- Can professionals be over-optimistic in their assessment of the situation, resulting in a minimising of the abuse/risks?
- A child who asks for help may be at increased risk because they may be 'punished' for calling in professional help.
- It is important never to ask a possible victim of domestic violence any question about any possible violence in the home while other family members are present or where he or she can be overheard.



Practice Note: Assessing domestic violence as a risk factor - Issues to consider

Always consider the child's immediate safety first.

Communicating with the child

- Keep the child in focus and do not look at domestic violence as an 'adult problem' only.
- Be prepared if the child cannot express him or herself and/or talk about the violence.
- A child who asks for help may be at increased risk because they may be 'punished' for calling in professional help.
- If possible, establish the child's understanding of the domestic violence taking place.
- Be aware that the child may be experiencing feelings of divided loyalties between the perpetrator and the non-abusing parent/carer.
- Be aware of the possibility that the child may be being, or has been, physically and/or sexually abused.
- Consider that the child may have taken on inappropriate roles and responsibilities within the family because of the domestic violence, e.g. does the child try to protect the non-abusing parent/carer or has the child been made to watch violent acts against him/her? Roles children may assume include caretaker, victim's confidant, abuser's confidant, abuser's assistant, perfect child, referee and scapegoat (Cunningham and Baker, 2004).
- When communicating with the child, be clear as to your role.

Obtain a detailed history of the child's experience of domestic violence

- When was the most recent incidence of violence?
- What are the nature, location, severity, frequency and duration of incidents that the child is exposed to?
- What is the child's involvement and how does he or she respond during these incidents, e.g. witnessing, physically involved, trying to intervene?
- Is the child forced to participate in the abuse?
- Does the child demonstrate inappropriate behavioural responses as a result of witnessing domestic abuse?

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- Does the child display emotional symptoms such as hyper-vigilance, attachment issues, 'clinginess', insomnia, nightmares, poor appetite, depression, not knowing how to play or relax as a result of an unpredictable and frightening parent?
- Does the child display behavioural issues and/or concentration deficits in school/early years setting?

The impact on the non-abusing parent/carer's ability to parent and protect the child

- What is the non-abusing parent's ability to parent and protect the child or children?
- The effects of violence (e.g. pain, distress, anger, irritability, fear, reduced mobility, hospitalisation) may affect parenting capacity, as may mental illness or substance misuse problems that emerge as a consequence of domestic violence.
- Consider interlinking risk factors that may be affecting parenting capacity, e.g. adult mental health issues, substance misuse, neglect issues, adult intellectual disability, social isolation, child disability.
- Practitioners need to be aware that domestic violence incidents are not necessarily individual occurrences, but rather part of a process within the context of the child's safety and welfare.
- Check with the non-abusing parent what explanations have been given to the child about the domestic violence and the perpetrator's behaviour.

Other important issues to consider during the assessment

- Are there any protective factors? What are they?
- Is the mother pregnant or had a baby in the last 18 months?
- Has there been involvement from the Garda? How often?
- Are there any legal issues to consider?
- Has the perpetrator breached protective Court orders for either mother or child?
- Does the perpetrator have a criminal record?
- Is the family experiencing financial stress?
- Are the mother and child isolated, with limited support?
- During home visits check for pets – animal abuse is often an indicator of domestic violence.

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What are the outcomes for this child?

- What is the long-term impact for each child of being exposed to sustained domestic abuse in the home?
- How does exposure to domestic violence impact on the child's overall well-being and all areas of child development?
- What is the evidence on which you base your assessment and analysis?

Risks to children who live with domestic violence

There are many risks to children who live with domestic violence, including:

- Direct physical or sexual abuse of the child or children.
- The child being abused as part of the abuse against the non-abusing parent.
- Being used as pawns or spies by the abusive partner in an attempt to control the non-abusive parent.
- Being forced to participate in the abuse and degradation by the abusive partner.
- Emotional abuse to the child from witnessing the abuse.
- Physical injury to the child by being present when the violence occurs.
- Hearing abusive verbal exchanges between adults in the household, including humiliation and threatened violence.
- Observing bruises and injuries sustained by their mother.
- Observing the abusive partner being removed and taken into Garda custody.
- Witnessing their parent/carer being taken to hospital by ambulance.
- Attempting to intervene in a violent assault.
- Being unable or unwilling to invite friends to the house.
- Frequent disruptions to social life and schooling because of moving house to flee violence or living in a refuge.
- Hospitalisation of the non-abusing parent/carer.

Perpetrator risk assessment

The main characteristic of domestic violence is that the behaviour is **intentional** and is **calculated** to exercise power and control within a relationship.

Examples of these behaviours

- **Psychological/emotional abuse** – intimidation and threats, social isolation, verbal abuse, humiliation, constant criticism, enforced trivial routines, marked over-intrusiveness.
- **Physical violence** – slapping, pushing, kicking, stabbing, damage to property, attempted murder or murder, physical restriction of freedom, stalking, forced marriage.
- **Sexual violence** – any non-consensual sexual activity, including rape, sexual assault, coercive sexual activity or refusing safer sex.
- **Financial abuse** – stealing, depriving or taking control of money, running up debts, withholding benefit books or bank cards.

Professionals need to have the confidence and skills to ask about violent and abusive behaviour, as well as being able to refer to appropriate services for either intervention or practical assistance.

Teenage dating/Relationship violence

The study by Burton *et al* (1998), *Young People's Attitudes towards Violence, Sex and Relationships*, found that 1 in 2 boys and 1 in 3 girls think that there are circumstances when it is alright to hit a woman or force her to have sex, and 36% of boys think that they might personally hit a woman or force her to have sex.

The age where domestic violence occurs in the highest numbers is in the 16-25 year-old age group, with pregnancy and teenage parenting adding additional vulnerability and risk (about 70% of teenage parents experience domestic violence). Professionals need to be aware of the risk factors associated with teenage pregnancy and ensure that protective factors are in place to reduce the risks.

3.2.3 Parental Mental Health Problems



Messages from research

- According to the Social Care Institute for Excellence in its report *Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare* (SCIE, 2009), between 1 in 4 and 1 in 5 adults will experience a mental illness during their lifetime. At the time of their illness, at least a quarter to a half of these will be

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parents. Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health. Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting impinge on adult mental health. Furthermore, the mental health of children is a strong predictor of their mental health in adulthood.

- The Royal College of Psychiatrists (2004) report that only a very small number of children die or are seriously injured by a parent with a mental health problem. However, many more children suffer less obvious, but still damaging effects since their own development or mental health may become compromised.
- According to Green (2002), many of these children can remain 'hidden' from support because fear of consequences can result in problems not being shared with the services that may alleviate them. There is also the potentially hidden problem of those children who care for their parents (young carers) and who may miss out on many opportunities available to other children.
- In the UK, Dearden and Becker (2000) estimated that the numbers of young carers nationwide vary between 10,000 and 40,000, of which about one-third care for a parent with a mental health problem. A NSPCC study showed that many of these children had significant experiences of loss, self-blame and stigma (Cooklin, 2006).
- Abused women are at least 3 times more likely to experience depression or anxiety disorders than other women.
- Women who use mental health services are much more likely to have experienced domestic violence than women in the general population.

Impact on children

- Children of parents with an uncontrolled mental illness face a high risk of physical neglect. Basic needs may not be met, such as having regular healthy meals and clean clothes (Cowling, 2004).
- Parents may fail to attend to children's emotional needs, which can instill a sense of isolation and possible mistrust in children. There are risks of physical and psychological abuse by parents if symptoms of illness contribute to the parent being violent, reactive or punitive (Cowling, 2004).

- Parental mental health problems can also increase the risk of perinatal complications due to possible side effects of medications, (e.g. anti-depressants) during pregnancy and high stress levels in mothers (Cowling, 2004; Huntsman, 2008). Attachment difficulties may arise for babies and infants of mothers with maternal mental health problems, such as depression (Cowling, 2004).
- Children of parents with mental health problems have also been found to be at risk of developing mental health problems of their own (Cowling, 2004). Problems in a child's cognitive development may also arise due to the parent's inconsistent and neglectful behaviour (Cleaver *et al*, 1999).
- The recklessness associated with anti-social personality disorder, and the tendency of those suffering from it to minimise the harmful consequences of their actions, can put a child at risk of serious or chronic illness, injury and death. In addition, the promiscuity and poor relationship choices made by some adults with anti-social personality disorder may put a child at risk of abuse from others (Newman and Stevenson, 2005).

How to talk to young people who may be caring for parents with mental health problems

A group of young carers in Merseyside came up with the following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

1. Introduce yourself. Tell us what your job is and who you are.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live here too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. **MAYBE IT COULD BE YOU.**



Practice Note: Assessing parental mental health as a risk factor

Attachment and relationship

- Is the child's attachment damaged due to inconsistent parenting?
- Is there consistent emotional warmth from adult caregivers?
- Is there appropriate parental response in accordance with the child's age and stage?
- Is parental incapacity affecting the child taking on too much responsibility?
- Are the child's emotional needs consistently met (including security, stability and affection)?

Living conditions

- Are the child's physical needs being consistently met?
- What are the child's living conditions like?
- Is the physical environment provided for the child good enough?

Financial circumstances

- Is there enough money to allow for adequate parenting/the child's needs to be met?

Social and environmental circumstances

- Does the parent's behaviour impact negatively on the child's treatment in the community (e.g. bullied, excluded, ostracised)?
- Is the child or young person and their family able to access resources in the community?
- Who looks after this child when the parent/carer is not able to care for them appropriately and/or in treatment/on medication?

What are the outcomes for this child?

- What is the long-term impact for each child of being exposed to parental mental health problems in the home?
- How does exposure to parental mental health problems impact on the child's overall well-being and all areas of child development?
- What is the evidence on which you base your assessment and analysis?

3.2.4 Parental Substance Misuse (includes alcohol and drugs)



Messages from research

- Research supports the connection between alcohol and drugs, and child abuse and neglect.
- The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children in both the short and long term.
- Parents significantly affected by the use of drugs and alcohol may neglect the needs of their children, spend money on drugs instead of household expenses or get involved in criminal activities that jeopardize their children's health or safety.
- Studies also suggest that substance abuse can influence parental discipline choices and child-rearing styles.
- The issue of children taking on inappropriate caring roles should not be underestimated and should be explored by practitioners.
- The critical issue in considering the potential impact on a child is not the adult's use of drugs or alcohol per se, but whether that causes any form of harm to a child. Such difficulties include any short- and long-term physical risks or any lack of appropriate physical or emotional nurturing that can be attributed to the use of alcohol, drugs or solvents by anyone responsible for the child's immediate care or longer term welfare.
- With regard to pregnancy, potential risks include significant harm to the unborn child, drug withdrawal difficulties at birth or potential problems relating to the appropriate care of the newborn child. Problematic substance use is often a chaotic relapsing condition, which may require continuing review in order to identify ongoing, long-term and flexible support.
- Children often know more about their parents' misuse than parents realise and they feel the stigma and shame of this misuse, but also fear the possibility of being separated from their parents and taken into care.
- Exposure to alcohol and drugs *in utero* may cause impaired brain development for the foetus and has also been found to have some of the most detrimental effects on infants, including mental developmental delay and neurological deficits.

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- In Ireland, the Coombe Women’s Hospital (2007) *Study of Alcohol, Smoking and Illicit Drug use, 1987-2005* found that 63% of women reported alcohol use during pregnancy, of which 7% drank 6 or more drinks per week.
- Taking the number of births each year and those engaged in high-risk drinking, these figures would suggest that at least 4,500 children each year are at increased risk of harm from maternal alcohol use.
- A report to the European Union by the HSE (2008), *Alcohol-related harm in Ireland*, estimated that between 61,000 and 104,600 children in Ireland are living in families adversely affected by alcohol.
- Women who are in a domestic violence relationship are 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs than the general population of women.
- 40% of Asian women who seek treatment for alcohol misuse are experiencing domestic violence.
- Some women are introduced to substances by their abusive partners as a way of increasing control over them.
- When a woman’s partner is also her supplier, it will be particularly difficult for her to end the relationship.



Practice Note: Substance misuse as a risk factor

Always consider the child’s immediate safety first.

Parenting and attachment relationship

- Is the child’s attachment damaged due to inconsistent parenting?
- Is there consistent emotional warmth from adult caregivers?
- Is there a level of unpredictability of the caregivers and inconsistencies in parenting, and how do these affect the child?
- Is there appropriate parental response in accordance with the child’s age and stage?
- Is parental incapacity affecting the child taking on too much responsibility?
- Are there any caregivers that do not use substances?
- Is there evidence of praise and encouragement?

Living conditions

- Are the child's physical needs being consistently met?
- What are the child's living conditions like?
- Is the physical environment provided for the child good enough?
- If drugs are kept in the home, is it possible that children can access them?

Financial circumstances

- Is there enough money to allow for adequate parenting/the child's needs to be met?

Potential for harm

- Is the child placed in physical danger?
- Are the child's emotional needs consistently met (including security, stability and affection)?

Social and environmental circumstances

- Does the parent's behaviour impact negatively on the child's treatment in the community (e.g. bullied, excluded, ostracised)?
- Is the child or young person and their family able to access resources in the community?
- How is alcohol and/or drugs sourced?
- What impact has this on the child?
- Who looks after this child when the parents are incapacitated, seeking treatment, sourcing alcohol/drugs?
- Culture of the family and how alcohol misuse affects family life, e.g. unknown adults coming into the family home, children and young people being taken to potentially risky environments.
- Is the child in contact with unknown/potentially risky adults at any time?
- Is the child (or children) left home alone at any time while adults source alcohol/drugs?

What are the outcomes for this child?

- What are the consequences and long-term impact for each child of being exposed to parental substance misuse in the home?
- How does exposure to parental substance misuse impact on the child's overall well-being and all areas of child development?
- What is the evidence on which you base your assessment and analysis?

3.2.5 Parental Intellectual Disability



Messages from research

- Parents with intellectual disabilities often need to overcome preconceived ideas among other people about their abilities to parent. For example, there is a willingness to attribute potential difficulties they may have parenting to their impairment rather than to disabling barriers or to other factors that affect the parenting of all parents. This has been described as the 'presumption of incompetence'.
- Where a parent has an intellectual disability, it is important not to make assumptions about their parental capacity. Having an intellectual disability does not mean that a person cannot learn new skills. Intellectually disabled parents may need support to develop the understanding, resources, skills, experience and confidence to meet the needs of their children.
- Several factors have been demonstrated to have an adverse effect on parenting: these include low socio-economic status, unemployment and social isolation or exclusion. All of these factors make parenting difficult. Parents with intellectual or learning disabilities are at greater risk of experiencing one or more of these disadvantages than other groups. Many parents with intellectual disabilities are unemployed, on low incomes and rely very heavily on benefits and statutory services; many are single mothers; and few have the same opportunities for 'informal social learning' from friends and extended family as non-disabled parents.
- Unless a parent with an intellectual disability has a comprehensive support network, it is likely they will need support from Children's Social Work Services and other agencies, including adult services. A study of children living with learning disabled parents who had been referred to the local authority's Children's Social Work Services highlighted the need for collaborative working between children and adult services (Cleaver and Nicholson, 2007).

Specific risks to children with parents with learning disability

- Poor pre-birth care because of late recognition of pregnancy and poor compliance with antenatal care.
- Impairment of their health and development through impaired parenting capacity.

- The child assuming a caring responsibility for the parent.
- The child being socially isolated and/or bullied.
- Men targeting a mother with learning disabilities to gain access to the child for the purpose of sexually abusing them.



Practice Note: Assessing parenting capacity where parental intellectual disability is a concern

In assessing the parenting capacity of intellectually disabled (also called learning disabled) parents, Horwath (2007) and Stevenson (2007) identify the following key issues to keep in mind:

- parent's cognitive functioning;
- co-morbidity, e.g. diagnosis of mental illness and/or substance misuse;
- poor self-esteem;
- lack of positive role models;
- lack of support;
- adverse social conditions;
- parent's ability to anticipate risk to the child;
- managing diverse and complex situations;
- parent's thought processes may be rigid, thus making adaption to change (e.g. the child's needs or behaviour) difficult.

In circumstances where a parent/carer has a learning disability, it is likely there are a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent's learning disability, their parenting and the impact on the child.

Any assessment should include an understanding of the needs of the family and individual children, and an identification of the services required to meet these needs.

It must be recognised that a learning disability is a lifelong condition. Assessments must therefore consider the implications for the child as they develop throughout childhood since children may exceed their parent's intellectual and social functioning at a relatively young age.

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The study by Buckley *et al* (2006), entitled *Framework for the Assessment of Vulnerable Children and Families: Assessment Tool and Practice Guidance*, outlines the following areas for consideration of the impact of having a disability on the parent/carer's parenting:

- size of family;
- parent/carer's general physical health and mobility;
- parent/carer's cognitive ability, language and/or communication skills;
- parent/carer's relationships;
- extent of parent/carer's knowledge about healthcare, child development, safety, responding to emergencies and discipline;
- expectation and responsibilities on child to play a caring role;
- financial situation;
- support systems available to and used by the parent/carer and their family;
- parent/carer's own experience of being parented and of receiving services as a child/young person.

Keep the focus on the child

It is important to have a very good understanding of the type and severity of the parent/carer's intellectual disability and how this impacts on the child on a daily basis.

- Does the child take on any roles and responsibilities within the home or in caring for a parent/carer that are inappropriate?
- Has the child been enabled to express their own views on what they want for themselves, taking into account their age, ability and level of maturity?
- How is the child coping with the parent's disability and what is their level of resilience?
- Is the child displaying emotional, psychological or behavioural symptoms that cause concern, and if so, what action has been taken to address this?

