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An examination of recommendations from inquiries into events in families and their interactions with State services, and their impact on policy and practice

Department of Children and Youth Affairs – Irish Research Council
Research Development Initiative

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It only remains for us to take total responsibility for the contents of the report.

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Executive Summary

This study was commissioned by the Department of Children and Youth Affairs with the overall aims of examining the recommendations from a number of specific inquiry reports in relation to child protection failings in Ireland, ascertaining the degree to which the recommendations were implemented in the context of concurrent reforms, and developing a template to guide recommendations in future reports. The study examines the recommendations of the following five reports of inquiry: Kilkenny Incest Investigation (McGuinness, 1993); Kelly – A Child is Dead (Joint Committee on the Family, 1996); West of Ireland Farmer Case (Bruton, 1998); Monageer Inquiry (Brosnan, 2009); and the Roscommon Child Care Case (Gibbons, 2010).

Objectives

The objectives of this research study were as follows:

- To examine the recommendations from the five reports.
- To produce an overview of policy and practice developments in child protection and welfare over the past two decades and demonstrate the degree to which recommendations were directly and indirectly responsible for reforms.
- To evaluate the recommendations in terms of their relevance to the report findings.
- To establish a template for recommendations that will inform the design and terms of reference for future reviews, be capable of comprehensively addressing the complexity of child protection practice and policy, and
  - be realistic and measurable;
  - promote learning;
  - reflect the principles underpinning the National Children's Strategy; and ultimately
  - enhance practice and produce better outcomes.
- Through the course of the research, identify key issues for policy and practice development.

This was a small-scale qualitative study, which focused on a very limited number of reports of inquiries on child protection failings and was based on documentary research and semi-structured interviews. The interviews were conducted with a selected group of 21 current and retired professionals who had been close to the inquiry process, either as members of inquiry teams or as managers with some responsibility for implementing recommendations. Information on implementation of recommendations was provided to the researchers by 21 informants. Some of the interviewees and informants provided documentation to the researchers about the implementation process, including plans and progress reports.

Inquiries and reviews into child protection failings

Since the early 1990s, there have been 29 inquiries and reviews in Ireland in response to concerns arising from the serious abuse and/or death of children known to the statutory child protection services, from which 551 recommendations have emerged. There have also been an unknown number of internal reports, which have not been published and which are not covered by this study.

The process and structure of inquiries, as well as their role and function, were examined in this research, together with the role played by them in public policy in Ireland and elsewhere. It was noted that even when inquiry proceedings are not publicly accessible, the inquiry report assumes a particularly important role in terms of providing re-assurance, allaying public concerns and restoring trust in the capacity of the public sector. Research that debated the usefulness of child abuse inquiries was reviewed and while the opportunities for change and development created by them was acknowledged, a number of perverse and unintended consequences flowing from the self-perpetuating nature of inquiries was identified. The evolution of the child protection and welfare system over the time span of the five inquiry

reports was tracked and mapped the emergence of different policy directions, the shift in focus from the narrow concept of 'child battering' by parents to the assumption of responsibility by the State for preventing child harm and upholding children's rights. The expansion of services, which was matched by the accretion of legal measures, regulations and guidelines, was described in terms of the different policy orientations which the system tried to adopt at various times, including early intervention and family support. The rise of child protection as a political issue, from its minor role in 1970 to its prominent position today, was profiled in the context of an increase in child protection and welfare reports to social work departments – from 243 in 1978 to 29,277 in 2010.

The inquiry process

The five inquiries at the centre of this study were examined in some detail, focusing on the composition of the different teams, the terms of reference used by each and the methods adopted by the inquiries. The reports were compared in terms of their length and presentation style. The views of interviewees affirmed that inquiries have become an inevitable part of modern life. Some were critical of the inquiry process and reflected on the need to re-orientate the process away from policy reform and more towards learning. While the role and function of inquiries received general support, it was considered that they came at a high price in terms of the personal trauma experienced by participating staff and the defensive practice that was seen to ensue.

Recommendations from the inquiries

The significance of the Kilkenny Report recommendations was acknowledged by research participants and it was observed that the recommendations of later reports had a lesser impact, partially because their focus was slightly narrower.

Recurrent themes in the recommendations were identified. These included the need for improved vigilance and identification of children at risk; better interagency cooperation, record-keeping and exchange of information; and protocols for child protection conferences. The need for revision and consistent implementation of guidance featured in the Kilkenny Report, and as it gradually became known that *Children First* and other guidance were not being fully implemented, this recommendation was reiterated in later reports. Each report cited the need for training on different topics and the need to prioritise child-centredness and children's rights was implicit in all of them.

While most research participants considered inquiry recommendations to be relevant and useful, critiques were expressed in terms of their quantity, predictability, vagueness and repetitiveness. It was considered that some level of consultation between inquiry members and policy-makers prior to finalising the report would be beneficial in pre-empting recommendations that would 'land the whole system in the soup'.

Implementation of recommendations

The inquiries examined in this study span the period from 1993 to 2010 and the inevitable development of policy and restructuring of relevant organisations over the past 20 years has altered the child protection system to the point where some recommendations from early inquiries have become irrelevant.

The study findings indicate that, with few exceptions, recommendations from the Kilkenny Report were implemented. The majority of the recommendations from the other two inquiries from the 1990s (Kelly Fitzgerald and the West of Ireland Farmer Case) were addressed by the

development of some national, but mostly local policies and protocols, but it was not possible to assess whether the changes were fully operationalised at the front-line of practice. In some instances, parts of recommendations were implemented, while other parts were not. Some recommendations were implemented locally, but not nationally. Others were implemented for a limited time, followed by reversion back to the former status quo. It appeared that a number of recommendations from the different reports acted as triggers for the implementation of policies and measures that had been planned and aspired to, but had not been fully operationalised due to lack of funding or lack of readiness on the part of society.

The two reports published in the late 2000s (the Monageer Inquiry and the Roscommon Child Care Case) received a more formal response. However, subsequent action in respect of the policy, organisational and management recommendations seems to have been partially obscured by other developments and the degree to which the new measures were deliberately intended to address the recommendations is not always clear. In some aspects, implementation is still underway.

There was a trend whereby certain recommendations made by each of the inquiries appeared difficult to implement in full or with any lasting effect. Those involving disciplines which one interviewee described as outside the 'sphere of child protection' were less likely to be implemented and the recommendations on management and exchange of information between disciplines by use of central registers or indexes also appeared complex to address.

Moreover, the present research draws a distinction between *addressing* and *implementing* recommendations. The limited scope of the study, which was not intended to be an audit, could not ascertain whether all the measures recommended to improve practice have been put into day-to-day operation. The findings made in previous reviews and investigations in respect of non-compliance with *Children First* and the Garda/Health Board protocols would suggest that caution should be applied in making any assumptions in that regard.

Implications for policy and practice

While the study has determined that inquiry recommendations, particularly those from the Kilkenny Report, have acted as a mechanism for positive change, findings also indicate that recommendations have become too numerous, predictable and repetitive. It has been suggested that the incremental contribution of more recent inquiries to developments in child protection practice has been less significant. The findings of this study have revealed a type of 'recommendation fatigue', which has developed following the succession of inquiries. It could be inferred that a critical mass has now been reached and the benefits from inquiries have succumbed to the law of diminishing returns. It is suggested that the development of internal quality assurance procedures should reduce the demand for inquiries into child protection failings in the future.

A fresh approach to recommendations

The findings from this study imply a need to re-evaluate the process of drafting and disseminating the recommendations from inquiries. It is proposed that recommendations should be drafted in a separate *forward-looking* phase of the inquiry process, using a different methodology to the fact-finding *backward-looking* initial phase of the inquiry. The approach will be based on an underpinning principle of collaboration. It is suggested that a consultative process should be undertaken by the inquiry team with key stakeholders.

The adoption of such an approach would address a number of concerns raised by the interviewees in this study. It would provide the inquiry team with access to a range of local and expert knowledge, and link the findings and proposed solutions to an evidence base. It would strengthen methodological rigour of the inquiry process and reduce the likelihood that the

inquiry findings and recommendations will be unduly biased by the values and perspectives of the inquiry team. Consultation about recommendations would also ensure that the intention behind them is clearly understood and promote the likelihood that they will be feasible and realistic. It would increase ownership of recommendations by policy-makers and service providers, and potentially reduce the negativity and resentment that sometimes follows inquiries.

Cognisant of the reservations expressed by some interviewees – that consultation might compromise the independence of the inquiry team – it is proposed that a protocol be drawn up. This could usefully be included in the terms of reference of the inquiry. Under the protocol, it is proposed that an advisory group should be established at the start of the inquiry, to assist the inquiry team. The members should be selected following consultations between the commissioner and the Chair, and should be drawn from a range of relevant disciplines. The role of the advisory group would be to provide the inquiry team with expert advice, including written advice, as required. In developing recommendations, the inquiry team should invite and consider written submissions from relevant stakeholders. Once the recommendations are drafted, the inquiry team should conduct a workshop with invited participants to discuss them. It is also suggested that the inquiry team should be involved in a series of briefings when recommendations have been finalised. Importantly, in order to protect the independence of the inquiry, the consultation processes will be managed, directed and controlled by the inquiry team.

Template for drafting CLEAR recommendations

The final part of this report presents a template for drafting recommendations that are primarily oriented towards the organisation, management and delivery of professional public services. The template consists of 5 individual and interlocking CLEAR components, as described below.

Case for change: A convincing case for change needs to be outlined as change may require modification of norms, perspectives and behaviours, as well as structures and policies.
Learning-oriented: Identify key learning points and any training/skill gaps that need to be addressed.
Evidence-based: Recommendations must draw on an evidence base when identifying solutions to policy and practice deficits identified in the report.
Assign responsibility: Each recommendation should identify the discipline, directorate or organisation with responsibility for implementation, recognising that some recommendations will require a collaborative response.
Review: Recommendations should be written in a manner that facilitates review. This can be achieved by clearly specifying desired outcomes and time lines, and any additional resources required to achieve them.

Case for change

Inquiry teams should clearly identify the issues that give rise to the need for change, outlining the likely consequences should no change occur. Importantly, the proposed change should be contextualised within current policy, or that which is known to be in preparation. This will indicate the level of congruence between current or planned policies and change proposed by the recommendation.

Learning-oriented

Recommendations should highlight key lessons for practice revealed by the inquiry process and should promote the transfer of learning. Deficits in knowledge or practice skills are not always attributable to lack of training, but can be linked with inadequate information and guidance. Such deficits may need to be addressed through additional research, expanded databases and practice guidance on specific topics. Messages for practice could be elaborated in a separate section of the report, which can reference research and theory.

Evidence-based

Recommendations should draw on different types of evidence. First, they should flow from evidence of any deficits in policy or practice revealed by the inquiry. Secondly, they should demonstrate knowledge of the context in which recommendations are to be implemented, for example, current and planned policy developments. Thirdly, recommendations in respect of policies, programmes or interventions should only be made if evidence exists and can be cited, indicating that their implementation will effectively address and remediate the deficits identified by the inquiry report.

Assign responsibility

Recommendations should clearly specify which discipline, directorate or organisation is implicated in their implementation. If a multi-agency response is required, each individual discipline or organisation required to respond should be identified, as well as a leader to carry responsibility for coordinating and overseeing implementation.

Review

A set of learning points and recommendations that follow the format proposed in this template should be amenable to review. It should also be feasible to link recommendations to regulatory processes, such as the HIQA standards for child protection, as well as the quality benchmarks that are planned for the Child and Family Agency.

Conclusions

The key messages from this study were, in summary, that inquiries in the future should take a fresh approach which minimises the number of prescriptive recommendations and focuses instead on key learning points which may be disseminated within and across organisations. It is proposed here that a consultative, collaborative approach is taken to the development of recommendations and a protocol for this process has been suggested. It is argued that a consultative approach would provide clarity, prevent misinterpretation and promote ownership. It should also ensure that the recommendations are informed by all relevant sources of information, knowledge and expertise, and it should ultimately render them more feasible and cost-effective. It is further suggested that recommendations should be framed in a way that illustrates the rationale for change, promotes learning, cites evidence, identifies the organisation or sector responsible for their implementation, and outlines them in such a way that progress in their application will be easy to evaluate. The proposed template for CLEAR recommendations has been designed to incorporate these messages and takes account of the difficulty of measuring outcomes in areas that involve the exercise of professional judgement.

1. Introduction

Over the past 20 years, 29 child abuse inquiries and reviews have been published in Ireland and have, between them, offered 551 recommendations, most of which proposed local or national policy changes. When the report of the Kilkenny Incest Investigation was published in 1993, child protection played a very minor role in the business of central government and the health and social services. Twenty years later, the sector is governed by a Department of Children and Youth Affairs, with a full Cabinet-level Minister and a standalone statutory Child and Family Agency will shortly be fully functioning. Thirty-two pieces of child-related legislation have been enacted in the interim, with two significant measures under consideration at the time of writing. An amendment to the Constitution reflecting the rights of children is imminent. Within this legislative framework, the Child and Family Agency will base its day-to-day operations on legislation, regulation and statutory guidance, as well as 185 separate policies, none of which were in existence in 1993.

It is generally assumed that inquiry recommendations have contributed to the shape of the current system, although the degree to which they did so has not, up to this point, been measured or documented. The question may also be legitimately asked whether a critical mass of policy recommendations has been reached and whether their approach might be usefully modified while new reforms are becoming embedded. The present research, which has been commissioned by the Department of Children and Youth Affairs (DCYA), addresses these questions by examining five intra-familial child abuse inquiries, analysing reforms in the child protection and welfare system since 1970 and holding interviews and consultations with key stakeholders and informants in the sector.

The report is divided into 7 chapters. This first chapter outlines the role of inquiries in public policy. It goes on to outline the aims and objectives of the study and describes the methodology used. *Chapter 2* provides a literature review on the topic of the inquiry process, including child protection inquiries, and discusses available research on the utility and effectiveness of recommendations from inquiries. *Chapter 3* describes and analyses child protection policy development from 1970 to 2010, which is the time span covered by the inquiry reports. *Chapter 4* focuses on the five inquiry reports that are the subject of this research – the Kilkenny Incest Investigation (McGuinness, 1993); Kelly – A Child is Dead (Joint Committee on the Family, 1996); West of Ireland Farmer Case (Bruton, 1998); Monageer Inquiry (Brosnan, 2009); and the Roscommon Child Care Case (Gibbons, 2010). It reviews the inquiries and begins to report on the findings from research interviews on aspects of the inquiry process. *Chapter 5* describes the recommendations from the five reports and, again, reports on the perspectives of the interviewees on their appropriateness. *Chapter 6* moves on to implementation and by drawing on documentary material, interview data and information received in consultations with relevant personnel, it offers a picture of the extent to which recommendations have been implemented to date. Finally, *Chapter 7* considers the findings from this study, suggests some alternative methods for getting the best out of inquiry reports and offers a suggested template for the development of recommendations from future inquiries of this nature.

Inquiries and public policy

Inquiries of various formats are established to investigate matters of significant public concern. Inquiries have been described as a 'cultural script' (Burgess, 2009, p. 4) which respond to the demand that 'something be done'. In responding to this demand, they can create the erroneous impression that adverse outcomes are avoidable or eradicable.

The purpose of inquiries has been variously described (*see* Burgess, 2009; PASC, 2005; Howe, 1999), but here we cite the six purposes of inquiries identified by the Law Reform Commission (2005): establishing the facts; learning from events; catharsis; re-assurance; accountability or blame; and political considerations.

As the use of inquiries has proliferated, their effectiveness has come under increased scrutiny and criticism (Mackie, 2012; Burgess, 2009 and 2011; Sulitzeanu-Kenan, 2006; PASC, 2005; Stutz, 2005). Criticisms directed at inquiries include claims that they are ineffectual, overly time-consuming and expensive, produce too many recommendations, are democratically unaccountable, present an unbalanced impression because they are only concerned with what goes wrong, assign blame inappropriately, do not position events in context and introduce prohibitions, restrictions and regulations that have unforeseen consequences (Burgess, 2009).

Evidence-based policy is now advocated in all areas of the public service and is seen as a '*natural consequence of more open and transparent government*' (Ruane, 2013). However, a 'natural' link between evidence and policy cannot be assumed since some sources of evidence will be excluded from policy debates while others will feature prominently. As Stevens (2011) has argued, the evidence base that underpins policy decisions is formed after choices are made between multiple and often competing sources of 'evidence'. He and others further observe that the complex processes that shape the evidence–policy relationship are opaque and do not lend themselves easily to negotiation or interpretation (Stevens, 2007 and 2011; Monaghan, 2010). Inquiries, it is argued, are just one of the many forms of evidence that enter into policy debates (Stevens, 2011).

If it is accepted that the influence of different types of evidence on policy debates and policy formation will be variable, unpredictable and at times difficult to discern, it might be assumed that not all of the evidence from a particular source, such as inquiries, will ultimately be reflected. Nonetheless, the establishment of an inquiry seems to bring with it an expectation that recommendations will be incorporated into public policy. This expectation seems to afford the recommendations that stem from the inquiry process a privileged authoritative status not proffered to other types of evidence. Stevens (2011, p. 247) points to '*distaste for uncertainty, complexity and contradiction within policy-making circles*'. If there is an appetite in policy-making circles for precision, certainty and accuracy, or at least a desire to claim these qualities, one can begin to see why inquiries might be an especially compelling source of evidence for policy-makers and also crucially why it might be politically damaging to openly contest inquiry recommendations. Inquiries reach definitive conclusions and present recommendations that carry an alluring promise of providing solutions to problems.