3.2.6 Children with disabilities



Messages from research

- Disabled children are children, first and foremost. They have the same rights to protection as any other child. People caring for and working with disabled children need to be alert to the signs and symptoms of abuse.
- Disabled children are at greater risk of abuse and neglect than non-disabled children. Disabled children in a large-scale US study by Sullivan and Knutson (2000) were found to be 3.4 times more likely overall to be abused or neglected than non-disabled children. They were 3.8 times more likely to be neglected; 3.8 times more likely to be physically abused; 3.1 times more likely to be sexually abused; and 3.9 times more likely to be emotionally abused.
- A number of studies have found that different types of disabilities have differing degrees of risk for exposure to violence. For example, Sullivan (2003) reported that those with behaviour disorders face greater risk of physical abuse, whereas those with speech/language disorders are at risk of neglect.
- There are no differences in which form of child maltreatment occurs the most often between disabled and non-disabled children. For both groups, neglect is the most prevalent, followed by physical abuse, sexual abuse and emotional abuse (Sullivan and Knutson, 2000).
- Disabled children are particularly vulnerable and at greater risk of all forms of abuse, including abuse whilst being cared for in institutions. The presence of multiple disabilities could increase the risk of both abuse and neglect.



Practice Note: Increased vulnerability of children who are disabled

In general, the causes of abuse and neglect of children with disabilities are the same as those for all children. However, several factors may increase the risk of abuse for children with disabilities:

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- Many disabled children are at an increased likelihood of being socially isolated, with fewer outside contacts than non-disabled children.
- They receive intimate personal care often from a number of carers, which may increase the risk of exposure to abusive behaviour. It may be difficult for a child to distinguish between appropriate and non-appropriate touching and their right of choice about who carries out such care.
- They have an impaired capacity to recognise, resist or avoid abuse.
- They are especially vulnerable to bullying and intimidation.
- They may have speech, language and communication needs, which may make it difficult for them to tell others what is happening. They often do not have access to someone they can trust to disclose that they have been abused.
- They may be inhibited from complaining through a fear of losing services.
- Disabled children in care are not only vulnerable to the same factors that exist for all children living away from home, but they are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day-to-day physical care needs.
- In addition to the risk factors that exist for all children, disabled children are at risk of particular forms of abuse, e.g. over-medication, poor feeding and toileting arrangements, lack of stimulation and issues around control of challenging behaviour, lack of information, lack of emotional support, etc.
- Disabled children are often seen as having no sexual identity and/or their sexual feelings are often not acknowledged. They may lack sex education and/or understanding, and this may increase their vulnerability. Sexualised and/or disturbed behaviour is frequently accepted as part of a child's disability without further thought or questioning.
- Disabled children are accustomed to being directed. They are rarely offered choices or provided with enough information to make a choice. This may mean they are less able to recognise abusive situations.
- There is a lack of recognition by many professionals and carers that disabled children are abused. Signs or symptoms of abuse may be 'explained away' as part of their normal behaviour. For example,

bruising could be said to be caused by a child's tendency to fall or sexualised behaviour may be put down to impairment. It is important, therefore, to check out all these explanations and not accept them at face value. It will be helpful to explore whether the child's behaviour is consistent with all carers.



Practice Note: Communicating with children who are disabled – keep the following in mind:

- Planning for children and young people with disabilities should anticipate various eventualities that should be considered at the planning stage of any assessment and/or interview.
- Always take account of the level of cognitive, social and emotional development and indicators of vulnerability of the child.
- Ensure, wherever possible, that the individual views, wishes and feelings of the child are taken into account.
- Some children may develop their own means of communication, the interpretation of which requires specialist knowledge of the child and, therefore, could limit those from whom the child can seek assistance.
- Assumptions must not be made about the inability of a child with disabilities to give credible evidence or to withstand the rigours of the Court process.
- In planning an interview with a child with disabilities, workers need to take account of how a child communicates. It will often be appropriate to involve other professionals with skills, in particular modes of communication. The onus is on the interviewer to understand and use the child's own method or system of communication.

Disabled children will usually display the same signs and symptoms of abuse as other children. However, these may be incorrectly attributed to the child's disability. All people who work with disabled children will need to be alert to the possibility of abuse and seek advice from appropriately trained professionals (e.g. paediatricians, social workers, nurses, specialist teachers) if they are concerned that a child may be, or may have been, abused. When undertaking an assessment, practitioners should take into account the nature of the child's disability and how this may affect the interpretation of indicators of possible abuse or neglect.

3.2.7 Unknown male partners and their history/association with the family



Messages from research

- Professionals face the challenge posed by men involved in the lives of abused children. These men may be the natural or adopting father of the child, they may be the foster father of the child, or they may be the co-habitee or casual boyfriend of the mother of the child. Whoever the men might be, and whichever race or culture they may stem from, in the past they have often been ignored or avoided in child protection work.
- The accelerating fragmentation of family life and dramatic increase in substitute father figures (e.g. boyfriends, male partners, stepfathers), many of whom have had little involvement or responsibility within the single-parent families they join, makes the involvement of unknown male partners critical.
- Research by Thorpe (1994) revealed a high number of child abuse allegations made about single-parent mothers. In the authority for which the author worked, it was found that 274 child abuse referrals were made to 6 inner city teams in a single year; over 75% (211) involved single-parent mothers. Over 60% (128) of these mothers, however, had associations with male partners who had been living with them for varying amounts of time.
- The non-involvement of men may occur during any one of the 6 principal phases of child protection work, namely: referral, investigation, intervention, case conference, care proceedings or fostering. One might assume that it occurs more often during

the investigation or intervention phase, but its roots may well be established long before, in what the professional thinks and does during the initial referral phase.

- Types of avoidance of men during the referral phase of children include when those taking the referral concentrate all their questioning on, or about, the mother; few if any questions are asked about the male partner, even though it may be obvious from the outset that the male partner is a significant factor in the alleged abuse.
- There are as many differing consequences of the avoidance of men as there are types of avoidance. There are three main categories: consequences for the mother; issues in the management of the case; and consequences for the child. By leaving men out of assessments and interventions, the assessment of need and risk is inadequate.



Practice Note: Assessing unknown male partners

- Be clear as to who exactly lives in the household and their relationship and involvement with the mother and individual children.
- Insist on knowing the identity and carry out background checks accordingly.
- Involve and interview the new male partner as part of the assessment.
- Ensure that information on 'new men' accessing families is shared between agencies and assessments undertaken when necessary.
- The background information should include appropriate checks with other agencies and the subject of the checks should be interviewed by the allocated social worker.
- Information should also be obtained on other adults having substantial contact with the children, including occasional carers such as baby-sitters.

Case example – Baby Peter: There is demonstrable danger in the man that preys on vulnerable women who are unable to protect their children from him. One of the most dangerous of these situations is where an anti-social man who is unrelated to the children joins the

household. The woman may not be able to stand up for her children and protect them because he is too intimidating. She may minimise his importance and involvement to others. It is essential that once there is awareness of the existence of any unknown man in a child protection investigation, professionals in authority insist on knowing his identity and check out his background thoroughly. There was a clear failure to establish the identity of Mr. H, to interview him and conduct checks on his background.

Source: Jones, A. (2010) Haringey Local Safeguarding Children Board. Serious Case Review, 'Child A', March 2009.

3.2.8 Families who are 'uncooperative' or 'hard to engage'

There can be a wide range of uncooperative behaviour by families or family members towards practitioners. From time to time, all agencies will come into contact with families or family members who may prove to be apparently (but not genuinely) compliant, reluctant, resistant or sometimes angry or hostile to their approaches. In extreme cases, there can be intimidation, abuse, threats of violence and actual violence. These families are sometimes referred to as 'hard to engage', 'hard to reach', 'highly resistant' or 'uncooperative' families.

This could include families who do not demonstrate positive change despite intervention and support from child protection services.



Messages from research

- There are different ways in which families can be 'hard to engage' or 'uncooperative':
 - **Ambivalence** can be seen when people are always late for appointments or repeatedly make excuses for missing them; when they divert the conversation from uncomfortable topics or use dismissive body language. Ambivalence is the most common reaction and may not amount to non-cooperation.
 - **Avoidance** is a very common method of uncooperativeness and includes avoiding appointments, missing meetings and cutting short visits due to other apparently important activity (often because the prospect of involvement makes the person

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- anxious and they hope to escape it). Extreme avoidance may include not answering the door, as opposed to not being in.
- **Confrontation** includes challenging professionals, provoking arguments, and often indicates a deep-seated lack of trust, leading to a 'fight' rather than 'flight' response to difficult situations. Parents/carers may fear, perhaps realistically, that their children may be taken away or they may be reacting to them having been taken away.
 - **Hostility, threatened or actual violence**, by a small minority of people is the most difficult of uncooperative behaviours for the practitioner/agency to engage with. This may reflect a deep and long-standing fear and projected hatred of authority figures. People may have experience of getting their way through intimidation and violent behaviour. Practitioners need to be aware of their personal safety. Indicators include physical violence; shouting; swearing; throwing things; intimidating or derogatory language; written threats; the deliberate use of silence; using domineering body language; using dogs or other animals as a threat, which sometimes can be a veiled threat; racial abuse.
 - **'Disguised' or 'false compliance'** involves a parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention (Reder *et al*, 1993). They are not overtly rejecting 'contact' from professionals and/or other outside agencies, but rather using 'avoidance' tactics (e.g. have another appointment, forgot appointment, letter of appointment arrived late, being available at unsuitable times). Other examples of disguised compliance would be a sudden increase in school attendance, attending a run of appointments, engaging with professionals such as health workers for a limited period of time, or cleaning the house before a visit from a professional.
 - **Adults diverting attention away from children** and leading professionals to focus on adult issues and problems, causing a loss of focus on the individual child or children. The complexities of the adults' problems often overshadow and/or divert attention away from the children's immediate

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needs. All practitioners need to be vigilant in keeping the child in focus and direct observation of the parent–child interaction remains essential in these cases.

- A family's lack of engagement or hostility can hamper a practitioner's decision-making capabilities and follow-through with assessments and plans. Other research studies describe instances where practitioners became overly optimistic, focusing too much on small improvements made by a family rather than keeping the family's full history in mind.
- Professionals working with highly resistant families need to focus on the relationship between the parent and the child, rather than focusing too exclusively on the relationship between the parent and the professional (Juffer *et al*, 2007).
- Working with potentially hostile and violent families or family members can place social workers under a great deal of stress and can have physical, emotional and psychological consequences for them.



Practice Note: Working with 'hard to engage' or 'uncooperative' families

- When considering non-compliance and lack of cooperation by a parent or carer, professionals must consider if the child protection concerns have been explained clearly, taking into account issues of language, culture and disability so that parents or carers fully understand the concerns and the impact on their care and needs of the child. Professionals should seek expert help and advice in gaining a better understanding when there is a possibility that cultural factors are making a family resistant to having professionals involved.
- Practitioners must inform their line manager/supervisor of any concerns they have with regard to adults whom they have assessed as hostile or uncooperative, and seek advice and support in finding the most effective way to continue to work with the family.
- Supervision and support from managers in working with uncooperative families is essential.

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- Any professional or agency faced with incidents of threats, hostility or violence should routinely consider, in addition to the implications for themselves, the potential implications for any other professional or agency involved with the family and should alert them to the nature of the risks. Information sharing is crucial to protect professionals and children.
- When assessing uncooperative parents, a written contract could be used that explicitly states the child protection concerns, the action that the parents/carers should take and the consequences of continued lack of cooperation.

Consider the impact on the child

The practitioner needs to be mindful of the impact the hostility to outsiders may be having on the day-to-day life of the child and to consider what the child is experiencing. The child may:

- be coping with his or her situation with hostage-like behaviour;
- have become de-sensitised to violence;
- have learned to appease and minimise (e.g. Victoria Climbié always smiled in the presence of professionals);
- be simply too frightened to tell;
- identify with the aggressor.

Remember that although working with hostile families or family members can be particularly challenging, the safety of the child is the first concern. If professionals are too scared to confront the family involved, consider what life is like for the child on a day-to-day basis.

3.2.9 Poverty and Social Exclusion

Many of the families who seek help for their children, or about whom others raise concerns in respect of a child's welfare, are multiply disadvantaged. These families may face chronic poverty, social isolation, racism and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, childcare, transport and education services, and limited employment opportunities. Many of these families lack a wage earner.

Poverty may mean that children live in crowded or unsuitable accommodation, have poor diets, health problems or disability, are vulnerable to accidents, and lack ready access to good educational and leisure opportunities. When children themselves become parents, this exacerbates disadvantage and the potential for social exclusion. Racism and racial harassment are an additional source of stress for some families and children, as is violence in the communities in which they live. Social exclusion can also have an indirect effect on children through its association with parental substance misuse, depression, learning disability and long-term physical health problems.



Messages from research

Poverty

- The majority of people living in conditions of poverty and isolation do not maltreat their children. Children of middle and high-income families are also at risk of neglect and maltreatment at the hands of their parents or carers.
- However, a disproportionate number of victims come from low-income families with multiple problems. Poverty, particularly when interacting with other risk factors such as depression, substance abuse and social isolation, can increase the likelihood of maltreatment.
- Poverty contributes to parents' inability to protect their children from exposure to harm and has systemic negative effects on children's health and development, including impaired school performance, possible delinquency, early childbearing and adult poverty.
- Homelessness, which results from poverty, can exacerbate the situation.
- Stevenson (2007) makes it clear that we must explore the financial position of families when assessing and understand the impact of poverty on individual family members; consider particular difficulties in managing money; and consider including financial advice or assistance in any support plan.
- In the wider context of social isolation, it is important to ask the question as to where this family sits in the wider community and how do they access support.

Single parents

- Lower income, the increased stress associated with the sole burden of family responsibilities and fewer supports are thought to contribute to the risk of single parents maltreating their children.
- Studies in the USA showed that compared to children living with married biological parents, those whose single parent had a live-in partner had more than 8 times the rate of maltreatment overall, over 10 times the rate of abuse and more than 6 times the rate of neglect.

Black and Mixed Ethnicity Communities

- It has been recognised for many years in the UK that children from Black and Mixed Ethnicity (BME) communities are over-represented with children's specialist services. The studies suggest a number of reasons why this is the case, most commonly pointing to the following:
 - Lack of access to appropriate preventative services.
 - BME children are more likely to be resident in larger, poorer, more socially excluded households with higher rates of parental and child disability present within the household.
 - Adult unemployment, often linked to uncertain immigration status, could be excessively high among these communities. Poverty rates are also linked to living in larger families.
 - Families from BME populations may be reluctant to engage with services for a variety of cultural reasons, including inappropriate or inaccessible services, or disparity may exist in terms of practitioners' treatment of BME children and families with whom they engage.
 - Some BME communities may feel particularly reluctant to report concerns in relation to child protection for a combination of reasons, including fear of stigma or belief that children's welfare and protection could best be met by accessing support from within the family. Alternatively, it could be argued that under-representation in welfare statistics is, in fact, reflective of the degree of levels of parenting support available to families.
 - For BME families living in an area where they are part of a very small community, or indeed households where

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residents are a minority group within a larger or different BME population, greater risk of social isolation may exist.

- Institutional racism and the ways in which this may impact on professionals' engagement with and treatment of cases involving BME families have been raised in a number of high-profile serious case reviews, not least that of Victoria Climbié.
- There is no systematic bias that exists in decision-making concerning BME children, although professionals are often more hesitant and sometimes confused over how best to meet the needs of these children.
- Problems with receiving interpreting services have been regularly reported for families where English is not their first language. Inevitably, this impacts significantly on both comprehension of access to services and in engaging with child protection proceedings or working with service providers.

3.3 Child protection in a multicultural context

The population of Ireland has changed over the last 20 years and now embraces a wide range of faiths, cultures and ethnic origins. This means that practitioners must be acutely aware of the culturally sensitive approaches required to work with children and families from different backgrounds. It does not mean that cultural differences allow children to be abused.

Awareness of cultural factors must remain high since they influence all aspects of child protection, from the occurrence and definition through to its treatment and successful prevention. Any intervention to be successful, whether for data gathering, prevention or even increasing public awareness, must take into consideration the cultural environment in which it occurs. Background or baseline conditions beyond the control of families or carers (such as poverty, inaccessible healthcare, inadequate nutrition, unavailability of education) can be contributing factors to child abuse. Social upheaval and instability, conflict and war may also contribute to increases in child abuse and neglect. Practitioners will need to become familiar with the issues raised in allegations of:

- child trafficking;
- female genital mutilation;
- forced marriage;
- so-called honour-based violence.

These and other issues require the practitioner to consult their manager, take advice on the cultural context and work sensitively with the child and family, keeping the child's safety and welfare as their primary concern.

3.3.1 Child Trafficking

Types of exploitation include domestic servitude, forced labour, forced criminality (street crime, petty theft, cannabis cultivation, drug dealing), prostitution or sexual abuse, illegal adoption, benefit fraud and forced marriage. Children may be trafficked within their own country or across borders. Irish children are also vulnerable to trafficking.

Signs that a child may have been trafficked

The following are some indicators that a child may have been trafficked (this is not a full list and not all of the indicators will apply to every child):

- symptoms of abuse (physical, sexual, emotional, neglect);
- child is recovered from a place of exploitation or reports exploitation;
- child's account appears coached or is similar to stories told by other young people;
- child harbours excessive fears;
- history of going missing or unexplained moves;
- not enrolled at school or with GP;
- registered at a 'hot' address;
- child never in when you visit;
- significantly older boyfriend;
- reluctant to provide details – personal, daily life, journey;
- unregistered private fostering arrangement;
- adult is not legal guardian and insists on staying with child;
- adult has brought other children into country previously/acted as guarantor on visa;
- adult claims not to have any documents for the child;
- restricted freedom of movement;
- owes money to people (e.g. for travel costs) or is deprived of earnings;
- entered country illegally, has false documentation;

- is unable to confirm the name and address of the person meeting them or arrives with a contact number of an unknown adult;
- has no money, but has a mobile phone;
- adults loiter around accommodation.

Traffickers are adept at avoiding the attention of the authorities and trafficked children are at high risk of disappearing. Whenever there are suspicions that a child may have been trafficked, it is important to act promptly before the child goes missing and to assess the child's levels of need/risk of harm.

3.3.2 Forced Marriage

A forced marriage is where one or both spouses do not consent to the marriage or consent is extracted under duress. Duress includes both physical and emotional pressure. Forced marriage cannot be justified on religious grounds and every major faith condemns the practice.

It is very important that a forced marriage is not confused with an arranged marriage, a tradition that has operated successfully in many communities. An arranged marriage involves the families of both spouses taking a leading role in arranging the marriage, but where the choice whether or not to accept the arrangement remains with the young people.

In Ireland, where the parties are under 18 years of age, the permission of the Circuit Court or High Court is also required (Family Law Act 1995). An application has to be made by the parents of each party who is under the age of 18 years, i.e. if both are under 18, then both sets of parents are required to make application; if only one is under 18, then that person's parents must apply. Marriage under the age of 18 would be culturally normal in a number of ethnic minority groups.

Where a young person under 18 is in the care of the HSE and wishes to marry, the application still has to be made by the parents, but the permission of the HSE is also required by the Court. Such situations have to be carefully assessed by the social worker since there have been examples where young people under 18 years have been pressured by their family to enter into an unsuitable marriage in order that the young person can come out of HSE care.

3.3.3 Female Genital Mutilation

Female genital mutilation (FGM), sometimes mistakenly referred to as female circumcision, is defined by the World Health Organization (WHO) as the range

of procedures that involve *'the partial or complete removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reason'*. FGM is typically performed on girls between the ages of 4 and 15, although in some cases it is performed on new babies and on young women prior to marriage. There are severe consequences to FGM, both psychological and emotional, while the medical consequences include extreme pain, shock, infection, haemorrhage, infertility, incontinence, HIV or death.

3.3.4 So-called Honour-based Violence

So-called honour-based violence, i.e. crimes committed in the name of honour, have been defined in various ways, but an 'honour' crime tends to be differentiated from other forms of domestic violence or killing on the grounds that it involves a premeditated act to restore family honour, with some degree of approval and/or collusion from the family and/or community. Usually the person is being punished for actually or allegedly undermining what is believed to be the correct code of behaviour. By not conforming, it may be perceived that the person may have brought shame or dishonour to the family or community. Women are predominantly (but not exclusively) the victims of so-called honour-based violence.

In addition, so-called honour-based crimes could include:

- attempted murder;
- manslaughter;
- procuring an abortion;
- encouraging or assisting suicide;
- conspiracy to murder;
- conspiracy to commit a variety of assaults.

3.4 Best practice for the use of interpreters

Within the context of a changing Irish society, the HSE Children and Family Services must be aware of the linguistic diversity of its clients. It is therefore vital that the services of interpreters who act in a fair, effective, impartial and courteous manner are engaged. Correct use of a skilled interpreter ensures that Children and Family Services receive and provide accurate information in order to meet its duty of care obligations. There will be occasions where interpreters should be offered in order to ensure that the family can fully participate in the assessment process. This should be identified at an early

stage in the process by the social worker. The Courts Service should be notified of this in advance in order to avoid adjournments or delays.



Practice Note: Best practice principles for the use of interpreters

- Promote access to interpreter services.
- Ensure strict confidential agreements.
- Be clear with the interpreter service about roles and responsibilities in the process of engagement with the family.
- Provide fair, accessible and responsive services that must be planned ahead where possible to meet the client's needs.
- Specify who can be used as an interpreter.
- The HSE should ensure that those used as interpreters are Garda-vetted and fully trained in the use of *Children First: National Guidance* (2011).
- The use of friends, family members and children as interpreters should be avoided.
- Interpreters should not be family members where child protection work is being undertaken.
- Maintain good records.
- Social Work teams should keep a record of clients' interpreter needs, including language and dialect, and whether the interpreter is required for oral and written communication. Where an interpreter is offered but declined by the client, this should also be recorded.
- Promote qualified interpreters who can work in partnership in the best interests of the child.

3.5 Assessment practice in child protection and welfare

Always consider the immediate safety of the child first and act accordingly.

Assessment is an integral part of social work with children and families. Practitioners continually endeavour to enquire, observe and make sense of the circumstances of a child's life, with a particular focus on developmental needs, harm, risk of harm, relationships, parenting capacity and environment.

Assessment is not an end in itself, but a means to developing meaningful strategies to improve outcomes for children.

Although assessment is an ongoing process, formal assessments using standard templates are required at critical junctures. In all cases, the following guidance will serve to enhance engagement with children and parents, while promoting rigorous analysis and decision-making.

It is important to note that assessment is undertaken within the context of relationships between practitioners, children and their families.

3.5.1 Key matters to consider in assessments



Messages from research

- Good social work practice requires forming a relationship with the child and family, and using professional reasoning to judge how best to work with the parents.
- Parenting capacity should be considered in all cases. This involves taking account of parental history as well as assessing the 'here and now'. This means finding out about an adult's own experience of being parented and forming a view as to how they have processed any experiences that may have caused them harm or upset.
- Assessments must be individualised and tailored to the unique strengths and needs of each family.
- Any assessment of needs and risks must include everyone in the household and in a position of care of the child, where possible.

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- Assessments should be culturally sensitive, while at all times being in compliance with the legislation. Professionals must acknowledge and show respect for the values and traditions of families from diverse cultural, ethnic, and religious backgrounds.
- The needs of the parents and families should never take priority or mask in any way the needs of the child.
- No delay. Interventions should not be delayed until the end of an assessment, but should be determined according to what is required to ensure a child or young person's safety, taking account of any indications of accelerated risks and warning signs.
- A description of events and circumstances is not an assessment. Assessment only has meaning when you apply your professional judgement and analyse the information and evidence that you have gathered in relation to the safety and well-being of the child with whom you are working.
- Risk assessment tools are not ends in themselves. Risk assessment matrices and checklists can be helpful in guiding understanding, but they cannot be absolutely relied upon to provide definitive answers to levels of risks faced by children.
- Good risk assessments construct a coherent story about the child's circumstances. They appreciate that there will be ambiguity and uncertainty about some matters; they have been constructed through the testing of hypotheses and a curiosity that sees people in their contexts; they are considered and thoughtful; and finally they allow for and enable change.
- Assessments are fallible and contexts are constantly changing. Therefore, professionals need to keep their judgements under constant critical review (Munro, 2008). Practitioners must be willing, encouraged and supported to challenge and, where necessary, revise their views throughout the period of any intervention.

Ireland: Serious Case Inquiries – Recommendations about assessment practice

Abbreviations: KF = Kelly Fitzgerald (1996); KI = Kilkenny Incest (1993); RO = Roscommon (2010); WI = West of Ireland Farmer (1998).

Assessment

Social workers should see and speak directly to every child where there is a concern about their welfare. It should be the responsibility of the Social Work Team Leader and the (Professional Manager 1) to ensure that this is done. Working directly with children and families are core social work tasks and their training provides them with the knowledge, skills and competencies required for this work.	Ro 5.3.1
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The formulation of an assessment must be priority, whether based on the outcome of the initial investigation, following a case conference or on the recommendation of a worker specifically assigned to gather all available information for a subsequent case conference.	KF
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Care should be taken to work with both parents and in particular workers should be proactive in seeking to engage fathers.	Ro 5.3.3
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It is recommended that the views of parents should be taken into account and checked against the facts and the views of concerned others.	Ro 5.3.6
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Third parties who express concerns should be interviewed as part of the assessment of the family. Full assessments require that those reporting concerns are interviewed wherever possible and their concerns investigated fully. The provision of feedback to those reporting concerns should follow the process outlined in the revised <i>Children First: National Guidance</i> (2011).	Ro 5.3.5
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It is recommended that all personnel be alert to parents and carers who consistently try to divert attention away from the primary concern, which is the well-being of the children.	Ro 5.3.6
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Where there are ongoing concerns of child neglect, as in this case, the appropriate frequency of home visits by the family's social worker should be agreed and carried through.	Ro 5.3.3
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Warning signs to look out for when carrying out an assessment

Serious Incident Reviews repeatedly describe ‘warning signs’ that agencies have failed to recognise or take account of, or that should have acted as indicators that children and young people were at risk of serious harm. Examples include:

- Children and young people might be hidden from view; they are ‘unavailable’ when professionals visit the family.
- Children and young people who might be prevented from attending school or nursery, or accessing healthcare or other services.
- Parents who do not cooperate with services, fail to take their children to routine health appointments and/or discourage professionals from visiting.
- Parents who appear to cooperate, but do so only in a superficial manner.
- Parents who are consistently hostile and aggressive towards professionals and might threaten violence.
- Children and young people who are in emotional or physical distress, but might be unable to verbalise this.
- Children and young people who are in physical pain (possibly from an injury) might be told to sit or stand in a certain way when professionals visit the family or might hide or otherwise disguise injuries.
- Children and young people who have gone missing/run away (with or without their families).
- Concerns relating to actual or potential harm should never be ignored and are an indication that immediate intervention might be needed to ensure the protection of the child from future harm.
- Actions to protect children and young people should never be delayed and where applicable, emergency measures should be considered.



Possible pitfalls and questions for practitioners and supervisors to address in practice

1. **An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.**

Questions for Practitioners – ask yourself:

- Am I remaining curious and inquisitive about what I am seeing and assessing?
- Am I open to new information?
- How confident am I that I have sufficient information upon which to base my judgements?
- Do I need to add a 'health warning' about the strength of evidence contained in this assessment and the implications for decision-making?
- Would I be prepared to change my mind about this case?
- Is sufficient time being allowed for critical reflection and evaluation of my judgements and decision-making?

2. **Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.**

Questions for Practitioners – ask yourself:

- Did you feed back your recording of the referral to the referrer and check for accuracy, as well as agreeing actions and method for feedback?
- Did you actively question the referrer to ensure you got as much information as possible and fleshed out anything that was unclear or incomplete?
- Have you checked that you have extracted the most important details from all of the details provided? If you did not check your notes against information from the referrer at the point of referral, what steps have you taken to do this subsequently?
- Do my notes record what action I have taken/will take? What action all other relevant people have taken/will take?

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3. Attention is focused on the most visible or pressing problems; case history and less 'obvious' details are insufficiently explored.

Questions for Practitioners – ask yourself:

- What is the most striking feature of this situation and if it were removed, would there still be concerns?
- Have I considered the presenting issue in context?
- Have I carefully examined a case history or have I been tempted to ignore it?
- Is there an up-to-date chronology from which trends and patterns can be identified?

4. Insufficient weight is given to information from family, friends and neighbours.

Questions for Practitioners – ask yourself:

- Would I react differently if these reports had come from a different source?
- How can I check whether or not they have substance?
- Even if they are not accurate, could they be a sign that the family are in need of some help or support?

5. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.

Questions for Practitioners – ask yourself:

- Do I have the confidence to challenge parents appropriately and to be honest and open about my concerns while acknowledging strengths?
- What is my relationship with the parent(s) and how does this influence my assessment?
- Have I spoken with, and listened properly to, those who know the parents better than I do?
- Am I open to being deceived (seduced/intimidated/threatened)?
- Have I unpicked and understood the difference between perceived and actual risk? If not, how can I get support with this case?
- Do I know who lives in/frequents this house and have I assessed their relationship to the child/potential risk?

- Have I taken steps to get to know other significant adults/absent parents who have a bearing on the child's life?

6. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.

Questions for Practitioners – ask yourself:

- Have I made a robust assessment of the support that this young person has in his/her formal/informal networks?
- Am I overly optimistic about this young person's resilience to presenting risks?
- Would I treat this young person differently if he/she were a much younger child, and is that appropriate?
- Have I probed this young person's history/presentation regarding risk factors, including going missing, self-harm, suicidal ideation and signs of child sexual exploitation?

7. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.

Questions for Practitioners – ask yourself:

- Am I open to being deceived?
- Am I open to and curious about information?
- Do I understand rules of information sharing and protocols?
- Do I ever use sentences like 'Well, I've told X' to alleviate my own anxiety about a case?
- Do I own professional responsibility for my role or am I overdependent on my manager?
- How can I ensure that information I have passed on has been understood?

8. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The Department may inappropriately signpost families to other agencies, with no follow-up.

Questions for Practitioners – ask yourself:

- Am I routinely writing to agencies to keep them informed at key points in a case, e.g. on completion of assessment, case closure or case transfer?

- Am I open to discussion with partner agencies regarding concerns on children?
- Am I clear and have I clarified respective roles and responsibilities with partner agencies?
- Do I know colleagues working in partner agencies locally and do I understand how they work?

Source: NSPCC (2010)

3.5.2 See life from the child's point of view



Messages from research

- The child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings.
- Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute.
- Parents and carers prevented professionals from seeing and listening to the child.
- Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.
- Agencies did not interpret their findings well enough to protect the child.

Keep the child as the focus point

- The needs of each individual child should be paramount.
- There may be an assumption that needs of 'the family' are consistent with the needs of all the family members, a factor which is not necessarily so.
- **Pay attention to what children say, what they do, how they look and how they feel.**



Practice Note: Focus on the child

Broadhurst *et al* (2010) suggest that practitioners clearly 'base judgements on evidence, not optimism'. In addition, the authors urge practitioners to 'see life from the child's point of view' and ask practitioners to consider whether the case file gives a real sense of the child's views and what life is like for them on a daily basis.

(continued)

Key questions to ask yourself

- Have I been given appropriate access to all the children in the family?
- If parents are cooperative, what type of cooperation was it? Was it, for example, ambivalent/hostile/confrontational?
- What is the child's account of his/her situation and needs?
- Have I taken full account of the child's additional communication needs, for example, in the case of children who are deaf or disabled?
- Have I sought appropriate specialist expertise to facilitate communication?
- If the child uses a language other than English, or a method of alternative non-verbal communication, have I made every effort to enlist help in understanding him/her?
- Did the interview with the child appear coached?
- What is the evidence to support or refute the child/young person's account?
- If I have not been able to see the child, is there a very good reason and have I made arrangements to see him/her as soon as possible?
- How should I follow up any uneasiness about the child(ren)'s health or well-being?
- What do I know about this child?
- Do I know what they enjoy, like, dislike, etc?
- How is the child moving, e.g. when crawling or walking?
- Have I consulted other relevant/specialist practitioners who have contact with the child to draw on their observations of any significant changes in the child's well-being or behaviour?
- Would I draw this conclusion or make this decision if the child were not disabled? Would I have taken any further protective action if they were not disabled?

Getting to know the child

As well as gathering information on the needs of the child and the manner in which the needs are being met, the practitioner must, as far as possible, try to get a 'sense' of the child, which requires more than factual information. As well as knowing the child, the practitioner should, by the completion of the assessment, be in a position to describe an average day in the child's life during school term, if relevant, and during the holidays.

Being able to describe a day in the life of a child means knowing:

- What happens to the child in the morning? For example, does anyone get him or her up in the morning? Does he/she have anything to eat? Are clean clothes available? Does the child have a wash? Who, if anyone, is responsible for getting them ready in the morning?
- What are the arrangements for bringing him/her to child-minder/nursery/school (as appropriate)? Is the child expected to make his/her own way or take siblings to child-minder/nursery? Is this age-appropriate?
- How does he/she spend the morning, whether at home, child-minder/nursery or school? Is the child tired and/or hungry at school? If at home, is the child supervised?
- What happens at lunchtime? Is lunch provided? What happens in the playground? Does the child have friends?
- Who collects him/her, if relevant, or is the child expected to find their own way home or take responsibility for other children? Is this age-appropriate?
- What does he/she normally do after school (in term time) or during the day in the holidays? Is the child expected to care for him/herself and/or others? Are they expected to get food for themselves and others? Is this age-appropriate? Is food available?
- Where does he or she play? At home? Outside? In a friend's house? Does he/she have friends over to his/her home to play? What types of activities does the child enjoy and what do they do? Does a responsible adult know where the child is and what they are doing? Is the child expected to run errands?
- Who is usually in the family home in the evenings? Is the child left on their own or in charge of other children or dependent adults? Is it age-appropriate?
- Does the child have an evening meal?
- What does the child do in the evenings, in term time or otherwise?
- What happens about the child going to bed? Where does the child sleep? Does anyone tell the child when to go to bed? Do they have a bedtime routine, e.g. washing, brushing teeth, changing clothes?
- Who stays in the house overnight? What impact does this have on the child? For example, is it too noisy for the child to sleep?

Source: Buckley et al (2006)

3.5.3 Attachment

Children may appear to display a strong attachment to an abusing parent, but, in fact, such an attachment is disorganised and insecure since it is virtually impossible for a child to form sound attachments within a dysfunctional family. In addition, we are also satisfied that, in fact, the children were coached by the parents to give the impression to outsiders that all was well and that this was not picked up by the professionals involved.

Source: Roscommon Child Care Inquiry (2010)

The dynamic interplay between a child's inner world and their social environment has become an important focus of enquiry in the area of child protection and welfare. The quality and character of a child's primary relationships is critical to their developmental progress and directly impacts on some key aspects of their capacity to function as adults. It is believed that the early months and years of a child's life are of particular importance in establishing secure attachments to their parents or other primary caregivers.

Attachment theory focuses on how attachments are formed in the very earliest months and years of life and contributes to an understanding of the effects of adverse parent-child relationships on life outcomes for children. Its inclusion in social work assessments can make an important contribution to intervention planning. Attachment behaviour is a complex phenomenon and judgements made about the quality of attachments in the course of social work assessments may be limited to observation of parent-child interaction during home visits or may be based on a thorough clinical assessment.

A wide range of factors influence child development, including family functioning, the environment and the larger socio-economic community. The early years of a child, particularly the first 3 years, are extremely important since this forms the foundation for development in all areas of a child's life.

When talking about children being attached to the caregiver, we mean a child having a tendency to seek proximity to and contact with the specific caregiver in times of danger, distress, illness and tiredness (Bowlby, 1984 as cited in Iwaniec, 2006). These attachments to only a few people are thought to be formed by the age of 7 or 8 months. Children are thought to become attached whether or not their parents are meeting their physiological needs. Findings show that infants become attached even to abusive mothers (Bowlby, 1958 as cited in Iwaniec, 2006).