Child abuse inquiries

For some decades, inquiries into child abuse and child protection failings have been a recurrent element of child protection policy and practice in Anglophone countries. In Britain, the regular use of the inquiry process began in the 1970s with an inquiry into the death of Graham Bagnall (Salop County Council, 1973)[1], which was quickly followed by the Maria Colwell Inquiry (London Borough of Brent, 1974). The Maria Colwell Inquiry is considered to have been transformative in terms of child protection practice (Reder and Duncan, 2004; Butler and Drakeford, 2005) and is directly attributed with a radical change in the approach to child protection services (Parton, 2004; Reder and Duncan, 2004) in Britain and in most English-speaking countries. Since the early 1990s, inquiries into child protection failings in Britain have been largely replaced by serious case reviews (SCRs), in an attempt described by Parton (2011, p. 7) *'to try and pre-empt and perhaps avert the need for time-consuming, expensive and high profile public inquiries … in the future'*. However, the use of inquiries has not been abandoned and the major policy and practice changes which stemmed from the Victoria Climbié Inquiry (Laming, 2003) suggest that they remain a powerful mechanism for bringing about systemic change. Similarly, in New South Wales, Australia, the Wood Royal Commission (2008) is credited with transforming the delivery of services in that state and with laying the groundwork for a national child protection framework.

[1] An inquiry into the death of Dennis O'Neil was held in 1945, but inquiries as a *regular* response to perceived failings only began in the 1970s.

Although it is acknowledged that inquiries have contributed to the development of child protection practices, it has also been contended that the repeated use of inquiries to examine child protection failings can impact negatively on child protection policy and practice (Dingwall, 1986; Butler and Drakeford, 2005; Munro, 2011). Despite criticisms, the detailed scrutiny and evaluation of inquiry recommendations is relatively recent (*see* Brandon *et al*, 2011; Devaney *et al*, 2011; Sidebotham *et al*, 2010; Rose and Barnes, 2008; Axford and Bullock, 2005). Critics have pointed to the frequency and repetitive nature of recommendations as evidence that inquiries are not effective tools for bringing about change in professional practices, which are dependent on independent thinking and decision-making and which cannot be reduced to mechanistic responses.

In Britain, child protection inquiries have been associated with an increased emphasis on the management of risk and an orientation towards defensive practice. Parton (2003) argues that public inquiries have been the '*key vehicle*' through which changes in child protection policy and practice have been brought about, which, he contends, place an emphasis on the production and recording of information but not necessarily on the adequate assessment and management of the information produced. Similarly, Munro (2011, p. 19) points to the role played by inquiries in fostering a culture of managerialism and claims '*each inquiry adds a few more rules to the book, increases the pressure on staff to comply with procedures, and strengthens the mechanisms for monitoring or inspecting practices so that non-compliance can be detected*'. She notes that while each addition makes sense when viewed in isolation *'the cumulative effect is to create a work environment full of obstacles to keeping a clear focus on meeting the needs of children'*. It is claimed that the emergence of an *'inquiry culture'* has resulted in professional social work being *'conducted in the shadow of possible investigation'*, which *'shapes how everything is done in a way that encourages self-protection'* (Burgess, 2009, p. 64).

Inquiries in Ireland

The Kilkenny Incest Investigation in 1993 marked the beginning of a series of inquiries into child protection failings in Ireland. In all, this study has identified 29 Irish inquiries and reviews into child abuse and child protection failings, published between 1993 and 2012. These are detailed in Chapter 4. It is noted that demand for inquiries into child protection failings may be reduced as a result of the ongoing development of a more rigorous system of internal quality assurance and in particular due to the reviews conducted by the National Review Panel established in 2010 following the publication by the Health Information and Quality Authority of *Guidance for the Health Service Executive for the Review of Serious Incidents including the Deaths of Children in Care* (HIQA, 2010).

The present study focuses on the five reports of inquiries that concerned cases of intra-familial child abuse, published between 1993 and 2010, namely: the Kilkenny Incest Investigation (McGuinness, 1993); Kelly – A Child is Dead (Joint Committee on the Family, 1996); West of Ireland Farmer Case (Bruton, 1998); Monageer Inquiry (Brosnan, 2009); and the Roscommon Child Care Case (Gibbons, 2010). To date, these reports and their recommendations have not been the subject of critical independent evaluation.

Aim and objectives of this study

The overall aim of this research study was to examine the recommendations of five Irish child abuse inquiry reports, to ascertain the degree to which they were implemented in the context of concurrent reforms and to develop a strategy to improve the relevance and achievability of recommendations in future reports. The specific objectives of the study were:

- To examine the recommendations from the five reports.
- To produce an overview of policy and practice developments in child protection and welfare over the past two decades and demonstrate the degree to which recommendations were directly and indirectly responsible for reforms.
- To examine the recommendations in terms of their relevance to the report findings.
- To establish a template for recommendations that will inform the design and terms of reference for future reviews, be capable of comprehensively addressing the complexity of child protection practice and policy, and
  - be realistic and measurable;
  - promote learning;
  - reflect the principles underpinning the National Children's Strategy; and ultimately
  - enhance practice and produce better outcomes.
- Through the course of the research, identify key issues for policy and practice development.

Methodology

This study uses qualitative research methods to assess the significance and implementation of the recommendations of five reports of inquiries into child protection failings. The reports scrutinised are the Kilkenny Incest Investigation (McGuinness, 1993); Kelly – A Child is Dead (Joint Committee on the Family, 1996); West of Ireland Farmer Case (Bruton, 1998); Monageer Inquiry (Brosnan, 2009); and the Roscommon Child Care Case (Gibbons, 2010).

Unlike quantitative research which seeks to identify causal and determinate relationships, and therefore generalisable patterns, qualitative research seeks to provide insight and knowledge which may be illuminating but not necessarily generalisable (Golafshani, 2003). Qualitative research is therefore especially useful for exploring and promoting a greater understanding of issues, such as the issue that this study is concerned with, which are nuanced and contested and do not lend themselves to a single definitive explanation.

This study recognises a range of perceptions regarding the recommendations of the reports of inquiry and adopts an interpretative stance in arriving at its assessment. Multiple methods were employed. As far as possible, data collected from the semi-structured interviews were verified by reference to documentary evidence or the evidence of other research participants or research informants. In this way, the study used triangulation as a strategy to ensure that the analysis presented is rigorous, thorough and probing (Denzin and Lincoln, 2008).

As quantitative and qualitative research are oriented towards different outcomes, it has been argued that quantitative and qualitative research should be evaluated using different criteria (Lincoln and Guba, 1985; Stenbacka, 2001). An assessment of validity and reliability may provide a good measure of quantitative research, but it may be more appropriate to evaluate qualitative research using different barometers. The reliability of qualitative research may be most usefully assessed by reference to criteria such as credibility, dependability and transferability (Golafshani, 2003). Similarly, rather than seeking to consider the validity of qualitative research, it may be more beneficial to consider the rigour, trustworthiness (Golafshani, 2003) and independence or neutrality of the research.

The evidence presented in this study has been carefully evaluated. While recognising a range of perceptions and interpretations of the inquiry process and inquiry recommendations, this study also sought to ensure that the views reported were credible and substantiated by other evidence. In accordance with these criteria, we have sought to conduct the study in a rigorous, sound and trustworthy manner, and to present results that are credible, dependable and transferable.

The principal research methods adopted were semi-structured interviews and documentary research, both of which are detailed below.

The study was commissioned by the Department of Children and Youth Affairs (DCYA) in 2012 and was conducted between 1st November 2012 and 30th April 2013.

Ethical approval

Prior to the commencement of the study, an application for ethical approval was submitted to the Research Ethics Committee of the School of Social Work and Social Policy, Trinity College, Dublin. Ethical approval was granted by the committee. All research participants were provided with a Research Information Sheet, which included an outline of the research project and set out the research aims and methodology, as well as the proposed dissemination and publication of the research findings (*see Appendix 4*). Participants were assured that direct (and anonymised) quotes would only be included in the report with their prior approval. All participants formally acknowledged that their participation in the research was informed and voluntary (*see Appendix 3*).

Advisory group

A 6-member advisory group was established at the outset of the research. Members included a representative of the commissioning body (the DCYA), two academics, a representative from the regulatory body for child protection and welfare, one person involved in the management of statutory child protection and welfare services, and a member of a children's rights advocacy group. The proposed research methodology was discussed and approved at an advisory group meeting prior to the commencement of the interviews. Two advisory group meetings were held during the course of the project.

Interviews – methods

Semi-structured interviews were conducted with 21 individuals, who provided a range of insights into the five reports of inquiries and their recommendations. People who were interviewed are referred to as 'research participants' or 'interviewees' throughout this report. People who were not interviewed, but who assisted the inquiry process are referred to as 'research informants'.

The interviews focused primarily on the recommendations within the five reports of inquiries on child protection failings. Secondary themes explored included research participants' views about the inquiry process; the role of inquiries as drivers of child protection policy and practice in Ireland; and how the inquiry process and inquiry recommendations could be improved. The interviews were conducted between January and March 2013 and ranged in duration from about 40 minutes to 1½ hours.

Twenty-one informants were not formally interviewed, but assisted the research by providing clarification or information on matters pertinent to the implementation of inquiry recommendations. Two informants had been invited for interview, but opted instead to engage with the research on a less formal basis. Informants provided information orally in the course of telephone conversations or in other instances forwarded it in writing by e-mail or post.

Recruitment of research participants

A range of research participants was purposively selected and included:

- inquiry team members;
- professionals who gave evidence to inquiries;
- professionals involved in the implementation of inquiry recommendations within both the HSE/Health Boards, the Department of Health/Department of Children and Youth Affairs, and An Garda Síochána.

Research participants were selected so as to ensure that perspectives regarding each of the five inquiry reports and the various inquiry processes could be gleaned. The participants included at least one member from each inquiry team, as well as people who presented evidence to inquiries; people involved in establishing inquiries; and people tasked with the implementation of inquiry recommendations.

The core group of senior child protection professionals in Ireland is small. The Principal Investigator for this study was able to draw on her own knowledge of key child protection professionals and an extensive network of contacts in order to identify potential research participants. There was also an element of 'snowballing'[2] in the sample selection, particularly in relation to people involved in the implementation of recommendations. A number of research participants were recruited after their names had been proffered by other research participants or research informants.

Potential participants were identified, contacted and provided with a brief outline of the research. For the most part, those contacted responded speedily and positively to the invitation to participate in the research. Efforts to contact one individual did not secure a response and the delayed response of another individual resulted in the planned interview not proceeding.

Interview process

Participants were provided with a list of themes in advance of the interviews. This approach was based on the concept that participants would be better able to give considered and coherent responses about reports and events which had occurred up to 20 years prior to the interview process if they were provided with a period of reflection and some advance indication of the matters likely to be explored. An individualised rather than a standard list of themes was used to reflect the singularity of participants' involvement in and knowledge of the inquiry process.

Some participants prepared for the interviews by reviewing documents and correspondence. Others re-read the reports of inquiry or sometimes the recommendations within reports. Some had conferred with colleagues prior to the interview. Only occasionally were participants reluctant to answer a question or to express an opinion.

The majority of the interviews were face-to-face and conducted at a venue chosen by the participant. Trinity College in central Dublin was the most popular choice of venue. A small number of participants opted to hold the interview at their workplace and in just one instance in a hotel. Seven interviews were conducted by telephone. Research information sheets and consent forms were sent in advance to participants who were interviewed over the telephone and they were also advised that they should allocate one hour for the process. At the outset of the interview, they were asked to confirm that they consented to participate in the research and that they understood that the interview would be recorded. Telephone interviews were conducted when participants indicated that this was their preference or when a face-to-face interview might involve a considerable amount of travel time.

[2] Snowballing is a form of non-probability sampling that is particularly suitable for small or difficult-to-access populations. The sample 'snowballs' as existing research participants identify other possible participants.

For the most part, interviewees were conscious that the inquiry process and inquiry reports may be contentious at times. Some had quite strong views on the topic and were keen to have their perspectives and their interpretation of events documented, coming to the interviews because '*they have something they want to say*' (Berry, 2002, p. 680). For a small number of participants, the interview could be described as 'cathartic' because it involved revisiting a period in their lives that had been very challenging and at times distressing. For these participants, it was perhaps especially important to have had an opportunity to contribute to the research.

A number of participants whose involvement with the inquiry process had been especially significant, and in some cases traumatic, drew on 'archival' memories during the interview process. Hoffman and Hoffman (1994, p. 124) define archival memories as '*recollections that are rehearsed, readily available for recall, selected for preservation over the lifetime of an individual*'. They compare the filtering processes involved in archiving memories as similar to that involved in selecting photographs to retain in a scrapbook and photographs to discard. Archival memories become indelible over time and are usually associated with events that are unusual or unique, significant or transformative in the life of the individual, and often highly emotional.

However, the involvement with the inquiry process for other participants was more routine than exceptional and consequently their memories of specific events tended to be less sharp, especially when they had been involved with a series of inquiries.[3] Despite having a period of time to prepare for the interviews, many participants who spoke in detail with regard to the processes and events that surrounded the early inquiries qualified their statements by acknowledging that their recollections were hazy. Transcripts are peppered with statements like 'I don't remember exactly' or 'I can't remember the details' or 'I'm stretching my mind back there'. At times, the interviewer would assist such participants by clarifying a date or sequence of events to trigger a memory.

The methodological process employed in the field work for this research is commonly described as 'elite' interviewing (Dexter, 2006) since it concentrates on a certain calibre of interviewees who currently or previously occupied important positions in their organisations. Kezar (2003) describes elites as 'persons in power', but Dexter's more nuanced explanation makes it clear that the definition of 'elite' will depend on the purposes of the interview. Therefore, in the context of this research project, which has a very specific focus on inquiries into child protection in Ireland, the senior professional status of the research participants within the sphere of child protection and/or their role in the inquiry process warrants that they be designated as 'elites'. However, as Smith (2006) points out, the designation 'elite' has connotations of power relations, which should not be accepted as 'natural' and which may not pertain in the interpersonal space of the interview.

Elite interviewing is sometimes described as interviewing 'up' (Desmond, 2004) and is associated with a number of specific difficulties. The difficulties identified with interviewing elites are around access (Burnham *et al*, 2004; Aberbach and Rockman, 2002; Goldstein, 2002); commitment to the interview process (Phillips, 1998); and control of the interview process and research results (Bygnes, 2008; Berry, 2002). However, this study suggests that in certain contexts the challenges identified in interviewing elites may not materialise since no such difficulties were encountered.

Participants were familiar with the research process: a small number had experience of providing inputs into child protection teaching at third-level institutions, many had completed a Master's degree, a number had contributed to publications on child welfare and protection, and several had previously commissioned relevant research. Participants knew what was expected of them at interview, but were also conscious that they had the power to selectively disclose information.

[3] A small number of participants had been involved in inquiries outside the arena of child protection.

The interview process was therefore very 'transparent' (Duke, 2002) and the researchers did not adopt any strategies to surreptitiously secure disclosures by participants (*see* Desmond, 2004; Leech, 2002; Pollitt Harrison and Marnoch, 1990).

Although no participants objected to the interviews being recorded[4], several asked for the tape to be stopped at points in the interview when they wanted to make 'off the record' disclosures and all participants made 'not for tape' comments at the end of the interview. The interview process could therefore be managed to a certain extent by the participants. This should not be interpreted as the interview process being controlled by the research participants. In the course of qualitative social research interviews, power is negotiated and negotiable, and shifts at various times between the researcher and the participant. Therefore, the interview can most usefully be understood as a joint enterprise between the researcher and the research participant, which neither has full control over. Interviews were recorded and transcribed.

During the course of the interviews, participants presented their understanding and interpretation of inquiry processes and recommendations. It was anticipated that this would throw up a variety of perspectives and views. However, it was also interesting to note that in some instances, and particularly in respect of some inquiries, participants presented multiple versions of 'facts' and varying accounts of the events and decisions that shaped inquiry processes and the publication of inquiry reports. It is suggested that the existence of opposing 'truths' regarding the same collection of events may be linked to a lack of transparency in the processes adopted.

Interviews were conducted by both members of the research team, both of whom also transcribed the interviews. Digital recordings were deleted after transcription. In so far as possible, the researchers transcribed recordings of interviews that they did not personally conduct. In this way, the detailed content of interviews was very familiar to both of them.

As is often the case, many participants spoke very freely to the researchers at the end of the recorded portion of the interview, once they were assured that they were not being recorded. Unrecorded statements are not referred to in this report, although they have informed the researchers' perspectives. In a few instances, while chatting with the researcher at the end of an interview, participants decided that they wished to add to the recorded interview and asked that the recording be resumed. In order to capture any post-interview musings or reflections and in recognition that for some participants the interview had aired traumatic events which had had serious personal consequences, participants were encouraged to contact the researcher if they felt they would like to clarify something they had said or address a matter that had not been raised. A small number of participants did contact the researchers subsequent to the interviews.