There are several forms of attachment:

Secure attachment

Secure attachment occurs when a child builds a mental representation based on accumulated positive experiences of an attachment figure who is available and responsive to his or her various needs and signals of distress. Parents/carers are consistent, sensitive, present, warm and attuned, thereby establishing a trustworthy psycho-social environment in which the child can prosper. Even in times of stress, the child has confidence that the caregiver will be responsive to their needs. The pattern is reciprocal – the caregiver’s own confidence and self-esteem is enhanced by successfully responding to the child.

Insecure attachment

Insecurely attached children are considered as lacking positive mental representation because their basic needs are not being attended to – often due to neglect, emotional unavailability and abuse (Iwaniec, 2006, p. 96). Parents/carers are unable or unwilling to prioritise the normal psycho-social needs of their child and the child’s developmental pathway can be significantly compromised. Resulting attachment patterns can be characterised as ‘avoidant’ or ‘ambivalent’, as follows:

- *Avoidant attachments* arise where parents are inclined to dismiss the emotional dependency of the infant or child, and reward behaviour that is undemanding. The child represses the normal expression of discomfort or distress, thereby displaying developmentally inappropriate and misleading independence.
- *Ambivalent attachments*, on the other hand, occur where a parent/carer is more concerned with feeling valued by the child and others rather than attending to the child’s needs. The child has to exaggerate discomfort and distress in order to activate parental response. Normal attachment behaviour by the child is not attended to consistently by the parent/carer.

Disorganised attachment

Avoidant and ambivalent attachment behaviours by the child can be characterised as organised in that they represent strategies that secure some degree of parental availability (Howe, 2005). However, where parents/carers are abusive towards their children or behave in ways that frighten them, the attachment pattern can be considered as disorganised. Parents/carers with significant unresolved childhood issues of their own are often associated with disorganised attachment. The maltreated or frightened child must turn for comfort to the person who is causing them harm. Normal developmental progress with regulating behaviour and emotions is severely disrupted, often leading to later challenging, anti-social or delinquent behaviour.

Impact on children

Whether the child is securely or insecurely attached to the primary caregiver can have both immediate and long-term consequences. Many research findings postulate that insecure attachment in infancy may influence subsequent behaviour, such as impulse control, conflicts and struggles with caregivers, difficulties in adaptations and seriously problematic peer relationships (Iwaniec, 2006, p. 109).

Failure to establish a responsible and caring relationship between parents and children can result in a number of problems, including development of a poor sense of self with resultant interpersonal difficulties; a tendency towards negative self-evaluation; dysfunctional cognition; and an impaired repertoire of defences and coping strategies (Ingram *et al*, 2001 as cited in Iwaniec, 2006).

Early abuse is extremely damaging to a child's developing brain and chronic and severe neglect is associated with major impairment of growth and failure to thrive, with long-term intergenerational effects. Failure to properly nourish a child, inflicting physical pain and injury, emotional injury or ignoring emotional needs of a small child can result in developmental delays across the broad spectrum, including cognitive, language, motor skills and social skills.

3.5.4 Carrying out Home Visits



Practice Note: Matters to consider when doing home visits

Planning: Are you clear about the purpose of every home visit and how this fits in with the overall assessment and outcome planning process for each individual child? **Preparing for a home visit is crucial.** It is important to stay on track and keep the focus on the child, not to get distracted by the issues that adults may present to divert attention from the child(ren).

Seeing the child: Are you in a position or you been able to meet each child individually and interview him or her separately to the parents? If permission is refused, the worker must reflect on the reasoning behind this and discuss with their supervisor or line manager if they have concerns.

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Home conditions: Are you in a position or have you been able to see conditions in the family home, including kitchen, bedrooms and bathrooms? Particularly in the initial stages of an investigation or in ongoing neglect cases, this may be necessary to do on an ongoing basis in order to determine whether changes have occurred.

Recording and analysis: Ensure that your observations are clearly recorded and the impact that the living environment has on the care, safety and well-being of the child. In this way, you can build up a picture of what life at home is like over time and whether any intervention and/or support from your/other services and agencies are having a positive impact.

Share information: Check your observations with other agencies/professionals involved with the family.

Critical reflection: This and an awareness of one's own emotional responses to home visits are vital. For example, it can come as a relief to a social worker if difficult families are not home when they call or they may avoid asking challenging questions of the family. Workers should share these feelings in supervision and reflect on how their own emotional response affects observations and how often they visit.

Sensitivity to cultural differences: Some families, for example, will appreciate if you offer to take your shoes off before walking into their house.

Safe working policies: About one-third of families can be hostile and resistant. Where a family is known to be hostile, joint visits are recommended. Social workers should carry mobile phones and report their whereabouts to managers. Mechanisms should be in place if social workers fail to return when expected. Please see Section 4.2 of the Practice Handbook for 'Personal Safety Questions and Risk Checklist for Practitioners'.

Key issues/points to check during a home visit

- Who exactly lives in the household, including lodgers/temporary visitors? What is their relationship and involvement with the parents/carers and children?
- Is there adequate heating, gas and water?
- What are the levels of hygiene of both the household and the children?

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- How are children kept clean?
- What are the sleeping arrangements for each child?
- What is the availability of appropriate clothing, bed linen, furniture?
- What is the availability of food for children, including age-appropriate food for younger children? Cupboards and fridges should be checked for food.
- Is the home environment safe for children?
- Is there adequate ventilation in the home?
- Are there any animals in the house? What is their level of care?
- What is the availability of toys, books, age-appropriate stimulation and development?
- Is the housing appropriate, e.g. wheelchair accessible, not overcrowded?

Always ask yourself whether you have a good picture of what life is like on a daily basis for each individual child in the household.

Scheduled *versus* unannounced visits

It must be determined whether it is in the child's best interests for the social worker to initiate an unannounced visit to interview the parent or to contact the parent to schedule an interview. The decision regarding announced or unannounced home visits will be based on a consideration of the following:

- the severity of the reported child protection concern;
- the child protection worker's ability to protect the child and to gather information in sufficient detail;
- the likelihood that the family will flee from the current address or jurisdiction.

Announced visits are generally preferred where it is assessed that there are no immediate threats to the child's safety. Arranged visits may be experienced by the family as being more respectful and may maximise the potential to engage the parent/caregiver in a discussion regarding the alleged concerns and possible solutions.

Unannounced visits may be necessary when:

- the worker needs to determine whether or not the perpetrator is in the home;
- there is fear that a family may flee;

- it is not possible to contact the family to arrange an appointment;
- it is necessary to interview the child immediately;
- it is necessary to assess the child's living conditions without the family having the opportunity to modify any of its usual conditions.

If, for any reason, the worker cannot gain entry and the concerns are of a serious nature (e.g. children being left alone), the Gardaí must be called.

3.5.5 Links between child abuse and cruelty to animals



Messages from research

There is increasing research and clinical evidence suggesting that there are sometimes inter-relationships, commonly referred to as 'links', between the abuse of children, vulnerable adults and animals (NSPCC, 2005). A better understanding of these links can help to protect victims, both human and animal, and promote their welfare.

Evidence of the links between child abuse, animal abuse and domestic violence is drawn mainly from studies in the USA that relate to cases of serious abuse. There is a growing research base in the United Kingdom.

Key findings include:

- If a child is cruel to animals, this may be an indicator that serious neglect and abuse have been inflicted on the child.
- Where serious animal abuse has occurred in a household, there may be an increased likelihood that some other form of family violence is also occurring and that any children present may also be at increased risk of abuse.
- Acts of animal abuse may in some circumstances be used to coerce, control and intimidate women and children to remain in, or be silent about, their abusive situation. The threat or actual abuse of a pet can prevent women leaving situations of domestic violence.
- Sustained childhood cruelty to animals has been linked to an increased likelihood of violent offending behaviour against humans in adulthood. However, this does not imply that children who are cruel to animals necessarily go on to be violent adults and adults who harm animals are not necessarily also violent to their partners and/or children.



Practice Note: Matters to watch out for

- Incorporate questions and be observant about the care and treatment of family pets in assessments of children and their families. Research indicates that most agencies do not routinely include cruelty to animals as part of their assessment.
- Incorporate questions about the behaviour of children or young people towards animals within assessments of children or young people who are harming others.
- Safety planning with victims of domestic violence should include planning for the safety of any children and animals in the household.
- While not making any assumptions, consider the possibility that children who are repeatedly harming animals may have been abused themselves or may be living in a climate of violence.
- Seek advice from the appropriate authorities if animal abuse is apparent within the household.

3.6 Assessing Parenting Capacity

Parenting capacity is the ability to parent in a 'good enough' manner long term. The term 'parenting capacity' is therefore differentiated from the term 'parenting ability'. An individual may be able to parent for a short period of time in specific circumstances (e.g. a supervised visit) and therefore demonstrate parenting ability, but not the parenting capacity to parent effectively over the long term.

Key areas of parenting capacity are basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, and stability.



Practice Note: What to look for when assessing parenting capacity

One needs to consider parent–child interaction and parental readiness to change, parents' understanding of concerns and parents' intention and commitment to change. As a practitioner, it is important that you establish the actual evidence to answer these questions.

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Where there is cause for concern about what is happening to a child, it is important to gather information about how parenting tasks are being carried out by each parent/carer in terms of:

- their response to a child and his or her behaviour or circumstances;
- the manner in which they are responding to the child's needs;
- the areas where they are experiencing difficulties in meeting needs;
- the effect this child has on them as individuals and parents/carers;
- the quality of the parent–child relationship;
- their understanding of the child's needs and development;
- their understanding of concerns about the child's safety and/or well-being;
- their comprehension of parenting tasks;
- the relevance of the parenting tasks to the child's developmental needs;
- the impact of any difficulties they may be experiencing themselves on their ability to carry out parental tasks and responsibilities;
- the impact of past experiences on their current parenting capacity;
- their ability to face and accept their difficulties;
- their ability to use support and access help;
- their capacity for adaptation and commitment to change in their parenting response.

Does the assessment list and answer specific questions? It should:

- Clarify what issues or questions are to be addressed regarding parental functioning, the problems or events that have given rise to the concerns, and the outcomes or options that will be affected by the findings.
- Provide a chronology of assessment activities, including full details of actions taken.
- Ensure the language used is written in a format that is clearly understandable for all involved (e.g. avoid use of jargon/give explanation of professional terminology).
- Avoid making definitive generalisations or statements that cannot be substantiated (e.g. 'This parent is unable to love because of her own history of deprivation.').
- Offer a recommendation for action that keeps the needs of the child or children at the centre and their welfare paramount.

3.6.1 Working with fathers/male partners as part of the assessment

See *also* Section 3.27 on 'Unknown male partners'



Messages from research

- Research shows that child welfare systems are often not making adequate efforts to establish contact with fathers, even when fathers were involved with the family.
- Agencies are less likely to assess the needs of fathers, to search for paternal relatives as possible placements or for other involvement, or to provide fathers with services as they do for mothers.
- If the mother was not contacted, then the father was also not likely to be contacted.



Practice Note: Working with fathers/male partners

If the father of the child is not living with the family, all efforts must be made to locate and involve him in the assessment/investigation and, if possible, any intervention plan for the child. Engaging fathers in the assessment or the plan (the latter may include therapeutic help) is crucial to a comprehensive assessment, where the child is central. The importance of parental roles is clear, yet research shows that the focus of many assessments is the mother.

Excluding fathers from assessments can mean that both positive and negative effects of an important element of the family relationship may be missed. When engaging fathers in assessments, practitioners should bear the following points in mind:

- Physical absence of fathers should not be equated with psychological absence.
- It is not advisable to make a second- or third-hand assessment of the father role in a child's life.
- It is unfair to put a child's mother in the situation where she is allocated all responsibility for her child's safety and welfare, and forced to mediate between her family and child protection and welfare services.

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- It is important to ascertain how a father figure understands his role as a responsible parent and positive role model and carer.
- It is important to ascertain a father's role in the child's everyday life, how he understands and meets the child's needs, how much time he spends with the child and the nature of the relationship that exists between them.
- It is important to ascertain the degree to which the father and the child's mother agree on aspects of parenting, particularly boundary setting and discipline.
- It is important not to apply different standards of care to fathers.
- It is also important to assess significant males in the family unit since often not enough information is known on these people (e.g. new partners).
- It is important that all referrals are examined in detail for accuracy and that no information is minimised by professionals, for example, allegations made in 'custody and access' cases or 'bad family or community relations'. Each referral must be investigated on the evidence presented. There may be truth in the allegations and checking for credibility can at times be a challenge.
- Time should be spent with each member of the family, both together and separately, explaining the purpose and process of assessment.
- Time should be spent observing the interaction between children and carers.
- Research has shown that investigations and assessments of child protection and welfare concerns often focus solely on the child's main carer. Children should always be included in the assessment process, along with their siblings.
- Always check differing or inconsistent explanations about any indication of harm to the child.
- Explore as many options available to the assessment process to ensure information received has credibility.

3.6.2 Evaluating child and family progress

Evaluating whether risk behaviours and conditions have changed is central to case decisions. Monitoring change should begin as soon as an intervention is implemented and should continue throughout the life of a case until appropriate outcomes have been achieved.

The importance of evaluating family progress is to help answer the following questions:

- Is the child safe? Have the protective factors, strengths or the safety factors changed, warranting a change or elimination of the safety plan or the development of a safety plan?
- What changes, if any, have occurred with respect to the conditions and behaviours contributing to the risk of maltreatment?
- What outcomes have been accomplished and how does the case worker know they have been accomplished?
- What progress has been made toward achieving case goals?
- Have the services been effective in helping clients achieve outcomes and goals and, if not, what adjustments need to be made to improve outcomes?
- What is the current level of risk in the family?
- Have the risk factors been reduced sufficiently so that parents or caregivers can protect their children and meet their developmental needs so that the case can be closed?
- Has it been determined that reunification is not likely in the required timeframe and there is no significant progress toward outcomes? If so, is an alternative permanent plan needed?

3.7 Supervising the assessment



Practice Note: Overseeing assessments

The questions below (from Macdonald, 2001 as cited in Buckley *et al*, 2006) provide a measure for judging the quality of an assessment and may be useful as a guide for recording. In the case of an initial assessment, the standard implicit in the questions will be only partly met.

Does the assessment:

- Begin with a clear statement of the purpose of or reasons for the assessment?

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- Say what was done in order to complete the assessment (and some indication of why)?
- Confirm that the purpose of the assessment was explained to all family members concerned and record their responses?
- Confirm that the nature of the assessment and the expectations placed on family members were made clear at the outset and record the responses of family members?
- Contain a summary of who's who in the family, possibly in the form of a genogram?
- Contain a social history?
- Provide evidence that the reasons why a certain kind of information is being sought is understood by family members, possibly as a statement to that effect?
- Contain the expressed views of all key parties, including children?
- Provide evidence that the views of the children have been sought/obtained in ways that are age-appropriate?
- Provide evidence that when indirect methods are used to obtain children's views (e.g. play), the theoretical or empirical basis used to organise the session(s) is made clear and appropriate caution is used in interpreting the findings?
- Use a number of sources of evidence (from different people, including other professionals)?
- Use a number of different types of evidence (including standardised measures, direct observation, official records/growth charts, as well as interview data)?
- Take a critical approach to the evaluation of evidence, e.g. consider alternative explanations, include attempts to measure problems (e.g. frequency, duration, intensity)?
- Provide evidence of a broad-based approach to data collection, covering all levels of influence relevant to child development and well-being?
- Provide evidence that the questions asked and topics covered reflect an up-to-date and sound knowledge base relevant to the main presenting problem(s)?
- Make it transparent to the reader why certain areas have been probed and others left?

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- Make explicit any theoretical assumptions made when recording and interpreting information, e.g. regarding the nature of attachment and its implications for development, the reasons for neglect, and – if known – the empirical support for such an assumption/theory?
- Consider alternative explanations or interpretations when drawing conclusions about the significance of particular aspects of a family's history or present circumstances?
- Include a problem formulation? This is a summary statement of the assessor's understanding of how a set of affairs has come about, what is maintaining the problem or problems, and what is preventing their resolution?
- Provide a rationale for the choice of problem formulation when alternative explanations or conclusions are possible?
- Phrase the problem formulation in a way that can easily be shown to be wrong?
- Provide evidence that information has been shared with family members and differences of opinion have been either resolved or noted if irresolvable?
- Make suggestions for interventions that are logically related to the problem formulation?
- Say what level of assistance is necessary?
- Say from whom this assistance should be sought?
- Indicate likely frequency, duration and intensity of assistance required?
- State clearly how progress/improvements will be monitored, including both qualitative and quantitative indicators?
- State clearly how one will be able to tell if the intervention were to prove successful?
- Make suggestions for an appropriate system of recording?
- Identify a maximum period for review?

An important supervisory task, in addition to the above, is to acknowledge and address the coping mechanisms that are commonly employed by practitioners in order to manage the emotional nature of the task. These mechanisms include:

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- **The fixed idea:** adhering to one hypothesis regarding a case irrespective of other information available that may refute the hypothesis. For example, the view that improving the family's accommodation situation would lead to automatic resolution of other problems.
- **Over-optimism:** focusing on the strengths in the family and underplaying the weaknesses.
- **Over-pessimism:** focusing on the weaknesses and issues and ignoring the positives.
- **Over-identification:** the worker sees the situation from the point of view of only one family member.
- **Fixed belief:** an attitude or belief about the case distorts the assessment, for example gay parents should not care for children.
- **Groupthink:** the professionals working together on the case develop a view about the situation and disregard other perspectives.

3.8 Record-keeping and file management

Record-keeping is of critical importance. Unless accurate records are maintained, the ability to adequately protect vulnerable children may be severely curtailed. It is essential that staff in Children and Family Services keep contemporaneous records of all reported concerns. These should include details of all contacts, consultations and any actions taken.

- Case notes should be succinct, focused and proportionate.
- Best practice requires records to be up to date, written clearly, with explicit details of any decisions taken, while explaining the reason for these decisions.
- Case notes must be signed by the social worker and by the Supervising Team Leader following each supervision session.
- Records should be factual, accurate and legible. They should also be dated and signed after each entry.
- Where possible, case notes should be recorded contemporaneously or on the day that the action took place.
- Records should be accessible at all times during a key worker's absence from the office.