Profile of research participants

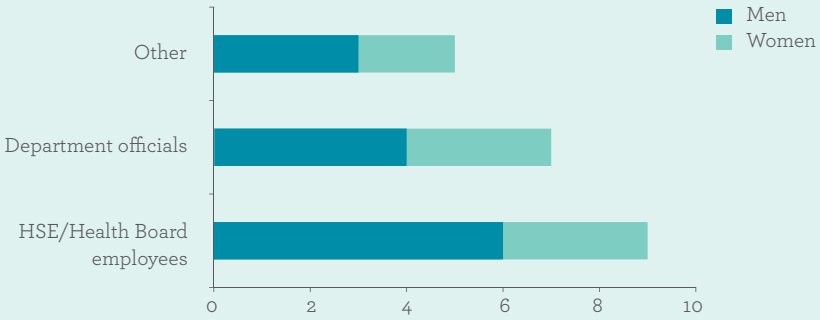
The research participants held a variety of professional positions during the course of this period, not all of which were related to child protection. They included people with experience in the delivery and management of statutory child protection services; people with experience in the development of child protection policy and child protection practice guidelines; people working, or who previously worked, in agencies with statutory child protection responsibilities; and people who are, or have been, engaged in advocacy on behalf of children either through an NGO or individually.

The 21 research participants consisted of 13 men and 8 women. Participants were not asked their age, but it is possible to provide an indicative age range of 40-65+. The most significantly sized cluster of participants was of current and former HSE/Health Board employees, who accounted for 9 of the research participants or 43% of the sample (*see Figure 1*). Officials and

[4] However, one of the informants who declined to be interviewed was concerned by the interview being taped.

former officials of the Department of Health, and later the Department of Health and Children, OMCYA and DCYA accounted for a further 7 of the participants (33%). The remaining 5 participants (24%) are simply described as 'other' in order to preserve their anonymity. A number of interviewees, who spanned all three groups, had been members of the inquiries being reviewed in this study. The five inquiry teams consisted of just 14 individuals. In order to protect the identity of inquiry team members who participated in the research, we have not provided any details of their professional role in child protection or elsewhere.

Figure 1: Profile of research participants



Coding of interview transcripts

Interviews were semi-structured and used mainly open-ended questions. This approach encourages reflective in-depth disclosures that would not be revealed by the use of a more structured approach. However, by encouraging participants to be more expansive and discursive, interviews take on a conversational mode, which may mean that the researcher has to adapt the planned structure of the interview to take account of the participant's disclosures (Ackerman and Rockman, 2002). The approach used provides participants with the freedom to present their understanding of events or issues that may be associated with a multiplicity of meanings and interpretations. It allows participants to explain and justify their views or '*why they think what they think*' (Ackerman and Rockman, 2002, p. 674). However, the process of collating and coding interview responses is more difficult when this more flexible interview format is adopted.

This study addressed these difficulties by firstly ensuring that all the available data were collected. This required the full transcription of all interviews. Both researchers read all the interview transcripts. In order to ensure that the transcripts were coded accurately and appropriately, both researchers collaborated in the process of generating coding themes. The themes that emerged from the data were discussed and an initial set of themes was agreed upon. The interview data were then coded thematically. As the coding progressed, a number of new themes emerged, which necessitated a further re-coding of the transcripts.

Documentary research – methods

The study also draws on a range of documentary sources including 'grey' literature such as Dáil reports; Health Board reviews of child abuse procedures; internal Departmental memorandums; and Ministerial briefings. Documentary sources were obtained through a number of different avenues. Several unsolicited documents were provided by research participants, others were obtained on foot of direct requests to individuals/organisations and Internet searches also located additional sources. Reports of inquiry and records of Dáil proceedings were also important sources of research evidence. The approach adopted in reviewing the reports and Dáil proceedings is outlined in further detail below.

Reports of inquiry

In conducting this research, the five reports of inquiries were a key data source and were analysed in depth. Chapter 4 compares and contrasts the reports and positions them chronologically in relation to other Irish reports of inquiry on child abuse and child protection failings.

In addition, other reports of inquiries into child protection failures in Ireland published between 1990 and 2012 were reviewed. Internationally, a considerable number of inquiries on child protection failures have now been conducted. It was outside the remit of this study to examine all such inquiries in-depth, but a number of recent reports were reviewed in detail (including Laming, 2003; Wood, 2008).

Dáil proceedings

The online archives of Dáil proceedings were searched at www.oireachtas.ie, using a variety of search terms in an effort to produce a manageable number of results. A search using the term 'Kilkenny incest' produced 1,450 results. Expanding the term to 'Kilkenny incest and child abuse' only reduced the number of results marginally – to 1,030. The term 'Kelly Fitzgerald' produced 11,200 results, while the expanded term 'Kelly Fitzgerald inquiry and child abuse' yielded a much smaller, but still significant pool of results (1,260). The term 'West of Ireland Farmer' revealed 13,100 results; even when this was coupled with 'child abuse', the search yielded 5,140 results. As an alternative, searches were conducted using the terms 'McColgan case' (192 results), 'McColgan case and child abuse' (126 results) and 'McColgan case and child sexual abuse' (87 results). A variety of search terms were used in relation to the Roscommon inquiry and produced a substantial number of results: 'Roscommon and child abuse' (6,170 results); 'Roscommon child abuse case' (5,470 results) and 'Roscommon child abuse inquiry' (3,210 results). In contrast, it is interesting to note that the search term 'Monageer inquiry' only yielded 163 results. This was further reduced when search terms of 'Monageer inquiry and child abuse' (118 results) or 'Monageer inquiry and child deaths' (68 results) were used.

Conducting searches using the name of the Chair of the inquiry was helpful in some instances (Kate Brosnan, 41 results; Owen Keenan, 157 results; Norah Gibbons, 268 results), but not helpful in others (Michael Bruton, 10,900 results; Catherine McGuinness, 5,820 results).

The large number of results for four of the five inquiries meant that search results had to be refined strategically by date.

Limitations of the study

This is a small-scale qualitative study, based on five reports of inquiry on child protection failings, a review of relevant policy documents and research literature, and interviews with a selected group of 'elite' professionals.

The time span of 20 years, between the first report and this study, has inevitably curtailed the accuracy with which events and their implications are presented in this research. Documentary evidence is not comprehensively available in respect of the implementation of recommendations, the recall of some interviewees was acknowledged to be imperfect and, as later chapters will show, parallel developments in child protection and welfare often obscured the impact of the inquiry reports. In presenting the views of research participants, the study does not claim that these views are representative of the wider body of child protection professionals, but rather seeks to present the views and perspectives of a selection of professionals who were closely connected to the inquiry process and/or to the implementation of inquiry recommendations.

Chapter 2 presents a review of the literature in relation to inquiries and in particular, inquiries concerning child abuse and child protection failures.

2. Literature Review

This chapter begins with an overview of the literature on inquiries in general. It outlines the different formats in which inquiries are conducted, their functions and their legislative basis. It goes on to focus on child protection inquiries and finally considers the literature on recommendations from inquiries.

It is beyond the scope of this study to present a comprehensive review of all of the available literature from these many disciplines. Instead, it focuses primarily on the generally accepted functions of inquiries and considers how the literature assesses their effectiveness in discharging them.

The diversity of the issues examined by inquiries has resulted in an eclectic body of literature, which ranges well outside the domain of child protection and across disciplines as varied as occupational safety (Pidgeon and O'Leary, 2000;Turner and Pidgeon, 1997); healthcare management (Walshe, 2003; Walshe and Higgins, 2002); organisational theory and crisis management (Elliot and McGuinness, 2002); law (Kilkelly, 2012; McHugh, 2003; Brady, 1999); political science (Burgess, 2011); and public administration (Sulitzeanu-Kenan, 2006; Stutz, 2005).

Tribunals of Inquiry

Inquiries established in Ireland under the Tribunals of Inquiry Acts 1921-2004 are formal statutory processes established to investigate matters of '*urgent public importance*' and to make recommendations to prevent their re-occurrence. They are vested with the powers, privileges and rights of the High Court and are usually chaired by a Judge. Although Tribunals of Inquiry are designed for inquisitorial fact-finding, they are associated with an adversarial legalistic process, which is both costly and ponderously paced. It has been recommended that their use be reserved for the '*most serious cases where no alternative means of protecting the public interest is available*' (Law Reform Commission, 2005, p. 21). The Tribunals of Inquiry Bill 2005 proposed substantial amendments to the existing legislation and '*had significant regard*'[5] to the Law Reform Commission's *Report on Public Inquiries and Tribunals of Inquiry*. The Bill was not enacted, but an alternative to Tribunals of Inquiry was provided for under the Commission of Investigations Act 2004, which is discussed below. In Britain, the Tribunals of Inquiry Evidence Act 1921 was repealed by the Inquiries Act 2005.

Commissions of Investigation

Commissions of Investigation are statutory public inquiries established under the Commissions of Investigations Act 2004. This Act provides for the establishment of commissions to investigate any matter considered by the Government to be of '*significant public concern*'. The provision for Commissions of Investigation should result in the less frequent establishment of Tribunals of Inquiry, which investigate matters of '*urgent public importance*'. Commissions of Investigation are independent and in general will hear evidence in private. The establishment of a Commission of Investigation may be proposed by a Government Minister, but any such proposal is subject to the approval of the Minister for Finance.

Unlike Tribunals of Inquiry, which are vested with the powers of the High Court, Commissions of Investigation must apply to the High Court if they seek to compel witnesses or disclosure of information. It has been claimed that '*the main difference between a Commission of Investigation and a Tribunal of Inquiry is that the Commission model facilitates voluntary co-operation, while having compellability powers in reserve*' (Considine, 2005). Another notable difference between Tribunals of Inquiry and Commissions of Investigation is that the Commissions of Investigations Act 2004 does not provide any statutory basis for the making

[5] Minister for Justice, Equality and Law Reform, Brian Lenihan, TD: *see* Dáil Éireann Debates, Vol. 641, No. 6, Column 1624, 20 November 2007.

of recommendations. McGee (2012, p. 3) argues that '*commissions have proved to be much less expensive and much speedier than unwieldy tribunals*'. However, the reduced cost and greater speed of Commissions of Investigation must be offset against the greater transparency of Tribunals of Inquiry.

Commissions of Inquiry

A Commission of Inquiry is a statutory process commissioned under specific enabling legislation. The Commission to Inquire into Child Abuse was established by the enactment of the Commission of Inquiry into Child Abuse Act 2000. Under this legislation, the Commission was established as a separate corporate body charged with carrying out its statutory functions independently. The Commission consisted of two committees – an Investigation Committee and a Confidential Committee; committee members were precluded from being members of both committees. The use of two tiers of committee took account of the exceptionally sensitive nature of the matter under investigation and allowed victims of child abuse to present their evidence in a forum which was as sympathetic and as informal as possible. The identity of witnesses who were subjected to child abuse is protected since the Act stipulates that while institutions and persons who committed abuse may be identified in the Commission's report, individuals who suffered abuse may not be identified.

Non-statutory inquiries

Non-statutory inquiries may be commissioned by a Minister, a State agency or indeed a private institution. Non-statutory inquiries are very flexible instruments of investigation, but they lack the power to compel the attendance of witnesses or the disclosure of documents or information. Such inquiries are almost always conducted in private, although their reports may be made public.

The scale, approach and format of non-statutory inquiries will largely depend on their terms of reference and the budget allocated for the inquiry process. The work of the inquiry may also be influenced by the independence of the inquiry team from the commissioning body.

In some cases, the cooperation of witnesses with non-statutory inquiries has been secured by threat rather than entreaty. This point can be illustrated by the terms of reference of the Lourdes Hospital Inquiry (Harding Clark, 2006, p. 17), which stated:

> 'In the event of the withholding or withdrawal of full cooperation from the Inquiry by staff or former staff of the hospital, by the North Eastern Health Board, its servants and agents, the former proprietors of the Hospital or any State authority, or any suggestion that cooperation is being withheld, to report that fact immediately to the Minister.'

It can be readily understood that when inquiry proceedings are not accessible to the public, they may be criticised because of their lack of transparency. But conducting inquiry proceedings in private may encourage disclosures that might not otherwise be forthcoming and may be especially appropriate for investigating sensitive matters such as child abuse.

Public inquiries

When an event or an issue causes considerable public concern, there are often demands for a 'full public inquiry'. The 'loose' (PASC, 2005, p. 7) and 'flexible' definition of public inquiries that has been pointed to in the UK is also evident in Ireland (*see* www.publicinquiries.org; Burgess, 2009). A report by the Comptroller and Auditor General (2008) lists 19 'public inquiries' conducted in Ireland between 1997 and 2007, but does not provide any definition of 'a public inquiry'. The list includes inquiries of various formats, including Tribunals of Inquiry,

a Commission of Inquiry, Commissions of Investigation and non-statutory inquiries. Only one of the five reports of inquiry that are the subject of this study (i.e. the West of Ireland Farmer Case – Bruton, 1998) was published in this period and is not included in this list.

Sulitzeanu-Kenan (2006, p. 624) defines public inquiries by reference to the following set of criteria: an ad hoc institution established for a particular task; formally external to the Executive; established by the Government or a Minister; as a result of the appointer's discretion; for the main task of investigation of past event(s); in a public way. However, it is proposed here that, in certain circumstances, inquiries that do not meet all of the criteria identified by Sulitzeanu-Kenan may be considered to be a public inquiry. In particular, public inquiries may include inquiries that are not established by the Government or a Minister. It is suggested here that a good working definition of a public inquiry is *an inquiry that satisfies the public demand that a matter is independently investigated and publicly reported on.* It is also considered that an inquiry will not satisfy the demand that 'something must be done' unless it is headed up by an independent Chair and reports publicly. For the purposes of clarity, this study refers simply to 'inquiries'.

Functions of inquiries

The purpose of inquiries has been variously described (*see* Burgess, 2009; PASC, 2005; Howe, 1999). We cite here the six purposes identified by the Law Reform Commission (2005, p. 20):

- To establish what happened, especially in circumstances where the facts are disputed or the course and causation of events is not clear.
- To learn from what happened, and so helping to prevent their recurrence by synthesising or distilling lessons, which can be used to change practice. This includes identifying shortcomings in law or regulations.
- To provide catharsis or therapeutic exposure, providing an opportunity for reconciliation and resolution, by bringing protagonists face to face with each other's perspectives and problems.
- To provide re-assurance, by rebuilding public confidence after a major failure.
- To establish accountability, blame and retribution; holding people and organisations to account, and sometimes indirectly contributing to assigning blame and to mechanisms for retribution.
- For political considerations – serving a wider political agenda for Government either in demonstrating that 'something is being done' or in providing leverage for change.

Strengths and weaknesses of inquiries

Inquiries provide an important check on the power of Government and State agencies. They do not privilege vested interests and can open up to public scrutiny deficiencies in public policies, legislation, resources and the poor performance of individuals. As ad hoc institutions, they can be designed for a specific purpose and dissolved when their job is done. The use of inquiries can be seen as consistent with a commitment to accountability and transparency in the management of the public sector. They have been very influential sources of evidence in the policy arena and have played important roles in shaping public policy in a number of areas.

However, inquiries also attract criticism, including claims that they are ineffectual, lack methodological rigour (Walshe, 2003), are overly time-consuming and expensive (PASC, 2005), produce too many recommendations (Burgess, 2011; Walshe, 2003), are democratically unaccountable, present an unbalanced impression because they are only concerned with what goes wrong (Elliott and McGuinness, 2002), assign blame inappropriately (Howe, 1999), do not position events in context (Walshe, 2003) and introduce prohibitions, restrictions and regulations that have unforeseen consequences (Burgess, 2009).

We structure a brief analysis of these criticisms by reference to the various functions assigned to inquiries, as outlined above. We begin by considering evaluations of the *explicit inquiry functions* of fact-finding and learning, which are normally set out in the inquiry's terms of reference, and then turn to assessments and comments on the *implicit inquiry functions* of catharsis, re-assurance, accountability and political considerations.

Explicit inquiry functions

Fact-finding vehicle

A British social risk analyst contends that inquiries are unlikely to be an efficient instrument for establishing the facts and asks why '*"finding out what happened" should be done through the expensive, elaborate and very public means of the public inquiry rather than one more internal to the relevant professionals. It is not difficult to appreciate that professionals with shared understandings and language are likely to come to an appreciation of "what went wrong" more quickly and efficiently without external legal, media, political and campaigning pressure*' (Burgess 2009, p. 35). A British Professor of Health Policy and Management also challenges the role of inquiries as fact-finding instruments and describes them as '*slow and unwieldy mechanisms for investigation*' (Walshe, 2003, p. 24). He points to a tendency to accept inquiry reports uncritically and suggests that the fact-finding processes adopted by inquiries warrant greater scrutiny. He argues that '*inquiry reports tend to be taken at face value and read with considerable respect, and their findings often carry considerable weight. Even so, the methodology of inquiries deserves more discussion and might be more contested than it generally is*' (*ibid*, p. 18). Walshe (2003) contends that inquiries should be expected to conform to the standards expected in any primarily qualitative research and that therefore the '*credibility, dependability and confirmability*' of the inquiry findings should be tested and scrutinised before assuming that they are transferable and generalisable.

There have also been claims that inquiries have presented factually incorrect accounts (Hey and Chalmers, 2000; Smith, 2000; Dyer, 1999), have been delayed and have generated a great deal of controversy on foot of claims that draft 'factual' accounts are 'value-laden', 'prosecutorial', 'contain errors of fact', 'selective' and 'inaccurate' (Dyer, 1999, p. 558).

Inquiries present the 'facts' that they compile in a report. Inevitably, the inquiry team must distil the evidence presented, which may be contradictory or competing at times, in order to arrive at the facts. The neutrality and impartiality of this process has been questioned (Elliott and McGuinness, 2002). Inquiry Chairs and inquiry team members bring with them certain skills and experiences that will inform their findings and influence how they evaluate the evidence presented. Elliot and McGuinness (2002) focus in particular on inquiries chaired by Judges and suggest that the perceived neutrality and independence of the judiciary must be set against their professional training, social background and social status, which the authors contend are likely to be consistent with an orientation towards protecting and upholding certain values and social institutions.

The issue of bias in inquiry reports is also addressed by Brown (2004 and 2000), who considers that inquiry reports are exercises in '*sense-making*' which privilege and legitimate powerful groups and institutions in society. Brown (2000, p. 45) contends that inquiry reports are '*rhetorical constructs*', which are '*designed to elicit verisimilitude attributions from their target audience*'. In other words, the inquiry story or narrative is presented in a manner that encourages readers to consider it to be truthful, plausible and authoritative (*ibid*, p. 48). He argues that inquiry reports are exercises in power which '*stifle potentially competing or contradictory plotlines*' (*ibid*, p. 67). He urges readers to '*unpick*' the '*totalizing mono-logic*' (*ibid*, p. 69) presented in inquiry reports. However, Walshe (2003) seems less concerned about the narrative in inquiry reports since he suggests that reports on failings in the UK's National

Health Service (NHS) are unlikely to be read in full by many people because they tend to be very lengthy and include an unduly long list of recommendations.

Sulitzeanu-Kenan (2006) points out that a great deal of information regarding the event or crisis that triggers an inquiry is likely to be in the public domain prior to the publication of the inquiry's report. He suggests that for the most part the public reach their conclusions on the facts surrounding the event on the basis of information provided by the media in the immediate aftermath of an event. The inquiry, which reports at some distance from the event, is not the primary source of the 'facts'. The research conducted by Sulitzeanu-Kenan suggests that rather than establishing the facts, the principal role of an inquiry may be to provide authoritative confirmation of judgements already reached. He claims that '*such a confirmation provides a source of empowerment*' (2006, p. 48). His research suggests that higher levels of credibility will be attributed to reports of inquiry when they are critical of the government.

Learning

The efficacy of inquiries as a tool for learning has frequently been questioned (Walshe, 2003; PASC, 2005; Burgess, 2009). Burgess suggests that the 'learning from events' role of inquiries assumes that the disaster was predictable and avoidable, and that the inquiry can therefore prevent the re-occurrence of a similar negative event. This assumption frames the circumstances and actions that surround the case or event under investigation primarily in relation to that event. This means that the randomness and uncontrollability of certain circumstances may not be acknowledged.

Elliott and McGuinness (2002) suggest that learning may be constrained if an inquiry focuses only on what went wrong in one specific instance, potentially ignoring other similar failures and the chance to learn from instances when things worked out successfully. They also point out that the knowledge and learning generated by an inquiry will depend on the inquiry's terms of reference. If these are inappropriately broad or narrow, the investigation may be similarly flawed.

Walshe (2003) points to the large volume of recommendations that are typically contained in inquiry reports and notes that writing recommendations is not sufficient to ensure learning. He suggests that lessons from inquiries need to be tailored and targeted to key audiences in order to '*maximise their acceptance and uptake*' (2003, p. 21). He notes that similar issues have been raised by repeated inquiries particularly in the areas of long-term care and child protection, and considers that this may suggest '*that the lessons from inquiries, embodied in their findings and recommendations, are not resulting in sufficient change in policy and practice to prevent their repetition*' (*ibid*, p. 22). He suggests that '*inquiries may provide a useful reiteration of past lessons rather than really saying anything new*' (*ibid*, p. 23). He points out that many common problems are '*cultural in nature*' and notes '*it is difficult for inquiries to make concrete recommendations for change in this area. Instead, their prescriptions are often structurally focused, proposing new procedures and systems. While those systems and structures may be necessary to prevent similar problems recurring, they may not be sufficient in themselves. Changes in attitudes, values, beliefs and behaviours may be needed too*' (*ibid*, pp. 22-23).

Implementation of recommendations

The extent to which recommendations are implemented may be some measure of the learning from inquiries. Stutz (2005) conducted a study of the implementation of the recommendations of 11 major inquiries. His central hypothesis was that governments implement the recommendations of inquiries in certain conditions. Two tiers of factors influencing the implementation of inquiry recommendations are identified. The first tier consists of factors that are within the control of the inquiry and the second tier consists of factors external

to the inquiry. Factors *within the control* of the inquiry and positively associated with the implementation of recommendations include feasible and affordable recommendations; implementation planning; and the absence of an undue delay in reporting. Factors *outside the control* of the inquiry and positively associated with the implementation of recommendations include follow-up reporting arrangements; professional interest among key stakeholders; a political champion; a supportive political environment; and an issue that affects a large cohort rather than a small minority in society. Stutz (2005, p. 519) concludes that '*the most obvious lesson is to design recommendations that are feasible and affordable. That, along with the political environment, seems to be the strongest factor influencing implementation*' and he contends that '*to be successful, inquiries should develop recommendations with input from the people and institutions that will be responsible for implementing them*'.

The conclusions reached by Stutz echo the findings of the 2005 investigation by the UK Public Administration Select Committee (PASC) of Government-commissioned inquiries, which advocate 'feasible and workable' recommendations and a system that provides for the testing of proposed recommendations, in addition to an audit to ensure recommendations have been implemented. The PASC report notes in particular the need to audit recommendations which involve behavioural and cultural change (PASC, 2005, p. 50).

Implicit inquiry functions

Catharsis/re-assurance

The re-assurance provided by inquiries is normally understood as a form of collective or public re-assurance. Inquiries can play an important role in rebuilding or restoring public confidence after a major failure. However, Burgess (2009) suggests that they may in certain circumstances heighten rather than allay public concern if they focus on events that cannot be guaranteed to 'never happen again'. Walshe (2003) also points out that inquiries may undermine public confidence if they point to major problems that are difficult and costly to address.

The format of inquiries may affect the degree to which inquiries can dispel concern and restore confidence. Private inquiries may not satisfy demands for public scrutiny. If inquiry proceedings lack transparency, the credibility and trustworthiness of the inquiry findings may be challenged. Catharsis or 'therapeutic exposure' (Walshe, 2003) may therefore be limited when an inquiry is held in private. Walshe also points out that those subject to criticisms in an inquiry may feel that private proceedings do not provide them with the appropriate forum in which to defend themselves.

Inquiries provide those most affected by the matter being investigated with a voice and an opportunity to tell their story. Burgess (2009, p. 37) claims that there has been a '*dramatic increase in the extent to which inquiries are oriented towards the perceived needs of victims*', which he claims is consistent with a wider trend to afford victims a prominent position in society and in Government policy. He also suggests that the use of '*sweeping and emotive*' (2011, p. 19) language has become more common in contemporary inquiry reports. Burgess contends that rather than inquiries seeking to legitimate the hegemony of dominant social institutions and groups, as Brown (2000 and 2004) suggests, they are more likely to align themselves on the side of the perceived victims in opposition to those in power. He argues that '*the character and impact of inquiries vary considerably, but there is a general tendency for inquiries to take quite different sides and align themselves more exclusively with those perceived to be victims and against those perceived to have power and control. Their fact-finding role may have become subordinated to that of providing public catharsis, a task that now is bound up with recrimination*' (Burgess, 2009, p. 53). The elevation of the role of the victim in society may mean that the catharsis provided by an inquiry is not limited to those immediately affected by the event, but rather affects a much broader constituency. Overall, it seems reasonable to infer that the cathartic function of inquiries is now more important than before.

Accountability and political considerations

Inquiries are generally recognised as promoting public accountability and transparency (Sulitzeanu-Kenan, 2010) and with contributing to the opening-up of society (Burgess, 2011). It has been suggested that inquiries may be used to '*divert heat from politicians*' (Smith, 2000, p. 716), but in fact inquiries are likely to be '*negative goods*' for elected representatives (Sulitzeanu-Kenan, 2010).

Howe (1999) warns of the risk that inquiries will infer culpability. He points out that it may be more re-assuring to the public to blame a disaster or tragic event on the acts or omissions of specific individuals since this makes it easier to believe that similar disasters can be avoided in the future. Howe also contends that attaching blame to individuals can distract attention from more important and significant managerial or system failures. Essentially, he highlights the danger that a process that claims to be inquisitorial can become adversarial.

The independence of inquiries can create something of a conundrum in that inquiries themselves are not accountable to any objective standard or yardstick, and it has been argued that placing a great deal of power in the hands of unelected 'experts' is inconsistent with the promotion of political accountability (Burgess, 2009).

Research suggests that the decision to commission inquiries in response to public crises is strongly influenced by short-term blame avoidance considerations, media salience and Government popularity (Sulitzeanu-Kenan, 2010). The appointment of an inquiry acknowledges failure and can be expected to be resisted. However, if the issue attracts a great deal of media attention, the acknowledgement of failure becomes unavoidable or a 'sunk cost' (*ibid*, p. 631) and resistance attenuates. The probability that an inquiry will be appointed increases if blame can be directed away from the appointer and reduces if the appointer is likely to be held accountable. The research also indicates that blame avoidance considerations are more prominent in election periods.

The increased use of inquiries (Burgess, 2011 and 2009) is linked to an increased emphasis on transparency and accountability in public sector management. This demand is also informing a growing expectation that all areas of professional expertise should be exposed to public scrutiny and examination. The deference given to professional expertise in the past has been replaced by distrust as inquiries' post hoc examination of the actions and decisions of professionals reveal their fallibility. Burgess attributes inquiries with ushering in the micro-management of professional conduct in a number of spheres.

Inquiries and child protection

Inquiries on child protection have been conducted for several decades. Lonne *et al* (2008, p. 18) highlight the cycle of '*tragic death, public inquiry, sense of outrage, new policies, and legislation*' that has been replicated over 30 years since the early 1970s in many Anglophone countries.

In Britain, the regular use of the inquiry process began in the 1970s, starting with the death of Graham Bagnall (Salop County Council, 1973). Inquiries into child abuse and child protection failures have taken a variety of formats and have had various commissioners. As Corby *et al* (1998) have pointed out, this has made it difficult to compile and present a complete history of child protection inquiries, but it can be asserted that since the early 1970s inquiries have been routinely and frequently established (Parton, 2004; Munro, 1999 and 2004; Corby *et al*, 1998 and 2001; Reder *et al*, 1993) and the inquiry process has produced thousands of recommendations.

Munro (2004) reports the decrease in public child abuse inquiries since 1991 following the introduction of internal (Part 8) reviews conducted by local agencies under the Children Act 1989, which in most cases replaced external inquiries. Part 8 reviews were later replaced by serious case reviews (SCRs). Overviews of a sample group of SCRs that identify areas of

learning and make recommendations for service development are now regularly undertaken (Brandon *et al*, 2011; Care and Social Services Inspectorate Wales, 2009; Brandon *et al*, 2008; Rose and Barnes, 2008; Ofsted, 2008, 2009, 2010 and 2011; Sinclair and Bullock, 2002). The development of a structured approach to the review of serious incidents and failures in child protection services has not obviated the use of external high-profile inquiries (Laming, 2003) and has not prevented continued public concern and media attention on child protection services and practices in certain instances when the deaths occur of children known to the child protection services (*see The Guardian*, 26 October 2010; *The Telegraph*, 27 May 2011).

In Australia, another English-speaking country with similar legislation to Britain and Ireland, inquiries into child abuse and child protection failures began somewhat later. Lonne *et al* (2012) list 32 inquiries between 1997 and 2011, the majority focusing on systemic issues rather than individual cases. Most recently, the Royal Commission on Institutional Responses to Child Sexual Abuse was established in January 2013 and hearings commenced in April 2013.

The USA employs a different process of responding to public child protection scandals and crises. Congressional select committees or more rarely a Presidential Commission are used to investigate matters of concern. A Presidential Commission on child and youth deaths was provided for in the Child Abuse Prevention Adoption and Family Services Act 1988, but was not convened (Costin, 1996). Investigations into non-accidental child deaths are conducted by Child Death Review Teams (CDRTs). There is no federal requirement to conduct child death reviews (CDRs) and there is considerable variance in the approach taken by different States (Vincent, 2012). CDRTs are interdisciplinary and multi-agency teams. The scope of cases reviewed varies: in some States, all child deaths from all causes will be reviewed, but in others only cases that fit into a predetermined protocol will be the subject of review (Vincent, 2012; Hochstadt, 2006). CDRs have over time largely shifted to a public health model, although they are still coordinated by social services in 11 States. The structure and operation of CDRTs is dependent on enabling legislation at State level. In general, teams are made up of groups of designated experts, organised at county/State/regional level, who meet regularly to review cases. Regional teams are especially useful in rural areas where child deaths are likely to be rare. Experts may include doctors, pathologists, social workers, mental health professionals, law enforcement personnel, nurses, teachers, paramedics and other professionals as necessary.

CDRTs adhere to strict confidentiality agreements. Records and information are exempt from the Freedom of Information Act and are not subject to legal discovery (Hochstadt, 2006). Hochstadt (2006, p. 662) argues that the level of confidentiality guaranteed by the review process makes it more useful and ensures that disclosures are more complete and frank. In some States, team members are also indemnified against any potential legal action arising from their work as a member of the CDRT.

The principal purpose of CDRTs is to prevent future deaths and improve systems that provide services to children. A number of public health and prevention campaigns have emerged from CDRTs.

In Ireland, 29 inquiries and reviews in relation to child abuse and child protection have been conducted since 1993. Full details are given in Chapter 4.

Importance of inquiries into child protection services

Inquiries have played an important role in the development of child protection services in Anglophone countries. In particular, they are credited with raising awareness of the issue of child abuse and putting information about its unpalatable reality into the public arena (Reder and Duncan, 2004). Reder and Duncan also suggest that the cathartic role of inquiries has been very significant (*ibid*, p. 108). They suggest that exposing the suffering of a child who has died and acknowledging the child as an individual and as somebody worthy of recognition not only serves the needs of the family, but also of the wider society.

It is difficult to measure the success of child protection interventions and even more difficult to measure the positive impact of inquiries in addressing child protection failures. Trends in the rates of violence-related deaths may provide a proxy indicator of the success of child protection services, although great caution must be exercised in interpreting longitudinal data which may reflect changes in awareness of child abuse as well as changes in the incidence of child fatalities.

The evidence is mixed. Research in the UK by Pritchard and Sharples (2008) drew on WHO data to study trends in the rate of violence-related deaths in children. The study presents evidence of a substantial decline in the rate of such deaths in children aged 0-14 in the period 2000-2002 when compared with the rate in 1974-76. A later study by Sidebotham *et al* (2012) used national data to chart UK trends in violent deaths in children and adolescents between 1974-2008. This study also pointed to a substantial decline in the rate of violent deaths in infants and children up to the age of 14, although rates of violent deaths for female adolescents (aged 15-19) had remained static and risen in the case of male adolescents. Research by Finkelhor and Jones (2006) also points to declining rates of child sexual abuse and violence-related deaths in the USA. However, a cross-national study that compared trends in child maltreatment of children aged 0-11 from 1970 onwards found no consistent evidence of increase or decrease of child maltreatment (Gilbert *et al*, 2012). The study compared rates and trends in violent death, maltreatment-related injuries and contact with child protection agencies in 6 countries (Australia, Canada (Manitoba), New Zealand, Sweden, UK and USA). The authors point out that large differences between countries in the rate of contacts with child protection agencies contrasted with little variation in rates of maltreatment-related injury or violent death (Gilbert *et al*, 2012, p. 1). The authors urge caution in interpreting their findings, noting that the results may be indicative of improved recognition of maltreatment, which would be consistent with decreases in the overall rate of maltreatment. Overall, we tentatively suggest that, on balance, the available evidence suggests that there are now fewer tragic outcomes for children. This may be partly attributable to more effective child protection services and a greater public awareness of child abuse. Inquiries have contributed to both of these developments.

Certain inquiries have been particularly influential. The present report points to the particular importance of the Kilkenny Incest Investigation (McGuinness, 1993) in securing additional resources for child protection services in Ireland. In Britain, the Maria Colwell Inquiry (London Borough of Brent, 1974) is considered to have been transformative in terms of child protection practice (Reder and Duncan, 2004; Butler and Drakeford, 2005) and is directly attributed with a radical change in the approach to child protection services and specifically with the establishment of Area Child Protection Committees, the consolidation of child protection registers, the introduction of the case conference and providing the catalyst for the 1975 Children Act (Parton, 2004; Reder and Duncan, 2004). Parton (2004) claims that the Maria Colwell Inquiry was a major influence on the child protection systems that evolved in Britain, but also points to the findings of subsequent inquiries which show that these systems were '*as much a part of the problem as a solution*' (*ibid*, p. 82). The major reforms in legislation, policy and practice introduced in the UK following the Maria Colwell Inquiry also had an impact here in Ireland (Buckley *et al*, 1997; Ferguson and O'Reilly, 2001) and further afield (Corby, 2006).