3.9 Use of chronology as part of the assessment process

A key issue identified in a number of case inquiries has been the absence of a well-structured and clear chronology. Keeping a chronology is recommended as good practice to assist in identifying trends/patterns of concern or positive change.

What it is: A chronology of significant events is a timeline representation of an agency's involvement with a child/family, milestones reached and any known significant events that will impact on the safety, care and well-being of the child. Chronologies are a key component of risk assessment where significant or 'key events' pertaining to risk should be recorded. They can reveal risks, concerns, patterns and themes, strengths and weaknesses within a family.

What it is not: A chronology is not an assessment, but only part of a comprehensive assessment. It is a working tool, not an end in itself, and also does not replace comprehensive case file notes.

The key objective of keeping an up-to-date chronology in child protection and welfare practice is:

- to compile a chronological history of significant events and provide easy reference to the contents of the records;
- to allow for patterns around issues/concerns to be detected and for these to be shared between professionals.



Practice Note: Key points of chronologies

- To be effective, the chronology must be accurate and rely on good up-to-date case recording.
- It should contain sufficient detail, but not substitute for recording in the file.
- Be flexible in recording – detail collected may be increased if risk increases.
- Review and analyse – it may be a helpful tool in preparing for and reflecting on for supervision.
- Different constructions of a chronology are needed for different reasons, e.g. current work and examining historical events.
- Record what action was taken and the decision underpinning decision-making at the time. Many chronologies list events and

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dates, but do not have a column setting out the action taken at the time. It is also important to include where no action was taken and the reasons for this.

- If chronologies are provided by several agencies, these could be set alongside each other in a comparative way so that possible relevant trends/patterns can be identified and the full extent of professional involvement can be established – both to enable the assessment of risk and the evaluation of positive progress.
- If you have difficulty explaining your concerns to a service user (e.g. parent/carer), the chronology may be a helpful tool in having this discussion.

What are significant information/events/core incidents to be included in the chronology?

A significant event is an incident that impacts on the child's safety and welfare, circumstances or home environment. This will inevitably involve a **professional judgement** based on the individual circumstances of the child and family. In deciding what events may be 'key' or 'significant' (and therefore included in a chronology), professionals need to use their professional judgement since the significance of events will differ from case to case, depending on the nature of the case.

Examples of significant/core incidents

- any previous Social Work involvement or child protection referrals;
- existence of a Child Protection Plan;
- assessments on child protection and/or child welfare;
- strategy discussions/meetings;
- changes of address and date of change if known;
- school exclusions;
- school attendance/major incidents, e.g. bullying;
- attendance/admittance to hospital/emergency department/changes in health;
- criminal proceedings and Garda involvement with the family;
- change in school;
- change in GP (e.g. this could be particularly significant in cases of Fabricated and Induced Illness);
- referrals to other agencies/teams;
- enquires to the Child Protection Notification System;

- child absconded/missing;
- child is taken into care/child is discharged from HSE care;
- bereavement in the family;
- parent/carer has new partner;
- another person moves into the family home or person moves out of the family home;
- birth of a new baby;
- police logs detailing pertinent information about family members/family home, e.g. reported incident of domestic violence, drunken behaviour of carers;
- any failure to attend pre-arranged appointments without explanation;
- individual crises that may impact on the well-being of the child, e.g. parental overdose, post-natal depression.

There are also a number of other incidents that may be significant to the child and family depending on their circumstances, e.g. a significant observation during home visits, the frequent presence of unknown adults, evidence of damage to the property.

If chronologies are to accurately reflect family circumstances, **positive factors** should also be recorded. Examples include:

- evidence of the family's engagement with professionals;
- parent's self-referral for help/guidance support with relevant agencies;
- the child's presentation in nursery/school significantly improves.

3.10 Children in Care

The HSE Children and Family Services have responsibility for children whom they place with relatives or with foster carers or in residential placements, as provided for in the Child Care Act 1991 and the Child Care Regulations 1995. 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. Children entering the care of the State may have previously been abused or neglected. Any allegation of abuse or neglect, past or present, must be dealt with sensitively and support provided to the child and others who have developed close relationships with that child, e.g. the foster carers and their family, other children in the residence.

3.11 Private Foster Care

Part 3 of the Children Act 2001 inserts a number of new provisions in the Child Care Act 1991 dealing with foster care. It defines what constitutes private foster care and provides for the regulation and control of such care services by the Health Service Executive.

A private foster care arrangement is one where a child is in full-time care for more than 14 days with a person other than their parent, guardian or a person co-habiting with a parent, guardian or relative.

Notification to the HSE of a private foster care arrangement

A person arranging or undertaking a private foster care arrangement shall give notice to the HSE of certain matters not less than 30 days before the placement. Failure to do so constitutes a criminal offence.

Where a child is placed in a private foster care arrangement due to an unforeseen emergency, both the person making the arrangement and the person undertaking must notify the HSE within 14 days after the placement.

Where the HSE believes that a person who is arranging or undertaking a private foster care arrangement has failed to notify the HSE of the arrangement or has failed to take all reasonable measures to safeguard the health, safety and welfare of the child concerned, it may apply to the District Court for a Supervision Order (S19), an Emergency Care Order (S13), an Interim Care Order (S17), a Care Order (S18) or an Order terminating the private foster care arrangement and the return of the child to his or her parent or guardian.

3.12 Management of Serious Incidents

At a corporate level, the management of serious incidents is governed by incident management policy and procedures. Any incident that is likely to cause extreme harm, or is likely to become a matter of significant concern to service users, employees or the public, must be notified.

Within the HSE Children and Family Services, serious incidents are governed by the criteria set out in *Guidance for the Health Service Executive for the Review of Serious Incidents, including deaths of children in care* (HIQA, 2010). This Guidance defines a serious incident as '*a death or potentially life-threatening injury or serious and permanent impairment of health, well-being or development.*'

The Office of the National Director, Children and Family Services, should be informed immediately of any serious incidents regarding the following children:

- children in care;
- children known to the HSE child protection system;
- when a case of suspected or confirmed abuse involves a serious incident to a child known to the HSE or a HSE-funded service.

3.13 Responding to a child's death

In the tragic circumstances where a child dies as a result of abuse or neglect, there are four important aspects to be considered: criminal, child protection, bereavement and notification.

Criminal aspects: This is the responsibility of An Garda Síochána and they must be notified immediately. The Coroner must also be notified and his or her instructions complied with in relation to post-mortems and other relevant matters.

Child protection aspects: These will be particularly relevant if there are other children in the family/in the same situation, and therefore will require immediate intervention by the HSE Children and Family Services to assess risk.

Bereavement aspects: The bereavement needs of the family must be respected and provided for and all family members should be given an opportunity to grieve and say goodbye to the deceased child.

Notification aspects: The HSE has a responsibility to notify the death of a child to the Health Information and Quality Authority (HIQA) in accordance with its *Guidance for the Health Service Executive for the Review of Serious Incidents, including deaths of children in care* (HIQA, 2010):

- all deaths of children in care, including deaths by natural causes;
- all deaths of children known to the HSE child protection system;
- serious incidents involving a child in care or known to the child protection services;
- deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or who were in receipt of aftercare services under Section 45 of the Child Care Act 1991.

4



Support and Guidance for Practitioners

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4.1 Supervision

There is a dedicated HSE Supervision Policy that applies to all Social Work staff (HSE, 2010b). In addition, The HSE's (2010c) *The Induction of Social Workers: A Policy and Guidelines for Children and Families Social Services* provides guidance on the management of caseloads by recommending limited caseloads, supervision and support for newly qualified social workers.

Supervision provides a regular, structured opportunity to discuss work, review practice and progress, and plan for future development. The main functions of supervision are:

- **Management** to hold the worker accountable for practice to ensure safe, quality care for children and families.
- **Support** for the individual staff member in what is a demanding and potentially stressful working environment. This may involve debriefing, which addresses the emotional impact of such work.
- **Learning and development** of each individual to identify their knowledge base, attitude, learning style and skills; to identify learning needs and the strengths and areas for development of the worker; and to plan and set targets for ongoing development.
- **Mediation** to ensure healthy engagement with, and communication between, the individual and the organisation.

REMEMBER

- If you have concerns about a case, do not wait until your next supervision session to discuss them. Bring them to the attention of your supervisor/line manager immediately.
- If you do not agree with a decided course of action, put your concerns in writing to your supervisor and follow up to ensure that you make your concerns clear.



Practice Note: How to make the best use of your supervision sessions

A shared responsibility – between you and your supervisor

Both you and your supervisor are responsible to ensure that you utilise the supervision process as efficiently as possible. Supervision is there for guidance and direction, but does not replace professional practice and accountability.

Prioritise your supervision sessions – book slots and keep them free

Supervision is a critical component of child protection and welfare practice and is vital for effective outcome planning and decision-making. Ensure that you keep these slots in your diary. Book some supervision preparation time in your diary beforehand and time afterwards to assimilate actions/decisions. Schedule enough time for your supervision session – especially if you have a particularly complicated caseload or families with a large number of children. Keep distractions to a minimum, e.g. no mobile phones as far as possible.

Keep it regular – reschedule ASAP if it has to be cancelled

The Supervision Policy states that regular supervision sessions must take place at least once a month. If you cannot, for some reason, go ahead with a scheduled supervision session, make sure that you reschedule it as close to the original time as possible.

Prepare for your supervision sessions – keep a list of issues/observations

To make your supervision session more productive, it will help if you do some preparation beforehand and be clear about particular issues that need to be addressed. It may help to take some time to reflect or keep a list of issues/observations you want to address while you are working on the case in between supervision sessions. Always have your case files ready for supervision and to be signed off by your supervisor.

Reflect and hypothesise – it's not just a 'to do' list

Supervision sessions are not about ticking off tasks on a 'to do' list for every case, even though it is important to keep track of actions to

(continued)

complete. Use your supervision sessions to reflect and hypothesise on issues and developments in your caseload.

Focus on outcome planning – look at each child individually

- What are the long-term consequences for this child?
- What are the long-term objectives for this child?

Write up your supervision records clearly - someone else may need to access your file in your absence. Supervision records must be:

- up to date;
- dated;
- clearly recorded;
- clearly state actions, decisions and desired outcomes;
- signed by both the practitioner and the supervisor;
- where appropriate, always include the last date of visiting the family.

Ask for feedback. Use the opportunity to discuss your practice and identify areas for development.

4.2 Personal Safety Questions and Risk Checklist for Practitioners

Questions for practitioners	Risk checklist
<p><i>Before you visit a household, think through your safety plan: ensure someone in your team knows where, when and why you are visiting, and when to raise the alert if you are not back.</i></p> <ul style="list-style-type: none"> ✓ Do I feel safe approaching this household? ✓ Do I feel safe inside this household? ✓ If not, why not? Exactly what in the family's behaviour and in my response makes me feel unsafe? ✓ How do the children and young people in this household appear to cope with hostility/aggression? ✓ Am I able to voice my concerns and ask for support, both from colleagues and my manager? ✓ How do I operate when I feel challenged or threatened? ✓ What is my coping strategy? How does this affect the families I work with? Am I aggressive, collusive, accommodating, hyperalert? Do I filter out or minimise negative information? ✓ If I, or another professional, should go back to the household to ensure the child(ren)'s safety, what support should I ask for? ✓ Does my manager know I am afraid and anxious? 	<ul style="list-style-type: none"> ✓ Why am I undertaking this visit at the end of the day when it is dark and everyone else has gone home? (Risky visits should be undertaken in daylight whenever possible.) ✓ Should this visit be made jointly with a colleague, other professional (e.g. Public Health Nurse or Gardaí) or manager? ✓ Is my car likely to be targeted or followed? If yes, it may be better to go by taxi and have it wait outside the house while I complete the visit. ✓ Do I have a mobile phone with me or some other means of summoning help (e.g. a personal alarm)? Is my phone charged? ✓ Could this particular visit be arranged at a neutral venue? How might I then organise to see the family at home under safer conditions? ✓ Are my colleagues/line managers aware of where I am going and when I should be back? Do they know I may be particularly vulnerable/at risk during this visit? ✓ Are there clear procedures for what should be done if a professional does not return or report back within the agreed time from a home visit? ✓ Does my manager know my mobile phone number and network, my car registration number, and my home address and telephone number?

(continued)

Risk checklist	
	<ul style="list-style-type: none"> ✓ Do my family members know how to contact someone from work if I do not come home when expected? ✓ Have I taken basic precautions, such as being ex-directory at home? ✓ Have I accessed personal safety training? ✓ Is it possible for me to continue to work effectively with this family?

Source: Broadhurst *et al* (2010)

4.3 Continuous professional development

Your line manager is the link between you (the practitioner) and sourcing the appropriate training to meet your training needs through consultation with your local Child Care Training Department. Training needs in relation to child protection and welfare are identified in the following ways:

- Training needs are identified by national, regional and local managers in relation to key national service delivery priorities. These are communicated to the Workforce Development, Education, Training and Research (WDETR) unit of the national office of the HSE Children and Family Services. This unit has responsibility for developing nationally standardised training programmes for local delivery to practitioners by the Child Care Training Departments.
- Training needs can arise from changes in legislation, policies, procedures and practices. Child Care Training Departments, in conjunction with the WDETR unit, update and/or develop training materials as training needs arise in this way. Child Care Training Departments communicate with Heads of Discipline and Services to keep them informed of new training programmes for staff members to attend.
- One of the four functions of staff supervision is the development function. This means that an integral part of the supervision process is the assessment of practitioners' training and development needs, and how they can be met. Both the supervisor and the practitioner have a role in identifying the individual worker's training needs through the forum of supervision. Once training needs are identified, the supervisor or line manager will contact the Child Care Training Department to discuss requirements.

4.4 Managing allegations against workers and volunteers

It is essential that any concern or allegation of abuse made about a professional or volunteer working with children is reported at the earliest opportunity for joint decision-making by partner agencies in accordance with the applicable guidance and procedures.

Section 6.2 and Appendix 9 of the *Children First: National Guidance* (2011) provide guidance on allegations against employees and volunteers. The HSE Children and Family Services receive allegations of abuse against people who have contact with children in their workplace or in a recreational setting.

All allegations of abuse have to be assessed according to a standard procedure. The HSEA (2005) publication *Trust in Care* provides guidance for HR in respect of investigating allegations against staff members.

4.5 Managing complaints

Engaging with families who are dissatisfied with decisions of the HSE Children and Family Services

The HSE Children and Family Services are committed to ensuring the safety and welfare of all children and young people with whom it works. A complaints procedure has been put in place to cover any situations that may arise when children/young people or their parents/guardians are dissatisfied with decisions made by HSE Children and Family Services. There are 4 stages to seeking to resolve a complaint:

- Stage 1: Local resolution where, for example, the parent and social worker seek to resolve the complaint.
- Stage 2: the Local Complaints Officer conducts a review investigation (this may be the Principal Social Worker).
- Stage 3: The complaint is referred to the Director of Advocacy, who appoints an Independent Reviewer to conduct a review.
- Stage 4: Complainant advised to seek a review by the Office of the Ombudsman/Ombudsman for Children if they remain dissatisfied following the internal review at Stage 3.

When dealing with families who are dissatisfied with decisions made by Children and Family Services, it is important that the families are aware of the complaints and appeals process.



Further information available on HSE website:

<http://www.hse.ie/eng/services/ysys/Complaint/> (Internet)

http://hsenet.hse.ie/HSE_Central/Consumer_Affairs/Complaints/
(intranet)

4.6 Protected disclosure

Confidentiality and making a protected disclosure

Section 103 of the Health Act 2007, which came into operation on 1st March 2009, provides for the making of protected disclosures by HSE employees. If an employee reports a workplace concern in good faith and on reasonable grounds in accordance with the procedures outlined in the legislation, it will be treated as a 'protected disclosure'.

If you have a concern that:

- the health or welfare of patients/clients or the public may be at risk,
- your employer is not meeting his or her legal obligations,
- there is a misuse or substantial waste of public funds,

then you may report your concerns without fear of penalisation from your employer and also without fear of civil liability.

Procedure for making a protected disclosure

The HSE has appointed an 'Authorised Person' to whom protected disclosures may be made.

Employees are required to set out the details of the subject matter of the disclosure in writing on the Protected Disclosures of Information Form and submit it to the Authorised Person at the following address: HSE Authorised Person, P.O. Box 1157, Dublin 2.

The Authorised Person will investigate the subject matter of the disclosure. Confidentiality will be maintained in relation to the disclosure insofar as is reasonably practicable.



Further information available on HSE website:

http://www.hse.ie/eng/staff/HR/Policies,_Procedures_and_Guidelines/Protected_disclosures_of_information.pdf

5



Resources

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5.1 National contacts for HSE Children and Family Services



Also listed on HSE website: www.hse.ie/go/socialworkers



HSE LoCall 1850 241 850

These contact numbers may be updated from time to time. Please check HSE website for latest information.

HSE Area	Address	Telephone No.
DUBLIN NORTH	Health Centre, Cromcastle, Coolock, Dublin 5	(01) 816 4200 (01) 816 4244
	Social Work Department, 180-189 Lake Shore Drive, Airside Business Park, Swords, Co. Dublin	(01) 870 8000
DUBLIN NORTH CENTRAL	Social Work Office, 22 Mountjoy Square, Dublin 1	(01) 877 2300
	Ballymun Health Care Facility, Ballymun Civic Centre, Ballymun, Dublin 9	(01) 846 7236
DUBLIN NORTH WEST	Health Centre, Wellmount Park, Finglas, Dublin 11	(01) 856 7704
	Social Work Department, Rathdown Road, Dublin 7	(01) 882 5000
DUBLIN SOUTH EAST	Social Work Department, Vergemount Hall, Clonskeagh, Dublin 6	(01) 268 0320 (01) 2680333
DUBLIN SOUTH CITY	Duty Social Work Carnegie Centre, 21-25 Lord Edward Street, Dublin 2	(01) 648 6555
	Public Health Nursing, 21-25 Lord Edward Street, Dublin 2	(01) 648 6730
	Family Support Service, 78B Church House, Donore Avenue, Dublin 8	(01) 416 4441
DUBLIN SOUTH WEST	Milbrook Lawns, Tallaght, Dublin 24	(01) 452 0666 (01) 427 5000
	Social Work Department, Old County Road, Crumlin, Dublin 12	(01) 415 4700

DUBLIN WEST	Social Work Department, Bridge House, Cherry Orchard Hospital, Ballyfermot, Dublin 10	(01) 620 6387
DUBLIN SOUTH	Social Work Department, Our Lady's Clinic, Patrick Street, Dun Laoghaire, Co. Dublin	(01) 663 7300
CARLOW	Carlow Social Work Office, Ground Floor, St. Dymphna's Hospital, Athy Road, Co. Carlow	(059) 913 6587
CAVAN	HSE Community Child and Family Services, Drumalee Cross, Co. Cavan	(049) 437 7305 (049) 437 7306
CLARE	Clare Duty Social Worker, River House, Gort Road, Ennis, Co. Clare Social Work Department, Shannon Health Centre, Shannon, Co. Clare Social Work Department, Kilrush Health Centre, Kilrush, Co. Clare	(065) 686 3935 (Monday – Friday, 2-5pm) (061) 718 400 (065) 905 4200
CORK	North Cork Social Work Department, 134 Bank Place, Mallow, Co. Cork North Lee Child Lee Social Work Department, (adjacent to Shopping Centre), Blackpool, Co. Cork South Lee Social Work Department, St. Finbarr's Hospital, Douglas Road, Cork West Cork Social Work Department, Coolnagarrane, Skibbereen, Co. Cork	(022) 54100 (021) 492 7000 (021) 492 3001 (028) 40447
DONEGAL	Links Business Centre, Lisfannon, Buncrana, Co. Donegal (East Team) Euro House, Killybegs Road, Donegal, Co. Donegal (West Team) Social Work Department, Millennium Court, Pearse Road, Letterkenny, Co. Donegal (East Central Team and West Central Team)	(074) 932 0420 (074) 972 3540 (074) 912 3672 (074) 912 3770

GALWAY	Galway City, Social Work Department, Local Health Office, 25 Newcastle Road, Galway, Co. Galway	(091) 546366
	Galway County, Tuam Social Work Department, Health Centre, Vicar Street, Tuam, Co. Galway	(093) 37200
	Loughrea Social Work Department, Health Centre, Loughrea, Co. Galway	(091) 847820
	Ballinasloe Social Work Department, Health Centre, Brackernagh, Ballinasloe, Co. Galway	(090) 964 6200
	Oughterard Social Work Department, Health Centre, Oughterard, Co. Galway	(091) 552200
KERRY	Social Work Department, HSE Community Services, Rathass, Tralee, Co. Kerry	(066) 712 1566
	Killarney Social Work Department, St. Margaret's Road, Killarney, Co. Kerry	(064) 663 6030
KILDARE	Social Work Department, St. Mary's Craddockstown Road, Naas, Co. Kildare	(045) 873200 (045) 882 400
KILKENNY	Social Work – Child Care Department, Child ,Youth and Families Carlow/Kilkenny, HSE South, St. Canice's Hospital, Dublin Road, Kilkenny	(056) 778 4057 (056) 778 4532
LIMERICK	Social Work Department, Health Centre, Kileely Road, Ballynanty Beg, Limerick	(061) 457 100
	Social Work Department Roxtown Health Centre, Roxtown Terrace, Old Clare Street, Limerick (East Team), Co. Limerick	(061) 417 622 (061) 483 091
	Parkbeg Social Work Department, Parkbeg House, 2 Elm Drive, Caherdavin Lawns, Ennis Road, Limerick, Co. Limerick	(061) 206 820
	Social Work Department, Southill Health Centre, O'Malley Park, Southill, Limerick, Co. Limerick	(061) 209 985
	Newcastlewest Social Work Department, Newcastlewest Health Centre, Newcastle West, Co. Limerick.	(069) 62155

LAOIS	Social Work Department, Child and Family Centre, Dublin Road, Portlaoise, Co. Laois	(057) 869 2567 (057) 869 2568
LEITRIM	Social Work Department, Community Care Office, Leitrim Road, Carrick-on-Shannon, Co. Leitrim	(071) 965 0324
LONGFORD	Social Work Department, Tivoli House, Dublin Road, Co. Longford	(043) 335 0584
LOUTH	Social Work Department, Local Health Care Unit, Wilton House, Stapleton Place, Dundalk, Co. Louth Ballsgrove Health Centre, Ballsgrove, Drogheda, Co. Louth	(042) 939 2200 (041) 983 8574 (041) 983 3163
MAYO	Ballina Social Work Team, Ballina Health Centre, Mercy Road, Ballina, Co. Mayo Castlebar Social Work Team, St. Mary's Headquarters, Castlebar, Co. Mayo Swinford Social Work Team, Swinford Health Centre, Aras Attracta, Swinford, Co. Mayo	(096) 21511 (096) 248 41 (094) 904 2283/4 (094) 905 0133
MEATH	HSE Children's Services, Navan Enterprise Centre, Trim Road, Navan, Co. Meath Community Social Work Services, Duty Social Work Department, 25 Brewshill, Navan, Co. Meath Community Social Work Services, Dunshaughlin Health Care Unit, Dunshaughlin, Co. Meath	(046) 909 7800 (046) 903 0616 (01) 802 4102
MONAGHAN	Social Work Department, Local Health Care Unit, Rooskey, Co. Monaghan	(047) 30426 (047) 30427
OFFALY	Social Work Department, Dery Suite, Castlebuildings, Tara Street, Tullamore, Co. Offaly	(057) 937 0700

ROSCOMMON	Social Work Team, Abbeystown House, Abbey Street, Roscommon, Co. Roscommon	(090) 662 6732
	Social Work Team, Roscommon PCCC, Lanesboro' Road, Roscommon, Co. Roscommon (Roscommon Area)	(090) 663 7528 (090) 663 7529
	Social Work Team, Health Centre, Elphin Street, Boyle, Co. Roscommon (Boyle Area)	(071) 966 2087
	Social Work Team, New HSE Offices, Knockroe, Castlerea, Co. Roscommon (Castlerea Area)	(090) 663 7851 (090) 663 7842
SLIGO	Sligo Town and surrounding areas: Markievicz House, Barrack Street, Sligo, Co. Sligo	(071) 915 5133
	South County Sligo: One Stop Shop, Teach Laighne, Humbert Street, Tubercurry, Co. Sligo	(071) 912 0062
NORTH TIPPERARY	North Tipperary Duty Social Work Team, Civic Offices, Limerick Road, Nenagh, Co. Tipperary	(067) 46 636
	North Tipperary Child Protection Services: Social Work Department, Annbrook, Nenagh, Co. Tipperary	(067) 41 934
	St. Mary's Health Centre, Parnell Street, Thurles, Co. Tipperary	(0504) 24 609
SOUTH TIPPERARY	South Tipperary Child Protection Services: Social Work Team, South Tipperary Community Care Services, Western Road, Clonmel, Co. Tipperary	(052) 617 7302 (052) 617 7303
WATERFORD	Waterford: Social Work Service, Waterford Community Services, Cork Road, Co. Waterford	(051) 842827
	Dungarvan and surrounding areas: Social Work Department, Dungarvan Community Services, St. Joseph's Hospital, Dungarvan, Co. Waterford	(058) 20906

WESTMEATH	Social Work Department, Athlone Health Centre, Coosan Road, Athlone, Co. Westmeath	(090) 648 3106
	Social Work Department, Child and Family Centre, St. Loman's, Springfield, Mullingar, Co. Westmeath	(044) 934 4877
WEXFORD	Gorey Health Centre, Hospital Grounds, Gorey, Co. Wexford	(053) 943 0100
	Enniscorthy Health Centre, Millpark Road, Enniscorthy, Co. Wexford	(053) 923 3465
	New Ross Health Centre, Hospital Grounds, New Ross, Co. Wexford	Contact through Ely House below
	Local Health Office, Social Work Department, Ely House, Ferrybank, Co. Wexford	(053) 912 3522 Ext. 201
WICKLOW	Social Work Department, HSE Glenside Road, Wicklow Town, Co. Wicklow	(0404) 60800
	Bray: Social Work Department, The Civic Centre, Main Street, Bray, Co. Wicklow	(01) 274 4180 (01) 274 4100
	Delgany: Social Work Department, Delgany Health Centre, Delgany, Co. Wicklow	(01) 287 1482

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Appendix 1: Summary of Key Legislation

Practitioners should always check relevant legislation, case law, regulations and standards, and consider the legal context of the case. The list below is not exhaustive, but aims to provide a quick reference to some of the most commonly used.



Irish Case Law (British and Irish Law Information Institute)
www.ucc.ie/law/irishlaw/cases/



<http://www.irishstatutebook.ie>

- Adoption Act (2010)
- Child Abduction and Enforcement of Custody Orders Acts (1992)
- Child Care (Placement of Children in Foster Care) Regulations (1995)
- Child Care (Placement of Children in Residential Care) Regulations (1995)
- Child Care (Placement of Children with Relatives) Regulations (1995)
- Child Care (Special Care) Regulations (2004)
- Child Care Amendment Act (2007)
- Child Care Amendment Act (2001)
- Child Care Act (1991)
- Children (Family Welfare Conference) Regulations (2004)
- Children Act (2001)
- Criminal Evidence Act (1992)
- Criminal Justice Act (2006) (Section 176 Reckless Endangerment of Children)
- Criminal Law Amendment (Sexual Offences) Act (2006)
- Criminal Law Amendment (Sexual Offences) Act (2007)
- Criminal Law Amendment Act (2006)
- Data Protection Act (1988)
- Data Protection Amendment Act (2003)
- Domestic Violence Act (1999)

- Draft National Children’s Standards (February 2010)
- Education Act (1998)
- Freedom of Information Act (1997)
- Freedom of Information Amendment Act (2003)
- Guardianship of Infants Acts (1964)
- Health and Social Care Professionals Act (2005)
- Human Rights Act (2003)
- National Standards for Children’s Foster Care (2003)
- National Standards for Children’s Residential Centres (2001)
- Non-Fatal Offences against the Person Act (1997)
- Protection for Persons Reporting Child Abuse Act (1998)
- Sex Offender’s Act (2001)
- United Nations Declaration on the Rights of Children (1990)
(ratified by Ireland 1992)

CHILD CARE ACT 1991

This Act provides the statutory basis for the HSE’s responsibilities to promote the welfare of children.

Part II: Promotion of the welfare of children

Section 3 – Functions of the HSE

The HSE’s statutory responsibility with regard to children derives from Section 3 of the Child Care Act 1991. Section 3 states, ‘It shall be a function of the Health Service Executive to promote the welfare of every child in its area who is not receiving adequate care and protection’.

Statutory duty to investigate allegations of abuse

This duty was interpreted by the Mr Justice Barr in the High Court case of *MQ v City of Dublin VEC, EHB and others*. Mr Justice Barr found the HSE has a proactive duty to protect children. Where an allegation of abuse is made, the HSE has a statutory duty to investigate all allegations of abuse and assess what potential risk if any the alleged perpetrator may pose to children. This emphasizes the requirement for Children and Family Services to ensure where a disclosure warrants further child protection intervention a risk assessment will be undertaken in respect of the alleged perpetrator.

Intra-familial and Extra-familial

Mr Justice Barr did not limit this duty to acting in the interest of specific identified or identifiable children who are already at risk of abuse and require immediate care and protection. The duty extends to children not yet identifiable who may be at risk in the future by reason of a specific potential hazard to them which the HSE reasonably suspects may come about in the future.

The HSE has a positive duty to investigate all allegations of abuse, including:

- suspected abuse within families;
- suspected extra-familial abuse;
- suspected retrospective abuse.

Retrospective disclosures by adults

The duty of the HSE is not limited by the fact that a disclosure is made by an adult of abuse suffered during their childhood since the HSE's duty includes the prevention of future risk.

Alleged abuser does not currently have access to children

The HSE should not delay or defer an investigation on the basis that an alleged abuser does not currently have access to children since this might significantly hamper its ability to investigate the allegations.

Coordination of information and interagency cooperation

The statutory duty of the HSE is entirely separate from the prosecutorial functions of the Gardaí and the DPP. The HSE should during its investigation liaise with the Gardaí. The HSE may be entitled to rely on a criminal conviction as evidence that a person may pose a risk to children.

General

Section 3 also states that the HSE, in carrying out its child protection function, will:

- regard the welfare of the child as paramount;
- give consideration to the wishes of the child having regard for his age and understanding;
- have regard for the rights and duties of parents;
- have regard for the principle that it is generally best for the child to be brought up in his own family.

Section 4 – Voluntary care

The HSE has a duty to take a child who requires care or protection into its care under this section.

The HSE cannot take or retain a child in its care against the wishes of a parent having custody of him or any person acting *in loco parentis* if that person wishes to resume care of him.

The HSE should record details of any agreement to place a child in voluntary care. This agreement is not an Order and can be revoked by a parent. If a parent indicates that they intend to withdraw consent to voluntary care, then the HSE must either return the child to the parent or bring a Court application to place the child in care. If the HSE intends bringing a Court application, it should seek agreement to bringing an application on an agreed date and recommend the parent seeks legal advice.

Where the child is in voluntary care, the HSE has no authority to give consent to medical treatment or to the issue of passport facilities unless powers have been granted to foster carers under Section 43A of the Child Care Act. If agreement cannot be reached with the parents, the HSE must seek a direction from the Court pursuant to Section 47.

The regulations in relation to the placement of children in care apply equally to children in voluntary care.

Part III: Protection of children in emergencies

Section 12 – Powers of An Garda Síochána to take a child to safety

If a Garda has reasonable grounds for believing there is an immediate and serious risk to the health/welfare of a child, he may remove a child to safety. The Garda must then as soon as possible deliver the child into the custody of the HSE.

The HSE should carry out an immediate assessment of the child's circumstances. The HSE then has two options:

1. return the child to parent having custody or a person acting *in loco parentis*;
2. make an application for an Emergency Care Order at the next sitting of the District Court. (If the next sitting in the same Court district is not within 3 days of the date of delivery of the child to the HSE, the HSE must make arrangements to either convene a special sitting or attend at a sitting of another District Court within 3 days.)

Section 13 – Emergency Care Order

If the HSE has reasonable cause to believe that there is an immediate and serious risk to the health or welfare of a child or there is likely to be a risk if he is removed from where he is for the time being, the HSE can apply for an Emergency Care Order. A Judge can grant an Emergency Care Order for up to 8 days.

Part IV: Care proceedings

The standard of proof in care proceedings is on the balance of probability.

Section 16 – Duty of the HSE to institute proceedings

Where it appears to that HSE that a child found in its area requires care or protection which he is unlikely to receive unless the Court makes a Care Order or a Supervision Order, it shall be the duty of the HSE to make an application for an Order.

Section 17 – Interim Care Order

The HSE can apply for an Interim Care Order if it has reasonable cause to believe that:

- (a) the child has been or is being assaulted, ill-treated, neglected or sexually abused; or
- (b) the child's health, development or welfare has been or is being avoidably impaired or neglected; or
- (c) the child's health, development or welfare is likely to be avoidably impaired or neglected; and
- (d) that it is necessary for the protection of the child's health or welfare that he be placed or maintained in the care of the HSE pending the determination of the application for the Care Order.

A Judge can grant an Interim Care Order for up to 28 days without parental consent or for longer if a parent consents. A Judge can extend the Interim Care Order if satisfied that the grounds for the making of the Order continue to exist.

Section 18 – Care Order

A Judge can grant a Care Order if satisfied that:

- (a) the child has been or is being assaulted, ill-treated, neglected or sexually abused; or

- (b) the child's health, development or welfare has been or is being avoidably impaired or neglected; or
- (c) the child's health, development or welfare is likely to be avoidably impaired or neglected; and
- (d) the child requires care or protection which he is unlikely to receive unless the Court makes an Order.

A Judge can grant a Care Order for so long as the child remains a child or for such shorter period as appropriate. A Judge can extend the operation of the Care Order if the Court is satisfied that the grounds for the making of the Order continue to exist.

When a Care Order has been granted, the HSE can:

- (i) give consent to any necessary medical or psychiatric examination, treatment or assessment with respect to the child; and
- (ii) give consent to the issue of a passport to the child, or to the provision of passport facilities for him, to enable him to travel abroad for a limited period.

Section 19 – Supervision Order

A Judge can grant a Supervision Order where there are reasonable grounds for believing that:

- (a) the child has been or is being assaulted, ill-treated, neglected or sexually abused; or
- (b) the child's health, development or welfare has been or is being avoidably impaired or neglected, or
- (c) the child's health, development or welfare is likely to be avoidably impaired or neglected; and
- (d) it is desirable that the child be visited by the HSE.

A Supervision Order authorises the HSE to visit the child and to give advice. A Judge can also give directions as to the care of the child, which may require the parents of the child or a person acting *in loco parentis* to cause him to attend for medical or psychiatric examination, treatment or assessment at a hospital, clinic or other place specified by the Court.

A Supervision Order can be granted for up to 12 months.

It is a criminal offence to fail to comply with the terms of a Supervision Order or any directions given by a Court.

Part VI: Children in the care of health boards

Section 37 – Access to children in care

The HSE must provide reasonable access between a child in care and a parent or any person who has a bone fide interest in the child.

Section 47 – Application for directions

The Court of its own motion or on the application of any person can make directions with regard to the welfare of the child. This Section is frequently used with regard to medical consent or consent to the issue of passport facilities.

GUARDIANSHIP OF INFANTS ACT 1964

The Court may give directions on issues such as guardianship, custody, access or maintenance. A guardian can apply to the Court for directions on any question affecting the welfare of their child. Welfare means the religious, moral, intellectual, physical and social welfare of a child.

Entitlement to guardianship

Parents are married:

Mother and father are legal guardians

Parents are not married:

Mother is legal guardian. Father can become legal guardian by agreement (completion of sworn declaration) or by Court order.