More recently the Victoria Climbié Inquiry (Laming, 2003) has had a notable impact and is credited with providing the impetus for legislative reform and the introduction of the *Every Child Matters* national policy, which gave rise to far-reaching reforms of the child protection system in England and Wales (Lachman and Bernard, 2006; Department of Education and Skills (UK), 2004). However, Rustin (2004) suggests that the major changes introduced in the period after the Laming Report were unlikely to have been based simply on the recommendations within the report. He contends that '*it is unlikely that governments really do make major decisions on such ad hoc grounds; it seems more likely that the Climbié case and the inquiry that it gave rise to have provided a populist rationalisation for what government*

for other reasons considered to be a desirable development' (Rustin, 2004, p. 13). The Victoria Climbié Inquiry received global media coverage and is credited with having had an impact on child protection practices internationally (Ferguson, 2004). In New South Wales, Australia, the Wood Royal Commission has been credited with transforming the delivery of services in that State and laying the groundwork for a national child protection framework (Wood, 2008).

Criticisms of child abuse inquiries

In general, the criticisms of inquiries that were discussed in the earlier part of this chapter are also directed at inquiries into child abuse-related tragedies. While inquiries have been an important influence on child protection practices, critics also point to certain negative and unintended consequences. For example, the publicity and increase in public awareness created by child abuse inquiries have also contributed to the increased demand for and expectations of statutory child protection services. As Burns and McCarthy (2012) have argued, the reporting rate for suspected child abuse, much of which is unsubstantiated, has increased following recent inquiries, creating significant pressure on front-line services and thereby diverting resources away from those cases that do warrant child protection interventions.

Inquiries are also linked to efforts to 'manage' child protection practice through bureaucratic procedures, which place undue emphasis on recording information rather than understanding and evaluating information (Featherstone *et al*, 2012; Munro, 2011; Kuijvenhoven and Kortleven, 2010; Parton, 2004). It is contended that inquiries have encouraged an undue focus on the management of organisational risk (Featherstone *et al*, 2012; Lonne and Thompson, 2005), which in turn promotes the management of '*the perception of accountability*' (Lonne and Thompson, 2005, p. 96) rather than promoting actual accountability. Munro (2011) argues that inquiries have contributed to a culture of managerialism in child protection and that while each addition makes sense when viewed in isolation '*the cumulative effect is to create a work environment full of obstacles to keeping a clear focus on meeting the needs of children*' (*ibid*, p. 19). Similarly, Kuijvenhoven and Kortleven (2010) claim that the time spent meeting bureaucratic requirements may displace good practice by reducing contact time with clients and therefore the ability to accurately assess needs and risks.

Munro (2004) contends that the inquiry process feeds the 'blame culture' that is evident in many aspects of modern life and perhaps, in particular, in the discourse around the public sector. She notes that while the allocation of blame is not an explicit inquiry function, child protection professionals have been castigated and subjected to intense scrutiny as a result of the inquiry process. There may even be an expectation created by the establishment of an inquiry that individuals will be 'named and shamed'. Munro notes that although inquiries into child abuse are invoked in Britain less frequently than they were in the past, child protection professionals work under the shadow of the threat of an inquiry. Such threats are linked to the development of a defensive approach to child protection work (Lachman and Bernard, 2006; Munro, 2004, p. 75) and to low staff morale (Munro, 2004).

Inquiry recommendations

Overviews of recommendations in the UK have raised concern about the large quantity of recommendations made in each inquiry. In response to this, Brandon *et al* (2011) conducted a study of recommendations from serious case reviews (SCRs). Findings indicate that while recommendations are becoming more focused, they continue to be too numerous. The researchers suggest that the abundance of recommendations may unduly restrict professional discretion and identify a need to curb '*what has become a self-perpetuating cycle of a proliferation of recommendations and tasks*' (*ibid*, p. 5). They also point out that a comparison with earlier reviews demonstrates a higher proportion of attention now being paid to management, staffing and organisational issues. They describe the recommendations in the

reports they studied as being '*much more wide ranging*' (*ibid*, p. 15) than recommendations in the reports studied by Rose and Barnes (2008) and Devaney *et al* (2011). They further argue that recommendations which seek to impact national practice or policy should be linked to an evidence base, commenting that this is rarely the case.

The analysis presented by Brandon *et al* (2011) suggests that authors of inquiries and SCRs should not necessarily seek to make their recommendations 'SMART' (Doran, 1981). ('SMART' is an acronym devised initially to guide the development of business goals and stands for *s*pecific, *m*easurable, *a*chievable, *r*elevant and *t*imely.) The transfer of business tools and business language to the assessment of the performance of the public sector has resulted in report-writers seeking to develop SMART – and even SMARTer – recommendations, which also provide for evaluation and re-evaluation. Brandon *et al* (2011) conclude that recommendations in SCRs have indeed become SMARTer, but point out that the downside of this is a proliferation of prescriptive tasks, which are thereby promoting a culture of compliance at the cost of developing professional judgement (Munro, 2010 and 2011). Brandon *et al* (2011) also question the utility of making recommendations 'measurable' and point to a lack of clarity in certain instances in relation to what/how improvements are measured.

Brandon *et al* (2011) argue that the 'achievability' of recommendations may be dependent on resources and capacity (*see* Burns and McCarthy, 2012) and suggest that recommendations need to be realistic and achievable. This is in keeping with the study carried out by Stutz (2005), which found that affordability was a key feature in determining whether or not recommendations of inquiry reports were implemented. Recent reports of inquiry on child protection in Australia address the issue of cost by including an indication of the expected cost of implementation for each recommendation (Wood, 2008).

Brandon *et al* (2011) suggest that the dictate in respect of 'relevance' may result in recommendations that are very case-specific. The authors contend that earlier studies of SCRs have highlighted that '*the narrower the applicability of the recommendation, the greater the risk of making potentially inappropriate or irrelevant decisions or procedures on the basis of a single case*' (*ibid*, p. 45). They also question whether the requirement that recommendations are 'timely' may result in unrealistic time limits being set for the implementation of recommendations, with a focus on process rather than outcome.

Munro (2011) argues that failings in child protection often stem from a confluence of errors, which individually are not significant but cumulatively may have disastrous consequences. She points to a '*tendency of the analyses of inquiries into child abuse deaths to invoke human error too readily, rather than taking a broader view when drawing lessons*'. She claims this '*has led to recommendations that focus on prescribing what professionals should do without examining well enough the obstacles to doing so*' (*ibid*, p. 16). Like Brandon *et al*, Munro warns against expecting recommendations that involve substantial change to be implemented in the short term. She advocates a systems approach to child protection, which she acknowledges requires deep-rooted change and which is unlikely to yield results in the short term since '*it will take time for experience with new ways of working to accumulate to the point where they can be fully effective*' (Munro, 2011, p. 135).

While Brandon *et al* (2011) question the wisdom of SMART recommendations in the area of child protection, they do not consider that the model should be abandoned. They advocate the inclusion of '*a proportion of recommendations that are not easy to audit or make SMART, that might encourage deeper learning and take longer to embed*' (*ibid*, p. 46).

It has also been claimed that the writing and rewriting of child protection policies and practices on foot of recommendations of inquiry reports is potentially counter-productive (Cummins *et al*, 2012) and that recommendations may sometimes impede rather than promote learning (Sidebotham *et al*, 2010). Similarly, research by Sidebotham *et al* (2010, p. 50) points

to concerns that '*a focus on making recommendations and implementing action plans can be a barrier to deeper learning*'. The authors suggest that '*there is a danger that practitioners and managers can become focused on implementing action plans that only address superficial aspects of procedures, rather than taking time to reflect on and learn from deeper issues in the systems, attitudes and practices of the organisation or individuals within it*' (*ibid*).

The 2011 study by Devaney *et al* of reviews of non-accidental deaths in Northern Ireland found that recommendations did not always follow from the findings in the review and the formulation of recommendations was sometimes rushed. Criticisms of recommendations related to the volume of recommendations in some reports; recommendations being made about matters already being addressed by previous reviews; the quality of the recommendations made, such as lacking specificity or achievability; the failure to audit the implementation of recommendations across all agencies to ensure that practice and services were improved; and lack of recognition of the organisational context, which, for some agencies at the time, were undergoing major change resulting in disruption and discontinuity in staffing (Devaney *et al*, 2011, p. 256).

An overview of recommendations conducted by Rose and Barnes (2008) points to the lack of a strategic, well thought-out approach to the drafting process and a poor fit between report conclusions and recommendations. They also observed that recommendations were not always properly integrated with the report findings or offered new proposals and were sometimes hurriedly drafted. They note that the crafting of '*viable and constructive recommendations*' requires '*careful discussion about cause and effect*' and agreement regarding '*effective strategies for achieving change*' (*ibid*, p. 45).

Axford and Bullock (2005) used a variety of research methods to investigate the arrangements for the review of child death and serious incidents involving children in different countries. Their review led them to contend that recommendations must be realistic, understood and helpful, both for children and families and for child protection staff. They suggested that recommendations should take account of the wider child protection systems and other initiatives for children and families, and that the implication of recommendations on legislation, policy and practice should be set out clearly. However, they caution that a good review may not contribute to the development of good child protection practices since '*recommendations can create cumbersome and expensive procedures and reinforce an adversarial and forensic approach that is not helpful for the majority of child protection work*' (*ibid*, p. 57).

Douglas and Cunningham (2008) conducted an exploratory analysis of US Child Fatality Review Team recommendations. A total of 338 recommendations were reviewed for the study; however, 25 were excluded because *'they were not clear or lacked sufficient context*' (*ibid*, p. 337). The authors suggest that all recommendations should be paired with an identified problem. Their analysis also highlights that recommendations often lack specificity and suggest that recommendations should identify the particular populations at which they are targeted.

Guidance on devising recommendations

A template is presented by Wirtz *et al* (2011) based on their study in the USA of over 1,000 recommendations from 21 randomly selected reports from Child Death Review Teams (CDRTs). The reports were all publicly available and produced by State or local CDRTs. The authors concluded that reviews are more successful at assessing problems than identifying solutions, and they proposed that recommendations should consider three key components – problem assessment, written recommendations and action on recommendations.

In Britain, the Social Care Institute for Excellence (SCIE) draws on the work of Fish *et al* (2008), which advocates a systems approach to serious case reviews. SCIE (2012, p. 7) distinguishes between three different types of issues which result in three different types of recommendation. These are:

1. Issues with clear-cut solutions that can be addressed locally and by all relevant agencies, e.g. creating a consistent rule across agencies of when and why to copy someone into a letter rather than addressing the letter to them directly.
2. Issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers, e.g. if we want more attention to be given to the critical aspects of the supervisor's role, we cannot assume spare capacity. Such decisions are the responsibility of senior management.
3. Issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level, e.g. addressing problems identified in new software would require experimentation to find solutions through more user-centred design.

This classification clearly establishes that serious case reviews (SCRs) may not be able to provide the solution to all the problems they identify. A process of consultation may be of assistance in producing solutions to issues that are contested, but when solutions are not apparent or cannot be agreed upon, the SCR may only be able to flag the problem and the need to address it. One would expect that inquiries into child protection failings would encounter similar types of issues as SCRs.

A consultative approach to inquiry recommendations

A number of inquiries into child protection failings and inquiries on a range of other issues have adopted a consultative approach to drafting inquiry recommendations. In the report of the inquiry into the death of Victoria Climbié, Lord Laming (2003) divided the work of the inquiry into two phases. Phase 1 addressed the circumstances surrounding the death of Victoria Climbié and the conclusions drawn from the evidence presented. Laming described Phase 2 as *forward-looking*: the product of this second phase of the inquiry were the recommendations for change, which were designed to prevent the re-occurrence of a similar tragedy. Laming noted that it was obvious from an early point in the inquiry that two types of recommendation would be necessary. The first type would be concerned with the particular circumstances of Victoria's case and the local agencies that were responsible for her care. He identified a second type of recommendation with the potential to impact '*relevant agencies across the country*' (*ibid*, p. 22). He considered that the inquiry needed to involve a '*wider audience*' to arrive at the second type of recommendation since it would be unwise to presume that the evidence presented to the inquiry about child protection practices and procedures in certain parts of London were representative of practices in place nationally. He commented that '*it would be an obvious mistake to assume that these same practices and procedures were necessarily followed elsewhere*' (*ibid*). It is noteworthy that Laming's approach has been endorsed by the Centre for Effective Dispute Resolution, which is conducting an 'Inquiry into Inquiries' and has recommended that inquiries should be separated '*into two distinct phases – a first phase which is investigative and a second phase which is about recommendations*' (Mackie, 2012, p. 15).

The Laming Inquiry did involve a '*wider audience*' in arriving at recommendations with national relevance through a consultation process. This invited submissions on an initial framework document that set out the broad issues identified by the evidence presented in the inquiry. In response to the many submissions received, the framework document was refined into a discussion paper, which was circulated widely. Submissions on the discussion document were invited with the proviso that they would be evaluated and could be rejected – in fact, just

77 out of over 200 submissions were accepted as evidence. In a further effort to involve a wider audience in Phase 2 of the Laming Inquiry, five seminars were held to discuss topics including assessment and early intervention, planning, capacity to deliver services and monitoring the performance of key agencies.

The consultation process ensured that the inquiry recommendations were informed by a variety of perspectives and did not rely solely on the particular circumstances and child protection practices that resulted in the very tragic outcome for Victoria Climbié. Crucially, however, the consultation process was controlled and directed by Lord Laming.

In their study of child protection professionals involved in the SCR process, Sidebotham *et al* (2010) identify measures such as workshops, briefings and dissemination events that could be used to develop recommendations and to promote learning from the SCR process. They consider a review process that is participative and collaborative is more likely to promote learning '*than a focus solely on documentary review and one-way transfer of information through practitioner interviews*' (*ibid*, p. 50).

The consultation process adopted by the Laming Inquiry was similar to that used earlier by the Bristol Royal Infirmary Inquiry (BRII) in 2001. After concluding hearings of evidence, the BRII held '*a series of expert consultations in the form of seven seminars on topics which had emerged as the key issues from consideration of the evidence*'. Twenty-five experts were identified for each topic and invited to participate in the seminar. This allowed the inquiry team '*to hear sharp debate between those with a special interest, rather than only hearing evidence presented directly to us. This was to be helpful not only in deciding on our recommendations, but also in giving us an idea of how different sectors of the community might react to these and to help us formulate them as sensitively as possible*' (MacClean, 2001, p. 599). Seminar participants and others were also invited to make written submissions on a number of key issues.

It may also be instructive to consider aspects of the approach adopted by the UK Equality and Human Rights Commission (EHRC) in conducting an inquiry regarding the progress agencies are making in relation to preventing and dealing with disability-related harassment. It is interesting to note that the inquiry was not prompted by any individual 'scandal', but rather by research that provided evidence regarding the scale of harassment experienced by people with a disability. The inquiry interviewed expert witnesses and considered a large body of evidence (over 500 pieces). The initial inquiry report, entitled *Hidden in Plain Sight*, was published in September 2011 and set out draft recommendations for action. The 7 core recommendations were supplemented by 79 more detailed ones. The follow-up report, *Out in the open – Tackling disability-related harassment. A manifesto for change*, was published in 2012, following a consultation process with a large number of Government, national and local organisations. The consultation period following the initial inquiry report was of 6 months' duration. The EHRC wrote to relevant organisations and requested them to prepare and submit their formal responses to the inquiry's recommendations and to inform the Commission of what they were planning to do differently in order to address the inquiry recommendations. The submissions received have been published on the website of the EHRC. The input from these various agencies was used to refine and redraft the original recommendations '*to make sure that they work and to ensure that those organisations own them*' (EHRC, 2012, p. 4).

The terms of reference of this EHRC inquiry were also the product of a process that consisted of the publication of draft terms of reference, consultation with stakeholders and the redrafting and publication of final terms of reference. The follow-up report sets out 43 strategic recommendations, grouped under 7 sections. Each section is clearly identified and dealt with separately in the follow-up report.

For each of the 7 sections of strategic recommendations, the follow-up report uses the following format to detail the process followed in arriving at the final recommendations:

- what we found;
- our original recommendations;
- responses to the recommendations;
- summary of our findings;
- final recommendations.

In this way, the EHRC has made the process of arriving at its final recommendations as transparent as possible and has also sought to craft recommendations that represent a synthesis of 'top down' and 'bottom up' perspectives, which approach may ensure that recommendations are more likely to be implemented.

The advantage of this approach is that it provides for the involvement of relevant stakeholders in the process of determining appropriate recommendations. Recommendations are arrived at by a process that is collaborative rather than dictatorial; this should ensure that recommendations are both relevant and achievable. The process also prioritises transparency and accountability. The submissions made by stakeholders are subject to public scrutiny and in certain instances can be seen to have resulted in the redrafting of recommendations. The planned evaluation process includes an assessment of progress and of the inquiry process.

Conclusions

The general literature on inquiries reviewed here illustrates a number of significant points. It illustrates the function of an inquiry as independently determining and exposing to public scrutiny the truth about events that are framed as disasters and 'scandals'. Inquiries are therefore devices that can address deficits in the trust and authority of political actors and of State bodies and other key institutions. They have been linked in particular to promoting public accountability and maintaining integrity in public life. Reports of inquiries present coherent *post hoc* accounts, which overwrite real-time contingencies and uncertainties. However, the public re-assurance that inquiries provide may create an impression that all adverse events can be avoided or eradicated. Understating risk may provide public re-assurance, but if this re-assurance is threatened by further 'scandals', the resulting public concern may in turn fuel the demand for further inquiries. The use of inquiries may therefore give rise to a culture of inquiry.

The literature also cautions that increased use of inquiries may now be producing perverse and unintended consequences, and may be contributing to unrealistic expectations with regard to the State's ability to control risk and to the increased prominence of the State's role as a regulator of risk. The proliferation of regulations and the imposition of constraints on professional conduct and reduced confidence in professional integrity may be attributable in part to the inappropriate use of inquiries as instruments of micro-regulation.

The relatively small amount of research on the usefulness and quality of inquiry recommendations demonstrates a growing dissatisfaction internationally with the amount of recommendations being made and in some cases their over-prescriptive tenor and lack of congruence with both current reforms and the economic environment. The current aspiration towards SMART recommendations was critiqued for its restrictive perspective.

In order to further contextualise the present study, Chapter 3 provides an outline of the development of child protection and welfare legislation policy in Ireland between 1970 and 2010.

3. Child protection and welfare policy development in Ireland, 1970-2010

This chapter outlines the shifts in child protection policy, together with contextual factors that could be claimed to have influenced the extent and nature of change during a 40-year period that spanned the latter end of the last century and the early years of the current one. These factors include the child abuse inquiries that form the basis of this project. What follows does not claim to be a comprehensive account of all developments in children's services, but is focused mainly on the responses made to a growing awareness of child abuse as a significant social problem and the need to promote prevention, together with effective early and longer term interventions. The time span is divided into three parts: 1970-1990, 1991-2000 and 2001-2010.

Trends and policy development – 1970-1990

The modern child protection system in Ireland began its evolution with the implementation of the Health Act 1970. This Act established the 8 Health Boards that were to have responsibility for community care services and were to consolidate a number of social and child care services, which had hitherto been managed by religious and voluntary organisations. A Government decision in 1974 to assign the main responsibility for child care services to the Minister for Health further clarified the lines of accountability for child protection and welfare. Between 1970 and 1990, the focus of child care provision made a significant shift from placing large cohorts of children in residential care to the provision of services for families and children in their own communities (Buckley *et al*, 1997; O'Sullivan, 2009).

Three additional factors would combine to shape the system over the following 20 years into a format that is still recognisable today. The first was the reform of legislation. The second was the growth of a regulatory structure and the development of guidelines for the identification and investigation of suspected child abuse. The third was the 'discovery' of child sexual abuse during the 1980s. These factors will be examined below.

Child Care Act 1991

Recognition of the inadequacy and obsolescence of the Children Act 1908 in both the Tuairim Report (1966) and the Kennedy Report (1970) led to the establishment of the Task Force on Child Care Services in 1975. The Task Force published its report in 1980, consisting of a main report and a supplementary report. The main report noted that the existing child care system was undeveloped and defined by notions about child development that were by this stage quite anachronistic. Among the recommendations made were the provision of comprehensive services to children and families, the establishment of family support services, and reform of out-of-home care. A supplement to the main report proposed the clarification of children's rights under the Constitution, which, it claimed, lacked a '*clear and unambiguous definition*' (Task Force on Child Care Services, 1980, p. 300).

In its efforts to redesign the system '*from the ground up*' (*ibid*, p. 377), the Task Force provided a blueprint for new child care legislation, which took a further 10 years to reach fruition. The Child (Care and Protection) Bill 1985 elicited a comprehensive submission by a large group of NGOs, who pointed out, among other issues, the failure of the Bill to establish the paramount rights of children or to resolve the existing confusion around this matter. The Bill was scrapped with the change of Government in 1977 and was followed by the Child Care Bill 1988 and ultimately the Child Care Act 1991. For the first time, child care legislation clarified the statutory role, duties and powers of the State to protect children and, importantly, to promote their welfare. The 1991 Act considerably extended the responsibilities of the statutory system, with Section 3(2)(a) compelling it to '*take such steps as it considers necessary to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area*'. The Act allowed for a range of new Court Orders, including Supervision Orders, and permitted the Courts to appoint Guardians ad Litem to represent the interests of children in Court proceedings. For the first time, it obliged

the Health Boards, acting on the part of the State, to account for the adequacy of their services. This Act was to be the first of three pieces of legislation related to children. The second and third were to deal with juvenile justice and adoption, respectively.

Child abuse guidelines

When the Health Boards set up their community care social work teams in the early 1970s, it had been envisaged that social work services would be comprehensive, encompassing the elderly, the disabled and the young, and including families where there were no children. In this context, as Skehill (2004) has observed, the role of social work in the newly formed community care teams remained unclear during the 1970s and most of the 1980s. Overall, the personal social services of the day were relatively unregulated, with each area responding to local need. During the late 1970s, however, the beginnings of regulation in the child care area led to a clearer definition of social work responsibility and ultimately altered its nature to that of an exclusive child protection and welfare service. There began to flow a series of increasingly detailed procedures, which, combined with a heightened awareness of child abuse, tended to reframe what had been a generic service into one that focused on families with children considered to be at risk (Department of Health, 1985).

Child protection services in the UK had, a few years earlier, been significantly reshaped in the aftermath of an inquiry into the death of Maria Colwell (London Borough of Brent, 1974). The majority of English-speaking countries subsequently adapted the new British model to fit with their own requirements and Ireland was no exception. The first two sets of guidelines reflected the evolving structures in the UK, with investigation, interagency working and case conferences as key activities (Department of Health, 1980 and 1983). Entitled *Guidelines on Procedures for the Identification, Investigation and Management of Non-Accidental Injury to Children*, the early procedures outlined the infrastructure through which child protection work should be delivered by a range of staff. As the title suggests, the guidelines tended to focus almost exclusively on physical abuse and the site of identification was generally assumed to be a hospital or GP surgery. Other aspects of child harm, including '*nutritional deprivation, neglect and emotional deprivation and trauma*' (Department of Health, 1976), were given less emphasis. By the time the third set of guidelines was produced in 1987, the focus had become broader, reflected in the main title of *Child Abuse Guidelines*. The 1987 document was longer and more detailed, and for the first time included child sexual abuse as a category. It contained a separate section on the particular features of child sexual abuse, with a strong focus on the role to be played by various professionals in the investigation and assessment of reports.

Child sexual abuse

The issue of child sexual abuse had been recognised in the USA and UK from the 1960s and 1970s. As O'Sullivan (2009, p. 258) has shown, 'interference' with children had in fact been a topic of discussion as far back as 1930, where it had been seen as an unpalatable example of immorality in the country. However, McKeown and Gilligan (1991) trace the first expression of professional interest in the topic in Ireland to a seminar on 'Incest' organised by the Irish Association of Social Workers (IASW) in 1983. The supplementary report attached to the main report of the Task Force on Child Care Services (1980, p. 34) had identified child sexual abuse as a justification for compulsory intervention and this was reflected in the Child (Care and Protection) Bill 1985.

However, it was not until the middle of the 1980s that the Department of Health began to address child sexual abuse seriously by starting to gather statistics that differentiated it from other forms of abuse, commissioning research and funding the Health Boards to establish arrangements for the assessment of children who were alleged victims. Department of Health statistics on reported child abuse during the 1980s show that an increasing proportion of reports concerned child sexual abuse: in 1984 these accounted for 18%, but by 1987 the

proportion had risen to 54%, reflecting a considerable increase in professional awareness (McGrath, 1996). Recommendations for legal reform in the area of child sexual abuse were also made in a report by the Law Reform Commission in 1990, which re-affirmed the need for earlier involvement of An Garda Síochána and a revamping of the Court system to render it more child-friendly. The report also recommended that reporting of suspected child sexual abuse should be made mandatory.

While the professional system was beginning to get to grips with the issue, public awareness about child sexual abuse had yet to be amplified. A report published by the Irish Council of Civil Liberties Working Party on Child Sexual Abuse (Cooney and Torode, 1989, p. 12) identified '*unresolved moral questions in Irish society which appear too threatening or divisive to debate freely and rationally*' and these '*moral questions*' were creating obstacles to adequately addressing the problem in Ireland. These are exemplified by the efforts of some groups to obstruct the adoption of sex education in schools and are reflected in Dáil Debates during the mid- to late-1980s about, for example, the closure of the Health Education Bureau. Nuala Fennell, a Fine Gael TD, argued that 'the main reason the Health Education Bureau have suffered the fate they have is to control them' [sic]. She was referring to what she described as the 'systematic campaign' waged by an organisation called 'Family Solidarity', which opposed a programme of sex education proposed by the Health Education Bureau. Slightly later, a group known as 'Parents Against Stay Safe' campaigned against the introduction of a child abuse prevention programme, which had been developed in partnership between the Department of Education and the Eastern Health Board (*see* Gogan, 1994; O'Toole, 1993).

Policy reforms and trends – 1991-2000

As the section above has shown, the groundwork had been laid over the previous two decades (1970-1990) for a professional system to respond to child abuse in the 1990s. The Child Care Act was enacted in 1991 by President Mary Robinson. However, the full implementation of the legislation was phased over several years, following what Gilligan (1993, p. 366) has described as '*the genteel pace of reform*'. By the end of 1992, just 16 of the 79 Sections in the Act had been implemented and a further trigger was required to expedite reform. A number of concerns, some of which were intertwined and others which had their roots in the previous decade, formed the backdrop to policy change during the 1990s. These included some high-profile events that shifted awareness of child abuse from the professional to the public domain, the fallout from the Kilkenny Incest case and the implementation of the Child Care Act 1991, a concern with provision of services for very troubled children and a focus on children's rights.

High-profile events in the early 1990s

Three incidents occurred in the early 1990s that combined to raise public awareness of child sexual abuse and managed to erase some of the earlier reluctance to deal with the issue. The first was a Court case involving a 14-year-old girl who had been raped by a neighbour in a middle-class area of Dublin and subsequently became pregnant. The matter, known as the 'X Case', is noted more for its implications for abortion legislation, but it also served the function of demonstrating that child sexual abuse could occur in 'ordinary' communities. The second incident, in 1993, was what became known as the Kilkenny Case and the third was the Brendan Smyth affair in 1994. The first and third of these had profound political ramifications, the latter causing the Government of the day to fall. However, the Kilkenny Case had the most impact on the development of child protection policy.

The event that brought the Kilkenny Case into profile was the 1993 trial of a father who was convicted of incest against his daughter. The combination of the reforms of the previous decade with the high level of public concern meant that this event received a more energised political response than might have occurred 20 or 25 years earlier. When it was reported that the victim had 100 contacts from health and social services before her abuse stopped,

Minister Brendan Howlin called what was to be the first major child abuse inquiry in the State, which ultimately produced the Kilkenny Report in 1993 (McGuinness, 1993). In the same way as the Maria Colwell Inquiry acted as a catalyst to usher in policy developments in the UK (Parton, 1985), what was known as the Kilkenny Case is seen to have elicited a similar reaction in Ireland. The recommendations, which will be elaborated upon in Chapter 5, addressed a number of concerns that had been raised earlier in the main report of the Task Force on Child Care Services (1980) and other campaigns and movements over the previous 10 years.

The impact of the Kilkenny Case on the political system meant that resources were finally made available to expedite a number of policy initiatives that had either started gradually or had been slowed down through lack of social support and finance. The most significant development was an undertaking to implement the Child Care Act 1991 in full. While a figure of £3 million had been previously committed, the Government now pledged £32 million to resource the services sufficiently to operationalise the provisions in the legislation. A Child Care Policy Unit was established within the Department of Health, giving the sector a distinct profile for the first time. The increased focus on child protection also made an impact on the profile of child care within Government circles and in 1994, Austin Currie was appointed as Minister of State in the Departments of Health, Education and Justice, with overall responsibility for coordinating child care services and services for young offenders. An Garda Síochána established a specialist unit to deal with family violence in 1994. Now known as the 'Domestic Violence and Sexual Assault Unit', it carried the earlier title of 'Mother and Child Unit'. Legislation for barring spouses was extended to co-habitants in the Domestic Violence Act 1996, which also allowed the Health Boards to apply for Barring Orders, increased the penalties for breaches and gave the Gardaí new powers of arrest to deal with cases of domestic violence.

One of the issues raised in the Kilkenny Report had been the poor level of cooperation between An Garda Síochána and the Health Boards. This had, in fact, been of concern in previous years and the Department of Health had been preparing a protocol that would require joint notification of suspected child abuse in consultation with Garda management (McCabe, 1992). The Kilkenny Report provided the impetus for the implementation of this protocol in 1995 (Department of Health, 1995a). These initiatives laid the foundations for the later establishment of joint initiatives between An Garda Síochána and the Health Boards/ HSE child protection services.

Implementation of Child Care Act 1991 and regulation of out-of-home care services

Between 1993 and 1996, while the remaining Sections of the Child Care Act 1991 were being implemented, child protection and welfare services within the Health Boards were transformed. The number of social work posts increased, family support and social care workers were added to community care teams and training departments were established in each of the Health Board areas. Monies were provided to the Health Boards for the development of programmes to treat adolescent perpetrators of sexual abuse.

Under the Child Care Act 1991, three sets of regulations were commenced in 1995 in respect of children in out-of-home care. These were the Child Care (Placement of Children in Foster Care) Regulations 1995, the Child Care (Placement of Children with Relatives) Regulations 1995 and the Child Care (Placement of Children in Residential Care) Regulations 1995. The regulations laid down minimum standards for children in out-of-home care and obliged the Health Boards to comply with a number of requirements, including the maintenance of records, the preparation of care plans, Child in Care Reviews, regular visitation and supervision, and protocols for the removal of children from placements. Monitoring of compliance with the regulations was carried out by the Health Boards until 1999.

Between 1996 and 1998, five more inquiry reports on child abuse were published. Two of these – Kelly – A Child is Dead (Joint Committee on the Family, 1996 – known as the Kelly Fitzgerald Report) and the West of Ireland Farmer Case (Bruton, 1998) – concerned intra-familial child abuse. Another focused on institutional abuse – the Madonna House Report (Department of Health, 1996b) was published 3 months after an RTÉ documentary about Goldenbridge Orphanage, entitled *Dear Daughter*, highlighted the issue of institutional abuse for the first time since the Kennedy Report (1970). In line with one of its recommendations, the Social Services Inspectorate was established on a statutory basis in 1999 under the provisions of the Child Care Act 1991 and took over the function of monitoring the compliance of Health Board residential services for children with statutory regulations. A fourth inquiry report concerned child abuse in swimming, which prompted the Irish Sports Council (2000) to develop its *Code of Ethics and Good Practice*. The fifth and final inquiry report of the 1990s involved alleged child abuse in a hospital setting (North Eastern Health Board, 1996), with recommendations made on the development of hospital protocols and procedures for reporting alleged abuse.

Debate on mandatory reporting and ensuing reforms

One of the tasks undertaken early in the term of the first Minister of State with responsibility for children was to explore the potential implications of introducing mandatory reporting of child abuse, a reform which had been first suggested by the Law Reform Commission in 1990 and reiterated in the recommendations of the Kilkenny Report. To deal with the issue, the Department of Health published two policy papers, the first of which was entitled *A Discussion Document on Mandatory Reporting*, published in 1996. The purpose of this paper was to initiate a consultation process on the merits or otherwise of introducing the type of reporting legislation that existed in some other jurisdictions, mainly in the USA. The main question posed was '*whether developing our services to protect children from abuse, improving existing arrangements for the notification of children and coordinating action in response to such abuse would better serve the interests of children than the introduction of mandatory reporting*' (Department of Health, 1996a, p. 28).

Following the consultation process, during which submissions were invited and which culminated in a large gathering of interested parties to discuss the issue, the Minister of State published another policy document, entitled *Putting Children First: Promoting and Protecting the Rights of Children* (Department of Health, 1997). This document provided the Government's appraisal of the debate conducted on the issue of mandatory reporting (*see above*) and the view that excessive reliance on legal obligations could hamper the balanced development of child care services. The 1997 document proposed a number of initiatives, some of which were new and others reflected policy recommendations or reforms that had recently occurred. It acknowledged that one of the positive functions of a mandatory reporting law would be to raise awareness of child abuse, but proposed instead to launch a campaign that would promote knowledge about the complexity of child abuse and provide information about services. It recommended revision of the 1987 *Child Abuse Guidelines*. It echoed the recommendations of the Kilkenny Report and the Kelly Fitzgerald Report – to develop multi-disciplinary training programmes on child protection. It proposed the establishment of local and regional child protection committees and stated the intention to link the funding of voluntary children's services with a requirement to have child protection policies and procedures in place. It also elaborated on an already-commenced new management structure, whereby the Director of Community Care post, which was established under the Health Act 1970 and had been traditionally filled by medical doctors, was to be scrapped. Under the new structure, General Managers were to be appointed to each Health Board area and Child Care Managers were to be appointed to manage and coordinate children's services. In acknowledgement of 'recent child abuse scandals', the document proposed the development of counselling and therapeutic services for victims of past abuse.