Miscellaneous

- Both parents remain the child's legal guardian upon divorce even if the child is not living with them and they have not been awarded custody of the child.
- A further guardian can be appointed on the death of a guardian by will or by Court order.
- Adoption transfers guardianship rights from the natural parents to the adoptive parents.
- The HSE are not guardians of children in care.

CHILDREN ACT 2001

The Children Act 2001 provides a framework for the juvenile justice system and also provides protection for children against persons who have the custody, charge or care of them.

Section 76B – Request to the HSE to be represented in the proceedings

The Court may request the HSE to be represented in criminal proceedings involving a child where it appears to the Court that the HSE may be of assistance to it in dealing with the case.

Section 77 – Request for HSE to convene a family welfare conference

The District Court can request the HSE to convene a family welfare conference if in the Court's view it is practicable for the HSE to hold such a conference having regard to the age of the child and his or her family and other circumstances.

Section 91 – Parental attendance at Court

The parents or guardian of a child are required to attend at all stages of any proceedings unless excused by the District Court.

Section 246 – Cruelty to children

It is an offence for any person who has the custody, charge or care of a child wilfully to assault, ill-treat, neglect, abandon or expose the child, or cause or procure or allow the child to be assaulted, ill-treated, neglected, abandoned or exposed, in a manner likely to cause unnecessary suffering or injury to the child's health or seriously to affect his or her well-being.

CHILD CARE (AMENDMENT) ACT 2011

The Child Care Amendment Act 2011 was passed at the end of July 2011 and is awaiting commencement. It gives the High Court statutory authority to deal with applications to detain children in Special Care. It sets out a comprehensive framework for those applications, as well as detailing the interaction of Special Care Orders with Criminal Courts dealing with children's cases. In particular, it sets out that the HSE is not prevented from applying for a Special Care Order where a child is charged with a criminal offence.

Appendix 2: Checklist for multi-agency contribution

Buckley *et al* (2006), in their report *Framework for the Assessment of Vulnerable Children and Families: Assessment Tool and Practice Guidance*, state that multidisciplinary work is regarded as fundamental to good practice in child protection and welfare. The authors list the practitioners and services that may be involved with a child and family, and the type of information they can provide.

Child Care Worker (Community and Residential)
History of involvement in the family
Interaction with parents
Child's developmental, educational, health, emotional and social needs and abilities
Child's perspective on family difficulties and means of coping
Child's care history
Child's feelings and wishes for their family
Child's likes and dislikes
Child's relationship with parents/carers and sibling(s)
Child's support networks and friendships
Child's willingness to engage with practitioners and services
Child's school attendance and opinion of school
Early Years/Nursery Staff
Physical health of child
Emotional well-being of child
Developmental milestones child has or has not reached
General appearance of child
Child's way of playing
Child's ability to perform tasks
Child's level of appropriate social skills
Parent/child interaction
Parent/child relationship, including separation issues and how that relates to attachment
Parenting skills
Parent's ability to follow advice given regarding children's needs

Dentist
Information on suspected or confirmed physical trauma or dental trauma
History of involvement with the family
Family's willingness to engage with services
Parent/child interaction
Community Pediatrician
Medical history of child, including hospital admissions
History of involvement with the child and family
Post-mortem investigation of fatalities of children
Family's previous contact with services in the hospital and the community
Clinical and forensic evidence of child abuse
Social Workers (Health Service Executive)
History of involvement with the family
Information regarding current and past difficulties within the family
Information regarding past interventions and outcomes with the family
Information regarding the involvement of other disciplines with the family
Family's pattern of functioning
Needs of the children
Parental issues and capacity
Support networks available to the family
Access to the family home
Interactions and relationships between parents/carers and children
Allegations and incidents of abuse
Notifications
Care history of the children
Family Support Workers
History of involvement with the family
Parental issues and parental capacity
Difficulties within the family
Children's experience of family life
Children's means of coping with family difficulties

Children’s attendance at school and ability to do homework
Children’s support networks and friendships
Relationship and interactions between children and parents/carers
Parents/carers’ supervision of children
Children and family’s support networks
Information regarding the involvement of different disciplines within the family
Family’s openness to practitioners and services
Financial and budgetary situation of the family
Employment history of carers
Information regarding the family from the local community

Drugs/AIDS/Alcohol Services

History of involvement with family
Past and current parental drug and alcohol use
Parental HIV and AIDS status
Parents’ ability to protect their children from HIV infection where relevant
Children’s HIV and AIDS status
Parental capacity to meet the needs of children
Interaction and relationships between parents and children
History of intervention with family and what has worked
Family’s willingness to engage with practitioners and services

Community Welfare Officer

History of contact with the family
Interaction between parents/carers and children
Access to family home
Information regarding difficulties within the family
Information regarding support networks
Information regarding the family from the local community
Financial situation of the family
Current benefits
Employment history of the parents/carers

Gardaí
Past and current involvement with family and extended family
Previous notifications to or from the Health Service Executive
Reports of maltreatment
Knowledge of issues related to aggression, assault, addiction, mental health issues, etc.
Knowledge of relevant orders, e.g. Barring Order, Safety Orders
Radiographer
Information on the type, frequency and number of injuries sustained by a child
General Practitioner/AMO
Physical and emotional development of child and carers
Medical history
Access to family home
Parenting issues and their impact on parenting capacity, e.g. alcohol use, mental health, learning disabilities
Pattern of contact with GP and medical services
Information regarding what interventions worked in the past
Current and past use of medication
Impact of medication on parental capacity
Any potential health risks
Psychiatric Services
History of contact with parent and family
Information regarding family history and needs of the children
Psychiatric diagnosis
Possible impact of condition on parenting capacity
Previous psychiatric history and the impact on parenting capacity
Treatment progress
Compliance regarding taking medication and impact on parenting of taking/ not taking medication
Attendance at appointments
Availability and take-up of services other than medication

Availability and take-up of family and community supports
Emotional availability to children
Emotional stability
Interaction with children

Psychologist/Counsellor

History of contact with parent and family
Information regarding family history and needs of the child
Level of cognitive and adaptive functioning
Psychological effects of maltreatment
Emotional and behavioural issues
Mood
Levels of self-esteem
Psychological formulation and conceptualisation of the situation
Feelings about the situation
Social contacts
Learning potential and need for additional support
Information regarding what intervention worked in the past
Interaction between parent and child

Social Workers (Maternity and General Hospital)

History of hospital admissions of parents/carers and children
Difficulties within the family
Health and medical needs of the children
Interactions and relationships between parents/carers and children
Initial bonding between mother and newborn baby and involvement of father
History of teenage pregnancies within the family

Disability Services

History of involvement with family
Information regarding disability and abilities of child
Parent/carer's ability to understand and respond to the child's needs
Impact of the disability on the family
Family's ability to access the services that they require
Family's view of quality of services provided

Availability of services to meet child's particular need
Financial implications of the disability for the family
Availability of respite care
Support networks available to the family
History or incidences of abuse

Physiotherapist
Gross motor development and analysis of cause of delay or abnormality development
Parental capacity regarding handling skills, general physical and play stimulation of the child development
Signs of non-accidental injury
Parenting skills
Attendance at appointments

Occupational Therapist
Child development
Development of functional performance
Child's ability to interact with his/her physical and social environment
Parent's understanding of child's performance problems

School
Educational ability, development and progress
Socialisation and behaviour with peers and adult staff
Play
Participation in social/leisure activities during and after school
Emotional development, including self-esteem, self-worth, withdrawn/aggressive
Liaison with home – is a home/school liaison teacher or education and welfare officer involved?
Contact and relationship between the school and parent(s)
Knowledge of siblings
History of contact between the family and the school
Child's ability to concentrate at school
Completion of homework satisfactorily to deadlines
Whether the child has appropriate books and equipment
Whether the child has a school lunch and whether it is nutritious
Whether the child is hungry or tired at school

What the child says at school about home
How the child is after the weekend
How the child feels about school
Any notable changes in the child's behaviour
Whether the child is collected from school, if age-appropriate

Public Health Nurse

Medical history
The child's developmental history
Information on deviations in normal development
Birth history
Attachment to carers
Immunisation take-up
Attendance at clinic and other appointments
The parents' physical and emotional well-being
Information regarding parents' upbringing
Parental skills
Roles taken on by parents and others in the child's life
Impact of parenting issues on parenting capacity
Family's current and past history of engaging with services
Access to and information regarding the home environment and family life
Information from neighbours, extended family and friends in the community regarding the family
Involvement of extended family members and the existence of support networks
Information on the development of siblings
Observations of the health and well-being of children in the home
Referrals made

Voluntary Organisations (service-specific)

History of involvement with family
Information regarding the difficulties and needs of children and parents/carers
Family's willingness to engage with statutory services
Family's support networks
Family's way of coping with difficulties

Speech and Language Therapist
Child's speech and language assessment and development
Parent/carer's capacity to understand and respond to child's difficulties
Child and parent's ability and willingness to engage with the service
Parent/carer's ability to work with speech therapy programme
Attendance at appointments
Difficulties within the family
Child's perspective on difficulties within the family

Source: Buckley *et al* (2006)

Appendix 3: Ireland: Serious Case Inquiries - Recommendations for practice

Inquiries into child protection practice in Ireland and other jurisdictions are a valuable source of information on the strengths and weaknesses of the child protection system and a useful source of learning for child protection practice.

The Practice Handbook links practice and process to the findings from these Inquiries, to give emphasis to the need for practice improvement. The recommendations listed here are a selection illustrating the key issues referred to in the Handbook. Readers should refer to the actual Inquiry document for the full context of the recommendation and its exact wording.

Abbreviations: KF = Kelly Fitzgerald (1996); KI = Kilkenny Incest (1993); RO = Roscommon (2010); WI = West of Ireland Farmer (1998).

Assessment

Social workers should see and speak directly to every child where there is a concern about their welfare. It should be the responsibility of the Social Work Team Leader and the (Professional Manager 1) to ensure that this is done. Working directly with children and families are core social work tasks and their training provides them with the knowledge, skills and competencies required for this work.	Ro 5.3.1
The formulation of an assessment must be priority, whether based on the outcome of the initial investigation, following a case conference or on the recommendation of a worker specifically assigned to gather all available information for a subsequent case conference.	KF
Care should be taken to work with both parents and in particular workers should be proactive in seeking to engage fathers.	Ro 5.3.3
It is recommended that the views of parents should be taken into account and checked against the facts and the views of concerned others.	Ro 5.3.6
Third parties who express concerns should be interviewed as part of the assessment of the family. Full assessments require that those reporting concerns are interviewed wherever possible and their concerns investigated fully. The provision of feedback to those reporting concerns should follow the process outlined in the revised <i>Children First: National Guidance</i> (2011).	Ro 5.3.5

It is recommended that all personnel be alert to parents and carers who consistently try to divert attention away from the primary concern, which is the well-being of the children.	Ro 5.3.6
Where there are ongoing concerns of child neglect, as in this case, the appropriate frequency of home visits by the family's social worker should be agreed and carried through.	Ro 5.3.3
Child Protection Conferences	
Parents/guardians should attend case conferences unless there are substantial grounds for their exclusion.	KI
Contact with children should appear on the agenda for every professional supervision meeting and form part of every report for a case conference. Where there is more than one child in a family, the needs, wishes and feelings of each child must be considered and reported on, as well as the totality of the family situation.	Ro 5.3.1
Case conferences should be arranged to facilitate the implementation of planned intervention or to review its continuing appropriateness or effectiveness.	KF
A key worker to be appointed to each case. All those involved in each case are to be aware of the key worker's identity and should share information with him or her.	KF
Personnel attending a case conference should, as far as practicable, be consistent over the duration of the Board's involvement with a child or family. The designated officer for conveying a case conference should have access to all previous information on contacts with the child or children's family, especially previous case conferences notes. This will require adequate secretarial and data retrieval facilities being readily available.	WI
In convening a case conference, arrangements should be made to have a chronological record of all community and hospital contacts between the Board and the child who is the subject of a case conference provided to all the participants at such a conference. Where a case conference is not called, the reasons should be recorded and circulated to appropriate personnel.	WI
The Director of Community Care (DCC) takes all reasonable steps to facilitate the attendance of relevant persons at the case conference. There must be an equal obligation on those required to attend to facilitate the DCC in arranging the case conference.	KI

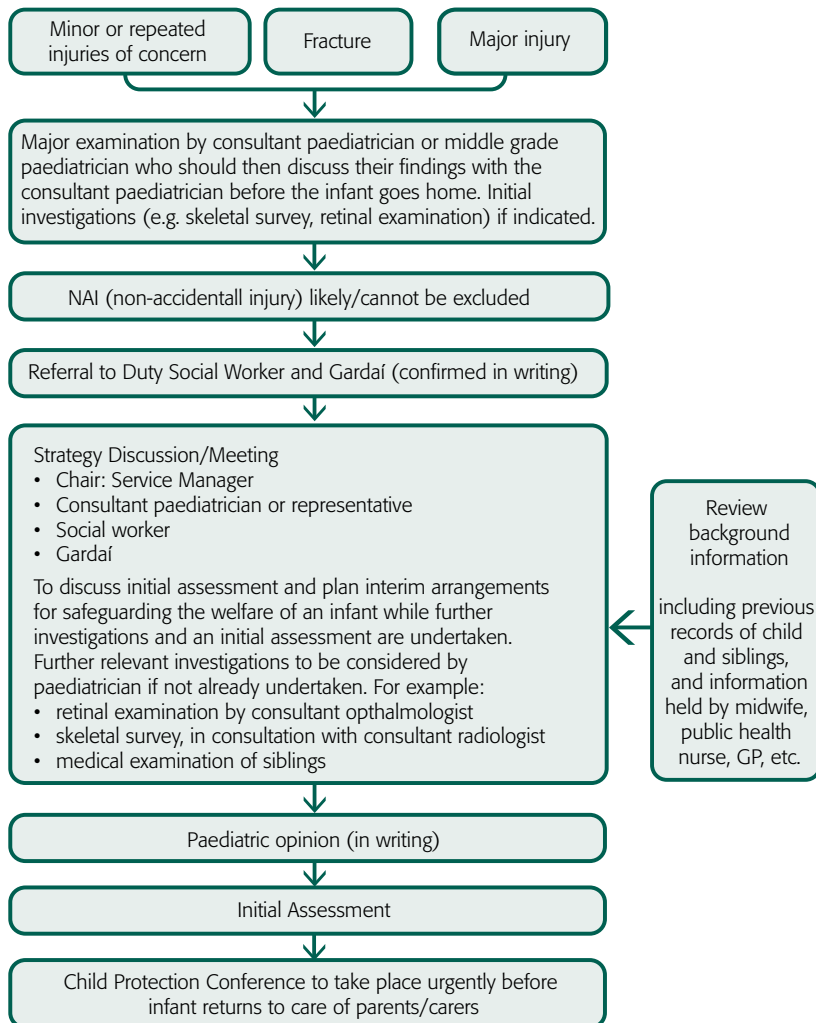
There is a need to have appropriate and systematic medical input into decision-making regarding children at risk. The General Practitioner (GP) has a key role and, if his or her attendance at a case conference is not possible, alternative methods of consultation with the GP must be found to ensure comprehensive assessment, monitoring and plan of action.	WI
Case Management	
In all child welfare and protection cases, explicit outcomes should be identified in respect of each family member, but particularly in respect of each child about whom there is a concern. Both short-term and long-term outcomes should be identified.	Ro 5.3.4
The case management plan should include how progress on each key element in these chronic neglect cases is to be measured.	Ro 5.3.4
Workers should be mindful of the need to consider alternative plans where the desired outcomes are not achieved. In all situations, it is important that the case file records the reflective thinking, planning and consideration of outcomes that are guiding the work for the child and family.	Ro 5.3.4
It is further recommended that where concern is expressed, or a referral made, concerning neglect and/or emotional abuse, each episode should be judged and assessed in the context of any previous concerns.	Ro 5.3.4
The key designated worker in chronic neglect cases should meet regularly with all personnel who are visiting the home to ensure that all are fully aware of the key concerns for the children.	Ro 5.3.4
Reporting	
Reporting of actual or suspected abuse to become a legal requirement for relevant designated staff, including HSE personnel, GPs, the Gardaí, teachers and staff of voluntary and private child care services.	KF
All designated personnel should be required to caution clients about their reporting obligations under a mandatory reporting law.	KI
There should be mandatory reporting of all forms of child abuse by designated persons to the Director of Community Care (or other nominated person within the health Boards).	KI
Persons other than those 'designated' should also be entitled to report abuse and receive the same immunity provided they do so in good faith.	KI
Mandatory reporting to be immune to any legal proceedings.	KF

Mobile Families	
Act when accurate, relevant and appropriate information is received about families who move to Ireland from other jurisdictions and whose children are considered to be at risk.	KF
Any authority to take action when a family has moved to another area and whose children are, or are suspected of being, at risk.	KF
Receiving authorities adopt a proactive approach in seeking information on any family that has recently moved into its area in relation to whom an allegation or referral is made.	KF
Recording	
Where following investigation of an allegation, it is decided not to take any further action, it is essential that this decision is recorded and explained.	KF
Where action is considered necessary following investigation of an allegation, a written report with substantiated recommendation is essential.	KF

Sources: McGuinness, C. (1993) *Report of the Kilkenny Incest Investigation*; Oireachtas Committee (1996) *Kelly Fitzgerald, A Child is Dead*; North Western Health Board (1998) *The Report of the Inquiry into the West of Ireland Farmer Case*; Roscommon Child Care Inquiry (2010) *Roscommon Child Care Case*.

Appendix 4: Flowchart – Response when an infant under 12 months presents with injuries

The recommended process to be followed is summarised in the flow chart below:



When a diagnosis, by a consultant or other senior paediatrician, indicates that non-accidental injury is likely, the infant should not be returned to relevant parent/carer(s) before a strategy discussion and an initial assessment have been carried out.