As later parts of this section will show, most of the proposed initiatives (many of which had already been in train) were put in place by the end of the 1990s, with some deviations from

the format outlined in the 1997 document. The issue of mandatory reporting arose again, however, in 1998. The Fianna Fáil Government, which took office in 1997, had made a pre-election promise to implement it and the following year, the response of the UN Committee on the Rights of the Child to Ireland's First Report on the implementation of the Convention (Government of Ireland, 1996) criticised its absence from legislation (UNCRC, 1998). The then re-named Department of Health and Children undertook a second consultation process in 1999 and commissioned a literature review on the topic. This was followed by a draft White Paper in 2000.[6] However, the issue of reporting legislation did not progress beyond that point during the following decade.

Secure accommodation

A recurring issue during the mid- to late-1990s was that of hard-to-place children and young people for whom mainstream residential or foster placements were unsuitable and who were deemed to require secure care but, in the absence of suitable arrangements, were often placed in bed and breakfast (B&B) accommodation. Section 5 of the Child Care Act 1991 provided for the accommodation of young people who were homeless, differentiating this group from other children and young people at risk. Lack of clarity over the criteria for implementation of this Section of the Act and concern over the suitability of the type of accommodation gave rise to a number of High Court cases and illustrated a gap in child care legislation. This would ultimately be filled by the insertion, through the Children Act 2001, of a new Section into the Child Care Act 1991 imposing a duty on the Health Boards to seek Special Care Orders that would allow them to detain children whose behaviour put their health, safety, development and welfare at risk, and when alternative options were insufficient to address their needs.

Children's rights

The legislative reform in respect of secure care outlined above was intended to vindicate the Constitutional rights of troubled young people. Concern about children's rights accelerated during the 1990s, but had actually begun to emerge during the 1980s. The supplemental report of the Task Force on Child Care Services in 1980 had demonstrated concern about the primacy of parental interests over those of children under the Constitution. A little later, the response of a combined group of organisations to the 1985 Child (Care and Protection) Bill argued that it did not sufficiently address the issue of children's rights.[7]

The first formal action taken to address this issue was the ratification by the Irish Government of the United Nations Convention on the Rights of the Child (UNCRC) in 1992. The following year, the Kilkenny Report reiterated concerns about the Constitutional position of the family and the absence of any explicit acknowledgement of children's rights in the Constitution and recommended amendment to Articles 40 and 41. This recommendation was later repeated in the Kelly Fitzgerald Report in 1996. In the meantime, the Children's Rights Alliance, an umbrella body representing children's services, was formally established in 1995 to promote the implementation of the UNCRC. A research study, commissioned by the Alliance and published in 1996, put forward a case for an Ombudsman for Children and outlined the potential functions and principles of the Office (Cousins, 1996).

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[6] In October 2000, Minister of State at the Department of Health and Children, Mary Hanafin, TD, told the Dáil that 'a draft White Paper on the Mandatory Reporting of Child Abuse is at an advanced stage of preparation and a draft memorandum for Government issued to a number of Departments for observations at the end of July 2000. The draft White Paper is at present being re-examined in light of some of the observations made. It is planned to bring the final draft of the White Paper to Government when these issues are fully considered' (Dáil Éireann Debates, Vol. 524, No. 2, 17 October 2000). However, the White Paper was never published.

[7] The response to the Children (Care and Protection) Bill 1985 was produced by an alliance of 14 professional and voluntary groups in May 1986.

In the meantime, the Irish Government submitted its First Report to the UN Committee on the Rights of the Child in 1996, in which it outlined current legislation and policy which it believed to be compatible with the Convention. The report claimed that the Child Care Act 1991 marked a '*movement towards recognising the child as a separate entity with rights distinct from its family*' (Government of Ireland, 1996, p. 8), particularly with regard to its underlying principle to ensure that the wishes of the child are respected where legal proceedings are taken. However, the report also reflected the views of some NGO representatives who expressed concern about the Constitutional position of children and highlighted a number of other areas where further development would be required in order to reach compliance with the Convention. The UN Committee made 'concluding observations' in response to Ireland's First Report, in which it affirmed the commitment of the Irish State to implement the rights of the child and praised the legal reforms that had already taken place (UNCRC, 1998). It also criticised the State on a number of levels, including what it described as the fragmented and uncoordinated response to the issue of children's rights. It made suggestions and recommendations, including the adoption of a National Strategy for Children which would incorporate the principles and provisions of the Convention in a systematic manner. It also suggested measures to deal with child abuse and neglect.

The Department of Health and Children commenced work shortly afterwards on developing the 10-year National Children's Strategy, *Our Children – Their Lives*, which was overseen by an interdepartmental group representing 8 Government departments and informed by two advisory panels and a broad-ranging consultative process with members of the public, parents, people who cared for and worked with children, as well as children and young people themselves (Department of Health and Children, 2000).

Children First: National Guidelines for the Protection and Welfare of Children

The final months of the 1990s brought further regularisation of the child protection system. The Department of Health and Children appointed a working group in February 1998 to develop a set of guidelines that would replace the 1987 *Child Abuse Guidelines* and reflect recent legislative developments and administrative reforms in the Health Boards. *Children First: National Guidelines for the Protection and Welfare of Children* was published in October 1999. It was a much larger document than previous guidelines and based on a number of principles, including the paramount concern of child welfare, the importance of early intervention, the importance of parental participation in the child protection process, inclusiveness and the necessity of interagency collaboration. *Children First* was informed by research evidence and by the findings of child abuse inquiry reports, many of which were already being incorporated into the practices of child protection staff. The new guidelines were intended to provide an overarching framework from which local areas and community-based services could develop their own guidelines. While *Children First* was not placed on a statutory footing, there was an expectation that it would be consistently implemented by statutory and non-statutory services. *Children First* was preceded by legislation in the form of the Protection for Persons Reporting Child Abuse Act 1998, which addressed a significant concern, particularly held by doctors and teachers, about their legal position should they inadvertently make an unfounded allegation of abuse.

The inclusion of the term 'welfare' in the title of the *Children First* guidelines formally established the centrality of family support in the child protection system and acknowledged the diversity of needs experienced by children and families who were either reported to child protection services or sought assistance themselves. Early intervention as a preventive measure had been recommended in a number of policy and research reports since the Task Force in 1980, but the difficulty of balancing the welfare and investigative elements of child protection had been highlighted in research (Impact/EHB, 1997). The contemporaneous development of Springboard family support projects around the country (*see* McKeown *et al*, 2000), as well as a number of initiatives contracted or provided by local Health Boards, provided a context in which supportive as well as protective interventions were to be made.

Trends and policies – 2001-2010

Developments during the first decade of the 21st century followed a number of contemporaneous themes. Proceduralisation continued on a wider scale than previously, with the adoption and development of the *Children First* guidelines by most children's services. Efforts to promote children's rights continued and early intervention and family support services began to expand. Child protection matters still dominated, however, with considerable investment in reviews and investigations into child abuse by religious orders and diocesan priests, and perceived failures by community-based services. Organisational change and restructuring reshaped policy-making and operations coincided with recognition of the need to standardise and regularise the delivery of front-line services.

Broader adoption of child protection policies and guidelines

Following the publication of *Children First* in 1999, the Health Boards appointed a group to guide its implementation. This was initially known as the National Steering Group and later changed its name to the National Advisory Group.[8] Training posts were created in each Health Board area to train Health Board staff, as well as staff in community and voluntary organisations, and a joint training programme for social workers and Gardaí was conducted across the country.

In addition, a number of organisations incorporated child protection measures into their overall operation. For example, the Irish Sports Council developed its *Code of Ethics and Good Practice* in 2000 in response to a report on child abuse in swimming (Murphy, 1998), while the Department of Education and Science produced revised guidelines for primary and secondary schools in 2001 and in 2004, and the Department of Health and Children (2002) produced *Our Duty to Care: The Principles of Good Practice for Children and Young People*, which was aimed at the community and voluntary sector.

National Children's Strategy

At the same time, a number of policy initiatives were put in place to further the implementation of the National Children's Strategy. The National Children's Office (NCO) was established by Government in 2001 and was staffed by civil servants seconded from the Departments of Education, Social Welfare, Health and Children, and Justice. It had an additional brief for progressing the policy issues identified by the Cabinet Committee on Children that required cross-Departmental action. The NCO had three main goals – allowing children's voices to be heard (participation), promoting understanding of children's lives (research) and ensuring that children received quality supports to promote their development (policy). The NCO's work focused particularly on creating opportunities for children and young people to express their views on policy through a variety of fora. It also prepared legislation for the establishment of an Ombudsman for Children, with the relevant legislation being passed in 2002 and the first Ombudsman for Children taking office in 2004. In 2005, on behalf of the Government, the NCO presented Ireland's Second Report to the UNCRC, outlining progress made on implementation of the UN Convention on the Rights of the Child. It reported on the rationale behind the decision not to adopt mandatory reporting of suspected child abuse and outlined the various measures taken to implement the National Children's Strategy. These initiatives were welcomed by the UN Committee members in their 'concluding observations', but again they expressed concern about the lack of action being taken in Ireland to prevent child abuse (UNCRC, 2006).

[8] Given later revelations about the inconsistency of implementation of *Children First* around the country, the change of name probably reflected a certain resistance to standardisation.

Organisational change

Some significant restructuring of child protection and welfare services took place in 2005. The Health Service Executive (HSE) was established to amalgamate the former Health Boards into a single organisation, within which the Children and Families Programme would now function on a national, instead of a regional basis. In the same year, a decision was made by Government to amalgamate the Child Care Policy and the Child Care Legislation units in the Department of Health and Children with the National Children's Office (NCO). This gave rise to the Office of the Minister for Children (OMC), with its own Director General. The Minister, although still in a junior capacity, now had a seat at Cabinet.

Early intervention and family support

The trend towards promotion of early intervention, initiated in the early part of the decade, was continued within the two newly established organisations (the HSE and the OMC). In its annual *Review of Adequacy of Children and Family Services* reports from 2006 onwards, the HSE consistently reiterated the need to re-orientate the services away from an investigation-driven approach to one which sought primarily to support children in their own communities, highlighting the growing proportion of reports made to child protection services that were categorised as 'welfare' rather than 'child abuse' (*see* HSE *Review of Adequacy* reports, 2006, 2007 and 2008).

Similar aspirations were expressed in the 2007 and 2008 annual reports of the Office of the Minister for Children (OMC, 2008) and the then-renamed Office of the Minister for Children and Youth Affairs (OMCYA, 2009b). The new title reflected the extension of the OMCYA's remit to include staff working on child care from the Department of Justice, Equality and Law Reform, and staff working on youth work and youth services from the Department of Education and Skills. Flagship early intervention services were established in three areas that were considered to be disadvantaged, supported by a combination of philanthropic and State funding (OMCYA, 2009b). The publication of *The Agenda for Children's Services* in December 2007 by the OMC was intended to consolidate the new approach by setting out a strategic direction and policy framework for the delivery of integrated children and family services, which were to be 'whole child' and 'whole system' focused, evidence-based and connected with family and community strengths. Children's Services Committees were established, initially in a pilot format in 2008, with the intention of promoting the collaboration required to reach these goals (OMCYA, 2009b).

Child abuse by religious

Within this context, where early intervention and prevention of child abuse were claimed as the underpinning principles, the issue of child abuse retained significance throughout the decade. In the late 1990s, a number of TV documentaries had raised public awareness and concern about child abuse by religious, in both institutions and communities. The Commission to Inquire into Child Abuse was established by the Government in 2000 and was to hold its inquiry for 10 years. Its brief was to investigate the abuse of children and young people who had lived in industrial schools and reformatories under the aegis of the Department of Education. In 2002, the Minister for Health set up the Ferns Inquiry, which was the first of three investigations into abuse by diocesan priests. When the Ferns Report was published (Murphy *et al*, 2005), it immediately precipitated the establishment of the Dublin Inquiry, which eventually included within its remit an inquiry into child abuse in the Diocese of Cloyne (Department of Justice and Law Reform, 2011). The HSE responded to the publication of the Ferns Report in October 2005 by setting up five working groups to implement the recommendations. They undertook to conduct a publicity campaign about child protection and HSE services, a review of *Children First*, an audit of the Church and child

protection practices, to provide treatment services for children and families, and a treatment service for abusers. Progress on the work of these groups is reported on an annual basis to date (*see* HSE, 2012).

Review of Children First

One of the major concerns arising from the Ferns Report was the matter of national compliance with *Children First*. In 2006, the OMC commenced a review of the guidelines. Three reports from the review were subsequently published by the OMCYA in 2008 (Buckley *et al*, 2008; OMCYA, 2008a and 2008b), followed by an investigation of compliance by the Ombudsman for Children, published in 2010. The reports published by the OMCYA reflected a view that while the *Children First* guidelines were robust, there were difficulties in implementation due to what were described as '*local variation and infrastructural issues*' (OMCYA, 2008a, p. 3). While it was considered that the substance and principles of the guidelines did not require revision, the Minister made a commitment to follow up on the recommendations of the review in respect of protection, access, standards, integration, implementation and monitoring. The report of the Ombudsman for Children was more critical, finding that insufficient efforts had been made to drive forward implementation of *Children First* from the outset by those with responsibility for doing so. The Ombudsman commented negatively on the failure of the OMCYA to acknowledge the industrial relations issues that, in her view, impacted significantly on the non-implementation of the guidelines. She made 20 recommendations, which referred to *Children First* but also had broader implications for the design and delivery of child protection services. A revised version of *Children First* was published online in 2010 by the now Department of Children and Youth Affairs (DCYA), but was not finalised for a further year (DCYA, 2011).

Appointment of Special Rapporteur for child protection

The appointment of a Special Rapporteur for child protection in 2006 was a further acknowledgement of increasing legalism in the sector. The Rapporteur was to produce an annual report, reviewing and auditing legal developments and identifying gaps in children's legislation. Between 2007 and 2010, the reports focused on the need for reform of legalisation in respect of vetting and barring, trafficking and child pornography, and the interaction between the legal system and children (McAuley, 2007; Shannon, 2007, 2008, 2009 and 2010). These themes were further developed in the 2008 report, which also called for improvements in the coordination and comprehensiveness of child protection and welfare services (Shannon, 2008). In his 2009 report, the Rapporteur again addressed the issue of children as witnesses and recommended further streamlining of the child protection services, including more service evaluation and independent statutory reviews of perceived failings (Shannon, 2009). Youth homelessness was a prominent theme in 2010 (Shannon, 2010) and the issue of placing *Children First* on a statutory footing was a recurrent topic in the Rapporteur's reports.

The Ryan Report

A number of events coincided in 2009 that re-oriented the policy focus towards the state of child protection services. Media reports about clerical sexual abuse in the Diocese of Cloyne, followed by reports about a child abuse case in Roscommon, resulted in the commissioning of inquiries. In May of that year, the Monageer Report was published and recommended reforms in respect of health, disability, nursing and social work services, as well as An Garda Síochána (Brosnan, 2009). The most significant event of the year, however, was the publication of the *Report of the Commission to Inquire into Child Abuse* (also known as the Ryan Report) in May 2009. Although the findings of the report related principally to historical events, the Government took the opportunity to go beyond the deficits identified in the report and

comment on the entire child protection system. An *Implementation Plan* was published by the OMCYA in July 2009, which laid down a blueprint for service development (OMCYA, 2009b).

The *Implementation Plan* from the Ryan Report responded to the lack of accountability uncovered by the Commission to Inquire into Child Abuse with a number of undertakings. These were principally concerned with review and evaluation of policy and practice, regulation, inspection and management of community-based and out-of-home services, and the revision and establishment of procedures and standards. Four progress reports were promised by the OMCYA to evidence the implementation of the planned reforms, three of which were published by the end of 2012 (OMCYA, 2009b and 2010; DCYA, 2012).

Standardisation of service delivery and restructuring of services

Following the establishment of the HSE in 2005 and the subsequent publication of the review of compliance with *Children First*, the necessity to organise HSE Children and Family Services in order to achieve standardised and consistent procedures was recognised. In early 2009, a Task Force was established, consisting of 8 different groups. Its purpose was to assess the current child protection system and accelerate the development of a national unified approach to the delivery of child protection services. In July 2010, a report was published detailing the work of the 8 groups (HSE, 2010c). They had examined compliance with *Children First* and developed formal child protection protocols and standardised business processes to ensure consistent responses to child protection concerns across the different local HSE Regions. The Task Force had also developed a self-assessment framework to manage risk and provide early warning of difficulties, clarified governance arrangements and standardised national policies. Performance measures and outcome measures were reviewed and modified, and a standard approach to statutory care planning was devised. The Standard Business Processes were subsequently refined and adopted nationally in different phases.

Following the completion of the Task Force report and picking up on the *Implementation Plan* from the Ryan Report, a management review was commissioned by the HSE. This review found that the service lacked direction and leadership, and required simpler structures for delivery of services (PA Consulting Group, 2009). It was particularly critical of the lack of 'intelligence' underpinning service development and recommended greater use of data currently available to improve services.

During subsequent months, the Government agreed first to the appointment of an Assistant National Director for Children and Family Services in the HSE. For the first time, a National Office was established, from which national policy would flow.