Appendix 5: Child Development Checklist 0-5 years

By the end of 3 months	
Social and Emotional	<ul style="list-style-type: none"> • Begins to develop a social smile • Enjoys playing with other people and may cry when playing stops • Becomes more expressive and communicates more with face and body • Imitates some movements and facial expressions
Movement	<ul style="list-style-type: none"> • Raises head and chest when lying on stomach • Supports upper body with arms when lying on stomach • Stretches legs out and kicks when lying on stomach or back • Opens and shuts hands • Pushes down on legs when feet are placed on a firm surface • Brings hand to mouth • Takes swipes at dangling objects with hands • Grasps and shakes hand toys
Vision	<ul style="list-style-type: none"> • Watches faces intently • Follows moving objects • Recognises familiar objects and people at a distance • Starts using hands and eyes in coordination
Hearing and Speech	<ul style="list-style-type: none"> • Smiles at the sound of your voice • Begins to babble • Begins to imitate some sounds • Turns head toward direction of sound
By the end of 7 months	
Social and Emotional	<ul style="list-style-type: none"> • Enjoys social play • Interested in mirror images • Responds to other people's expressions of emotion and appears joyful often
Movement	<ul style="list-style-type: none"> • Rolls both ways (front to back, back to front) • Sits with, and then without, support on hands • Supports whole weight on legs • Reaches with one hand • Transfers object from hand to hand • Uses hand to rake objects
Vision	<ul style="list-style-type: none"> • Develops full colour vision • Distance vision matures • Ability to track moving objects improves

<p>Language</p>	<ul style="list-style-type: none"> • Responds to own name • Begins to respond to 'No' • Can tell emotions by tone of voice • Responds to sound by making sounds • Uses voice to express joy and displeasure • Babbles chains of sounds
<p>Cognitive</p>	<ul style="list-style-type: none"> • Finds partially hidden object • Explores with hands and mouth • Struggles to get objects that are out of reach
<p>By the end of 12 months</p>	
<p>Social and Emotional</p>	<ul style="list-style-type: none"> • Shy or anxious with strangers • Cries when mother or father leaves • Enjoys imitating people in his/her play • Shows specific preferences for certain people and toys • Tests parental responses to his/her actions during feedings • Tests parental responses to his/her behaviour • May be fearful in some situations • Prefers mother and/or regular caregiver over all others • Repeats sounds or gestures for attention • Finger-feeds him/herself • Extends arm or leg to help when being dressed
<p>Movement</p>	<ul style="list-style-type: none"> • Reaches sitting position without assistance • Crawls forward on belly • Assumes hands-and-knees position • Creeps on hands and knees • Gets from sitting to crawling or prone (lying on stomach) position • Pulls self up to stand • Walks holding on to furniture • Stands momentarily without support • May walk 2 or 3 steps without support
<p>Hand and Finger Skills</p>	<ul style="list-style-type: none"> • Uses pincer grasp • Bangs 2 objects together • Puts objects into container • Takes objects out of container • Lets objects go voluntarily • Pokes with index finger

<p>Language</p>	<ul style="list-style-type: none"> ● Pays increasing attention to speech ● Responds to simple verbal requests ● Responds to 'No' ● Uses simple gestures, such as shaking head for 'No' ● Babbles with inflection (changes in tone) ● Says 'Dada' and 'Mama' ● Uses exclamations, such as 'Oh-oh!' ● Tries to imitate words
<p>Cognitive</p>	<ul style="list-style-type: none"> ● Explores objects in many different ways (shaking, banging, throwing, dropping) ● Finds hidden objects easily ● Looks at correct picture when the image is named ● Imitates gestures ● Begins to use objects correctly (drinking from cup, brushing hair, dialing phone, listening to receiver)
<p>By the end of 2 years</p>	
<p>Movement</p>	<ul style="list-style-type: none"> ● Walks alone ● Pulls toys behind while walking ● Carries large toy or several toys while walking ● Begins to run ● Stands on tiptoe ● Kicks a ball ● Climbs onto and down from furniture unassisted ● Walks up and down stairs holding on to support
<p>Hand and Finger Skills</p>	<ul style="list-style-type: none"> ● Scribbles on his or her own ● Turns over container to pour out contents ● Builds tower of 4 blocks or more ● Might use one hand more often than the other
<p>Language</p>	<ul style="list-style-type: none"> ● Points to object or picture when it is named for him/her ● Recognises names of familiar people, objects and body parts ● Says several single words (by 15 to 18 months) ● Uses simple phrases (by 18 to 24 months) ● Uses 2- to 4-word sentences ● Follows simple instructions ● Repeats words overheard in conversation
<p>Cognitive</p>	<ul style="list-style-type: none"> ● Finds objects even when hidden under 2 or 3 covers ● Begins to sort by shapes and colours ● Begins make-believe play
<p>Social</p>	<ul style="list-style-type: none"> ● Imitates behaviour of others, especially adults and older children ● More aware of him/herself as separate from others ● More excited about company of other children

Emotional	<ul style="list-style-type: none"> • Demonstrates increasing independence • Begins to show defiant behaviour • Separation anxiety increases toward mid-year, then fades
By the end of 3 years	
Movement	<ul style="list-style-type: none"> • Climbs well • Walks up and down stairs, alternating feet (one foot per stair step) • Kicks ball • Runs easily • Pedals tricycle • Bends over easily without falling
Hand and Finger Skills	<ul style="list-style-type: none"> • Makes up-and-down, side-to-side and circular lines with pencil or crayon • Turns book pages one at a time • Builds a tower of more than 6 blocks • Holds a pencil in writing position • Screws and unscrews jar lids, nuts and bolts • Turns rotating handles
Language	<ul style="list-style-type: none"> • Follows a 2- or 3-part command • Recognises and identifies almost all common objects and pictures • Understands most sentences • Understands placement in space ('on', 'in', 'under') • Uses 4- to 5-word sentences • Can say name, age and sex • Uses pronouns (I, you, me, we, they) and some plurals (cars, dogs, cats) • Strangers can understand most of his/her words
Cognitive	<ul style="list-style-type: none"> • Makes mechanical toys work • Matches an object in hand or room to a picture in a book • Plays make-believe with dolls, animals and people • Sorts objects by shape and colour • Completes puzzles with 3 or 4 pieces • Understands concept of 'two'
Social	<ul style="list-style-type: none"> • Imitates adults and playmates • Spontaneously shows affection for familiar playmates • Can take turns in games • Understands concept of 'mine' and 'his/hers'
Emotional	<ul style="list-style-type: none"> • Expresses affection openly • Expresses a wide range of emotions • By 3, separates easily from parents • Objects to major changes in routine

By the end of 4 years	
Movement	<ul style="list-style-type: none"> • Hops and stands on one foot up to 5 seconds • Goes upstairs and downstairs without support • Kicks ball forward • Throws ball overhand • Catches bounced ball most of the time • Moves forward and backward with agility
Hand and Finger Skills	<ul style="list-style-type: none"> • Copies square shapes • Draws a person with 2 to 4 body parts • Uses scissors • Draws circles and squares • Begins to copy some capital letters
Language	<ul style="list-style-type: none"> • Has mastered some basic rules of grammar • Speaks in sentences of 5 to 6 words • Speaks clearly enough for strangers to understand • Tells stories
Cognitive	<ul style="list-style-type: none"> • Correctly names some colours • Understands the concept of counting and may know a few numbers • Tries to solve problems from a single point of view • Begins to have a clearer sense of time • Follows 3-part commands • Recalls parts of a story • Understands the concepts of 'same' and 'different' • Engages in fantasy play
Social	<ul style="list-style-type: none"> • Interested in new experiences • Cooperates with other children • Plays 'Mom' or 'Dad' • Increasingly inventive in fantasy play • Dresses and undresses • Negotiates solutions to conflicts • More independent
Emotional	<ul style="list-style-type: none"> • Imagines that many unfamiliar images may be 'monsters' • Views self as a whole person involving body, mind, and feelings • Often cannot tell the difference between fantasy and reality

By the end of 5 years	
Movement	<ul style="list-style-type: none"> • Stands on one foot for 10 seconds or longer • Hops, somersaults • Swings, climbs • May be able to skip
Hand and Finger Skills	<ul style="list-style-type: none"> • Copies triangle and other shapes • Draws person with body • Prints some letters • Dresses and undresses without help • Uses fork, spoon and (sometimes) a table knife • Usually cares for own toilet needs
Language	<ul style="list-style-type: none"> • Recalls part of a story • Speaks sentences of more than 5 words • Uses future tense • Tells longer stories • Says name and address
Cognitive	<ul style="list-style-type: none"> • Can count 10 or more objects • Correctly names at least 4 colours • Better understands the concept of time • Knows about things used every day in the home (money, food, appliances)
Social	<ul style="list-style-type: none"> • Wants to please friends • Wants to be like friends • More likely to agree to rules • Likes to sing, dance and act • Shows more independence and may even visit a next-door neighbour by him/herself
Emotional	<ul style="list-style-type: none"> • Aware of gender • Able to distinguish fantasy from reality • Sometimes demanding, sometimes eagerly cooperative

Source: Centers for Disease Control and Prevention (CDC) (2011), *Developmental Milestones*.

Appendix 6: Parental issues that can impact on parenting capacity

1. Unborn Child	
Key concerns	Protective factors
<ul style="list-style-type: none"> • Genetic transmission of some forms of mental illness. • Foetal damage brought about by intake of harmful substances. The impact will depend on which substances are taken, the stage of the pregnancy when drugs and alcohol are used, and the route, amount and duration of drug or alcohol use. • Foetal damage as a result of physical/domestic violence. This may include foetal fracture, brain injury and organ damage. • Spontaneous abortion, premature birth and low birth weight, and still birth. 	<ul style="list-style-type: none"> • Good regular antenatal care. • Adequate nutrition, income support and housing for the expectant mother. • The avoidance of viruses, unnecessary medication, smoking, illicit drug or alcohol use, and severe stress. • Support for the expectant mother of at least one caring adult. • An alternative, safe and supportive residence for expectant mothers subject to violence and the threat of violence.
2. Children aged 0-2 years	
Key concerns	Protective factors
<ul style="list-style-type: none"> • Drugs and alcohol use and violence during pregnancy may have caused neurological and physical damage to the baby. • Babies may be neglected physically and emotionally to the detriment of their health. • The child's health problems may be exacerbated by living in an impoverished physical environment. • Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglecting behaviour. • Children may fail to develop a positive identity because they are rejected and are uncertain of who they are. • Babies suffering withdrawal symptoms from foetal addiction may be difficult to manage. 	<ul style="list-style-type: none"> • The presence of an alternative or supplementary caring adult who can respond to the developmental needs of babies. • Sufficient income support and good physical standards in the home. • Regular supportive help from primary healthcare team, social services, extended family, including consistent day care. • An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.

<ul style="list-style-type: none"> • A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses that lead to faulty attachment. 	
<h3>3. Children aged 3-4 years</h3>	
<p>Key concerns</p>	<p>Protective factors</p>
<ul style="list-style-type: none"> • Children are placed in physical danger by parents whose physical capacity to care is limited. • Children's cognitive development may be delayed through lack of stimulation, disorganisation and failure to attend pre-school facilities. • Children's attachment may be damaged by inconsistent parenting. • Children may learn inappropriate behavioural responses through witnessing domestic violence. • When parents' behaviour is unpredictable and frightening, children may display emotional symptoms similar to those of post-traumatic stress disorder. • Children may take on responsibilities beyond their years because of parental incapacity. • Children may be at risk because they are unable to tell anyone about their distress. • Children may have their physical needs neglected, e.g. they may be unfed and unwashed; not toilet-trained. • Children may be subjected to direct physical violence by parents. 	<ul style="list-style-type: none"> • The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child. • Sufficient income support and good physical standards in the home. • Regular supportive help to the family, including consistent day care, respite care, accommodation and family assistance. • Regular attendance at pre-school facilities. • An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.

4. Children aged 5-9 years	
Key concerns	Protective factors
<ul style="list-style-type: none"> ● Children may be at increased risk of physical injury and show symptoms of extreme anxiety and fear. ● Academic attainment is negatively affected and children's behaviour in school may become problematic. ● Identity, age and gender may affect outcomes. Boys more quickly exhibit problematic behaviour, but girls also affected if parental problems endure. ● Children may develop poor self-esteem and may blame themselves for their parents' problems. ● Inconsistent parental behaviour may cause anxiety and faulty attachments. ● Children's fear of hostility. ● Unplanned separation can cause distress and disrupt education and friendship patterns. ● Children feel embarrassment and shame over parents' behaviour. As a consequence, they curtail friendships and social interaction. ● Children may take on too much responsibility for themselves, their parents and younger siblings. ● Children may model themselves on inappropriate role models, e.g. exhibit bullying behaviour. 	<ul style="list-style-type: none"> ● Children have the cognitive ability to rationalise drug and alcohol problems in terms of illness. This enables them to accept and cope with parents' behaviour more easily. ● The presence of an alternative, consistent, caring adult who can respond to the cognitive and emotional needs of the children. ● Sufficient income support and good physical standards in the home. ● Regular supportive help to the family, including consistent day care, respite care, accommodation and family assistance. ● Regular attendance at school. ● Sympathetic and vigilant teachers/school nurses. ● Attendance at school health appointments. ● An alternative, safe and supportive residence for mothers and children subject to violence and the threat of violence. ● A supportive older sibling. Older siblings can offer significant support to children, particularly when parents are overwhelmed by their own problems. ● A friend. Children who have at least one mutual friend have been shown to have higher self-worth and lower scores on loneliness than those without. ● Social networks outside the family, especially with a sympathetic adult of the same sex. ● Belonging to organised out-of-school activities, including homework clubs. ● Being taught different ways of coping and being sufficiently confident to know what to do when parents are incapacitated. ● An ability to separate, either psychologically or physically, from the stressful situation.

5. Children aged 10-14 years	
Key concerns	Protective factors
<ul style="list-style-type: none"> • Children fear being hurt. • Children at increased risk of actual injury. • Children are anxious about how to compensate for physical neglect. • Children's education suffers because they find it difficult to concentrate. • School performance may be below expected ability. • Children may miss school because of looking after parents or siblings. • Children reject their families and have low self-esteem. • Children are cautious of exposing family life to outside scrutiny. • Friendships are restricted. • Children fear the family may be broken up. • Children feel isolated and have no-one to turn to. • Children are at increased risk of emotional disturbance and conduct disorders including bullying. • An increased risk of sexual abuse in adolescent boys. • The problems of being a young carer increase. • Children may be in denial of own needs and feelings. • Information on how to contact relevant professionals and a contact person in the event of a crisis regarding the parent. • Unstigmatised support from professionals. Some children derive satisfaction from the caring role and their responsibility for and influence within the family. However, many feel their role is not sufficiently recognised. • An alternative, safe and supportive residence for mothers subject to violence and the threat of violence. 	<ul style="list-style-type: none"> • Sufficient income support and good physical standards in the home. • Practical and domestic help. • Regular medical and dental checks, including school health appointments. • Factual information about puberty, sex and contraception. • Regular attendance at school. • Sympathetic and vigilant teachers/ school nurses. • Belonging to organised out-of-school activities, including homework clubs. • A mentor or trusted adult with whom the child is able to discuss sensitive issues. • An adult who assumes the role of 'champion' and is committed to the child. • A mutual friend. Research suggests that positive features in one relationship can compensate for negative qualities in another. • The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated. • An ability to separate, either psychologically or physically, from the stressful situation.

6. Children aged 15 and over	
Key concerns	Protective factors
<ul style="list-style-type: none"> • Teenagers have inappropriate role models. • Teenagers are at greatest risk of accidents. • Teenagers may have problems related to sexual relationships. • Teenagers may fail to reach their potential. • Teenagers are at increased risk of school exclusion. • Poor life chances due to exclusion and poor school attainment. • Low self-esteem as a consequence of inconsistent parenting. • Increased isolation from both friends and adults outside the family. • Teenagers may use aggression inappropriately to solve problems. • Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime. • Teenagers' own needs may be sacrificed to meet the needs of their parents. 	<ul style="list-style-type: none"> • Sufficient income support and good physical standards in the home. • Practical and domestic help. • Regular medical and dental checks. • Factual information about sex and contraception. • Regular attendance at school or a form of further education. • Sympathetic, empathetic and vigilant teachers/school nurses. • For those no longer in full-time education, a job. • A trusted adult with whom the child is able to discuss sensitive issues. • An adult who assumes the role of 'champion' and is committed to the child. • A mutual friend. Research suggests that positive features in one relationship can compensate for negative qualities in another. • An ability to separate, either psychologically or physically, from the stressful situation. • Information on how to contact relevant professionals and a contact person in the event of a crisis regarding the parent. • Unstigmatised support from relevant professionals who recognise their role as a young carer. • An alternative, safe and supportive residence for young people subject to violence and the threat of violence.

Source: NESPC (2011)

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What is the *Child Protection and Welfare Practice Handbook*?

The *Child Protection and Welfare Practice Handbook* has been written as a practice resource to support best practice in front-line child protection and welfare work. It is designed to be a companion volume and to complement *Children First: National Guidance for the Protection and Welfare of Children* (2011) and sets out the key issues in the areas of recognising abuse, responding to referrals, risk factors, assessment, planning and intervention.

Who is the Practice Handbook for?

It is written primarily for HSE Children and Family Services' Social Work practitioners, with Section 2 of the Handbook dedicated to allied professionals and volunteers who work with children and their families. It will be of use to the whole spectrum of agencies and services that are directly or indirectly involved in the protection and welfare of children.

How to use it

The Practice Handbook is intended as a practical resource that is easy to carry and to use for reference when needed. It is divided into 5 key sections and seeks to support practitioners with key messages from national and international research, findings from official Inquiries and learning from good practice. Please see Section 1.1 for further information on how to use the Practice Handbook.

Where to find it

Download an electronic version from www.hse.ie/go/childrenfirst
OR www.worriedaboutachild.ie

If you have any further questions about the Handbook and *Children First: National Guidance* (2011), please visit the FAQ section on www.hse.ie/go/childrenfirst OR www.worriedaboutachild.ie

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