While the reforms following the *Implementation Plan* from the Ryan Report were designed to streamline the child protection system and respond to the failings identified over the previous years, 2010 brought a renewed, negative focus on the services. Two child abuse inquiry reports, which had been completed sometime previously, were brought to publication via the Oireachtas Committee on Health and Children. These reports, combined with the highly profiled abduction and murder of Daniel McAnaspie[9], a child in the care of the HSE, raised questions about the capacity of the State to meet the needs of children and young people in the community and in its care. The inability of the HSE to readily compute the deaths of children known to its services over the previous decade further diminished confidence in the system. A number of simultaneous responses followed: the OMCYA commissioned an Independent Child Death Review Group to review the deaths of all children in the care of, or known to, the Health Boards and the HSE over the previous 10 years (Shannon and Gibbons, 2012); the HSE followed a recommendation of the *Implementation Plan* from the Ryan Report and appointed the National Review Panel to conduct ongoing reviews of serious incidents,

[9] Dáil Éireann Debates, Vol. 709, No. 2, 18 May 2010.

including the deaths of children in care. These events were followed by a decision by the then Minister for Children, Barry Andrews, TD, to establish the post of National Director for Children and Family Services, creating for the first time a standalone child protection and welfare services directorate. It was in this context that the last of the five reports under review for this study was published – the Roscommon Child Care Case (Gibbons, 2010).

Conclusions

This review of child protection policy reforms over the four decades up to 2010 has illustrated the evolution of what was quite an embryonic service in the 1970s to one which is comparable in shape to other systems in the Anglophone world and based on similar principles. Over the 40-year period, the concept of child abuse has morphed from 'child battering' by parents to a concept that holds not only families, but the State responsible for meeting the totality of a child's needs and for preventing future harm or abuse. The number of reports made to social work departments in the Health Boards/HSE increased from 243 in 1978 to 29,277 in 2010 (Ferguson, 1996; HSE, 2012). In keeping with other jurisdictions, legislation, regulation and proceduralisation have all increased and the system has gradually adopted an approach based on children's rights to safety and fulfilment of their potential, while maintaining child protection as a central focus. As the standards in the services are becoming more measurable, the expectations of the public are concurrently rising, resulting in an increasing politicisation of the child protection and welfare sector, and a low threshold for delay, error or dereliction of responsibility. This type of environment tends to promote the use of inquiries as a method of demonstrating transparency and accountability.

4. Inquiry reports in Ireland and the inquiry process

This chapter narrows its focus to inquiry reports in Ireland, with particular emphasis on the five inquiry reports at the centre of this study. Inquiries into child abuse and child protection services in Ireland are variously described as investigations, reviews and commissions of inquiry/investigation. First, a brief chronological account is given of all reports of inquiries and reviews into child abuse and child protection failings in Ireland since 1993. The five inquiry reports examined in this study are positioned within this timeframe. A detailed discussion follows, with Part 1 reviewing each of the five inquiry reports and Part 2 reporting on the data produced from interviews with research participants, all of whom were selected because of their involvement in the inquiries either through membership of the inquiry teams or for their roles as policy-makers and senior managers in the Department of Health, the Health Boards or the HSE around the time of the inquiries. This review offers a broader understanding of the inquiry processes and the work of the inquiry teams, and will help to contextualise recommendations from these reports of inquiries, discussed in Chapter 5.

Overview

In total, 29 inquiries and reviews have been held into child abuse in Ireland between 1993 and 2012, including those in respect of institutions, dioceses and families (*see Table 1*). Of this total, 26 were conducted on a non-statutory basis. Two were established as Commissions of Investigation (Dublin and Cloyne).[10] The Ryan Inquiry was a statutory inquiry established under the provisions of the Commission to Inquire into Child Abuse Act 2000. Complaints about child protection services have also been reported on by the Ombudsman for Children (Office of the Ombudsman for Children, 2006). The list in Table 1 does not include unpublished internal inquiries conducted by the HSE, the Health Boards or any other organisation.

In chronological terms, the inquiries form two clusters. Six inquiries were published between 1993 and 1998. Although three inquiries were established between 1999 and 2005, no reports of inquiries on child abuse or child protection were published during this period. Between 2005 and 2012, 23 reports of inquiries and reviews into child abuse and child protection failings were published, including 12 by the National Review Panel. Since 2005, five reports of inquiries on child abuse and child protection failings have highlighted abuse of children by diocesan priests and members of religious orders.

[10] Commissions of Investigation are a form of statutory public inquiry established under the Commissions of Investigations Act 2004.

Table 1: Publicly available reports of inquiries and reviews into child care and child protection failings in Ireland

[**Note:** The five inquiry reports at the centre of this study are indicated in **bold** type]

	Inquiry (known as)	Date of publication	Date of commissioning	Commissioner of inquiry	Inquiry format	Issue examined
1	**Kilkenny**	**May 1993**	**March 1993**	**Minister for Health** (the inquiry was ordered by Brendan Howlin, TD, but the inquiry was established and the Chair appointed by the South Eastern Health Board)	**Private/ non-statutory**	**Intra-familial abuse, including sexual abuse**
2	**Kelly Fitzgerald**	**April 1996**	**May 1995**	**Western Health Board**	**Private/ non-statutory**	**Intra-familial abuse and neglect**
3	Madonna House	May 1996	September 1993	Sisters of Charity/ Department of Health	Private/ non-statutory	Sexual abuse of children in residential care
4	International Missionary Training Hospital, Drogheda	June 1996	November 1995	Board of the International Missionary Training Hospital, Our Lady of Lourdes, Drogheda, with the cooperation and support of the North Eastern Health Board and the Department of Health	Private/ non-statutory	Examination of the response of the hospital to claims of child sexual abuse and hospital protocols and procedures to prevent child abuse
5	**West of Ireland Farmer**	**July 1998**	**March 1995**	**North Western Health Board**	**Private/ non-statutory**	**Intra-familial abuse, including sexual abuse**
6	Murphy	July 1998	February 1998	Minister for Tourism, Sport and Recreation	Oireachtas Committee	Sexual abuse of children by swimming coaches
7	Ferns	October 2005	March 2003	Minister for Health and Children	Private/ non-statutory	Handling of allegations, complaints and concerns about child sexual abuse in the Diocese of Ferns prior to April 2002
8	McCoy	December 2007	April 1999	Western Health Board	Private/ non-statutory	Allegations of past child abuse in the Holy Family School and Brothers of Charity Services in Galway
9	Dr. A	April 2008	July 2007	Health Service Executive	Private/ non-statutory	Inquiry into concerns following the conviction for sexual offences of a lecturer in a third-level institution
10	**Monageer**	**May 2009**	**June 2007**	**Minister for Health and Children**	**Private/ non-statutory**	**Familicide**
11	Ryan	May 2009	May 2000	Government of Ireland	Commission of Inquiry/ statutory	Abuse of children in institutional care
12	Dublin	July 2009	March 2006	Minister for Justice, Equality and Law Reform	Commission of Investigation/ statutory	Handling of allegations, complaints and concerns about child sexual abuse in respect of diocesan priests
13-14	Review of the Death of Child A and B	April 2010	*not known*	Health Service Executive	Private/ non-statutory	Review of the Death of Child A and B in the care of the HSE

continued

	Inquiry (known as)	Date of publication	Date of commissioning	Commissioner of inquiry	Inquiry format	Issue examined
15	**Roscommon**	**October 2010**	**January 2009**	**Health Service Executive**	**Private/ non-statutory**	**Intra-familial abuse, including sexual abuse**
16	Cloyne	December 2010	March 2009	Minister for Justice and Law Reform	Commission of Investigation/ statutory	Handling of allegations, complaints and concerns about child sexual abuse in respect of a group of diocesan priests
17-22	National Review Panel Reports 2011	October 2011	2010 onwards	Health Service Executive	Non-statutory	Review of serious incidents, including the deaths of children in care or known to child protection services
23	Independent Child Death Review Group	June 2012	July 2010	Minister for Children and Youth Affairs	Private/ non-statutory	A review of the deaths of children in the care of the State and known to statutory child protection services between 1 January 2000 and 30 April 2010
24-29	National Review Panel Reports 2012	May 2012	2010 onwards	Health Service Executive	Non-statutory	Review of serious incidents, including the deaths of children in care or known to child protection services

PART 1: The five inquiry reports at the centre of this study

The five inquiries examined in this study all stemmed from perceived failures of the child protection services in Ireland to intervene effectively to protect children from abuse and/or neglect whilst living with their families. The inquiries are identified here first by their full titles and thereafter throughout the report are referred to by their colloquial names:

- **Kilkenny Incest Investigation** (known as the Kilkenny Report, *see* McGuinness, 1993);
- **Kelly – A Child is Dead** (known as the Kelly Fitzgerald Report, *see* Joint Committee on the Family, 1996);
- **West of Ireland Farmer Case** (known as the West of Ireland Farmer Report, *see* Bruton, 1998);
- **Monageer Inquiry** (known as the Monageer Report, *see* Brosnan, 2009);
- **Roscommon Child Care Case** (known as the Roscommon Report, *see* Gibbons, 2010).

Each of these five inquiries relates to the case of a child or children who had contact with social and/or child protection services prior to their suffering considerable harm or death as a result of harm inflicted by family members who were their main carers. The Monageer Inquiry could be considered to be an outlier in this group since there was no ongoing contact between the Dunne family and child protection services at the time of the death of the Dunne children, Lean and Shania. In fact, a number of research informants contended that child protection was not the main focus of this inquiry.

Four of the five fathers in the families at the centre of these inquiries were convicted of criminal charges. Two mothers were also convicted of criminal charges, including, in one instance, charges of sexual abuse. Criminal charges that might have resulted from the deaths of Lean and Shania Dunne could not be pursued due to the co-terminous death of their parents.

The five inquires, their processes and reports are analysed below under the following headings:

- events that led to the establishment of an inquiry;
- format of inquiry;
- Chair and inquiry team;
- terms of reference;
- inquiry process;
- reports of inquiries.

Events that led to the establishment of an inquiry

Kilkenny Report

The Kilkenny inquiry was established at the conclusion of a Court case that culminated in the imposition of a 7-year term of imprisonment on a father following his conviction on charges of rape, incest and assault. The charges covered the period 1976-1991. The victim of this man's crimes was his daughter, who is referred to by the pseudonym 'Mary' in the report. When this case came to trial, Mary was aged 27 and was the mother of a 10-year old son, who was the child of her father. Mary had been physically and sexually abused by her father for many years. In late 1982/early 1983, she disclosed the physical and sexual abuse that she had suffered to a social worker. She was over 16 at that point and in the eyes of the law was no longer a child, and as a consequence, no legal action could be taken to remove her from her parents' care. Mary left the family home with her son in 1985 and moved to a hostel in Dublin with the assistance of a social worker. Her father discovered her whereabouts with the help of the local Gardaí and she was prevailed upon to return home. Public concern about the case was inflamed when it was revealed in the media that Mary had over 100 contacts with health and social services before the abuse stopped.

Kelly Fitzgerald Report

Kelly Fitzgerald died in a London hospital in February 1993, just days after arriving in an emaciated and critical state from her family home in Ireland. She was 15 years old. Her parents were convicted in November 1994 on charges of wilful neglect and both were sentenced to terms of imprisonment of 18 months. These events (and their proximity to the Brendan Smyth affair, which had resulted in the collapse of the previous Government) prompted the new Government to request the Western Health Board to commission an inquiry. The period during which Irish health and social services were in contact with the Fitzgerald family prior to Kelly's death was relatively short since, prior to December 1990, the family had lived in England. Kelly's contact with Irish health and social services was especially short because she had initially remained in England in the care of members of her extended family when her parents and siblings moved back to Ireland. She only came to Ireland to live with her family in September 1992. Staff in Lambeth Social Services alerted the Western Health Board of concerns regarding Kelly and another child in the family when they became aware that the Fitzgerald family had returned to Ireland.

West of Ireland Farmer Report

This inquiry was established in 1995 after a father received a very lengthy term of imprisonment following his conviction on charges of physical and sexual assaults of his children. Four of the 6 children in this family were subjected to horrific abuse. The abuse began in 1976 when the three oldest children were aged 7, 6 and 4. It continued until 1993. From 1979, social workers, the family GP and the Gardaí were aware of the physical abuse of children in this family. In 1979, the mother requested that one of her daughters be taken into care and signed a voluntary admission to care order in respect of the child. This was not acted upon and

the child was not taken into care. In April 1982, a criminal case was taken against the father in relation to an assault on one of his children. The case was adjourned for 6 months and then struck out. In 1983, the eldest child was placed in voluntary care after he presented at the local Garda station with a teacher and stated his unwillingness to return home. While in care, the child disclosed the sexual abuse of himself and his sister. Despite this, the child was returned to his home for weekend visits and after a number of months left the care home. There was no engagement between the family and social services between 1984 and 1993, when the full extent of the physical abuse was revealed by the children, three of whom were then adults.

Monageer Report

In April 2007, Lean and Shania Dunne were found dead in their home, along with their parents Ciara and Adrian. Lean was just days away from her 5th birthday and Shania was 3 years old. The children died from asphyxia. Ciara Dunne had been strangled and Adrian Dunne died due to hanging. The deaths were treated as a murder/suicide. Both the Dunne children had very limited vision due to congenital conditions and Adrian Dunne was almost blind. Ciara Dunne had a learning disability. The family had had contact with an array of health and social services, including child protection services, since the birth of Lean and Shania. In April 2007, there was no ongoing contact with child protection services. Concern about the Dunne family was brought to the attention of An Garda Síochána, both orally and in writing, by a local undertaker after Adrian Dunne made inquiries regarding funeral arrangements and he and Ciara called to the undertaker's premises to inspect coffins and discuss arrangements for the funerals of two adults and two children. The inquiry was established amidst concerns that interventions by An Garda Síochána or child protection services might have prevented the death of the family members.

Roscommon Report

Contact between child protection services and the family at the centre of the Roscommon Child Care Case began in 1989, shortly after the birth of the first child, and continued until May 2005, when care orders under Section 18 of the Child Care Act 1991 were granted in respect of all 6 children. More than 8 years prior to the granting of the care orders, an application for supervision orders was discussed in November 1996 at the first case conference held in respect of this family, but no application was made to the Court at this time. In October 2000, following discussions regarding a co-parenting arrangement with relatives, the mother obtained an ex parte High Court order which restrained the Western Health Board (WHB) from removing the children from her custody without a further order of the High Court. In July 2001, the WHB applied for supervision orders in respect of the 6 children, but following a number of adjournments the application was struck out in March 2002 at the request of the WHB. In the summer of 2004, one of the children asked to be taken into care and in October 2004 the remaining 5 children were placed in care on foot of an emergency care order. A total of 12 case conferences were convened in respect of this family between November 1996 and November 2004. The mother was sentenced to a term of imprisonment of 7 years in 2008, following her conviction on charges of incest, ill-treatment and neglect. The father was sentenced to a term of imprisonment of 14 years in 2010, following his conviction on charges of rape and sexual assault.

Format of inquiry

All of the five reports were the product of private non-statutory inquiries. This format meant that the inquiry teams had no powers to compel witnesses to attend and there was no provision to reimburse any legal costs incurred by witnesses. The non-statutory basis of these inquiries allowed them to be conducted on an informal inquisitorial basis. This may have encouraged some witnesses to be frank and fulsome in interview, but it may also have

allowed other potential witnesses not to engage with the inquiry process (*see Table 2*). The West of Ireland Farmer Report notes that the non-statutory nature of the inquiry meant that *'participants could not, therefore, be afforded the same rights as they would have in appearing before a statutory inquiry and this was made clear'* (Bruton, 1998, p. 6).

All the inquiries were conducted in private; there was no facility for the public or the media to observe the inquiry proceedings. The Kilkenny Report explains the decision to conduct the inquiry in private and states (McGuinness, 1993, p. 14):

> 'It was decided that the investigation be conducted in private. This decision was taken because of the personal and sensitive nature of the information, the family's right to privacy and the need to facilitate full and frank discussion of the issues involved. The holding of the investigation in private also concurred with the Minister's wishes to preserve anonymity.'

Non-statutory inquiries are generally recognised as being speedier and less costly than statutory inquiries. However, it is difficult to assess the savings associated with the use of this format since the cost of just one of these inquiries – the Monageer Inquiry – has been publicly reported.[11]

The processes and procedures adopted by non-statutory inquiries are less legalistic than those associated with statutory inquiries. It is therefore possible for non-statutory inquiries to complete their work much more quickly than the work of statutory inquiries. The Kilkenny Incest Investigation is the exemplar in this regard – the inquiry report was published just 9 weeks after the inquiry had been commissioned. However, the absence of a statutory basis can lead to legal challenges that can delay the publication of an inquiry report or result in the redaction of sections of the report. In three of the five inquiries examined in this study, the non-statutory format resulted in challenges to the publication of the inquiry reports (*see below*).

The Western Health Board disputed the findings of the Kelly Fitzgerald Report and did not publish it. It was eventually published 5 months after it was completed, after it was submitted to the Houses of the Oireachtas through a Joint Committee on the Family. Speaking in the Dáil in March 1996, some weeks prior to the report's publication, Minister of State Austin Currie commented:[12]

> 'It has become increasingly clear that a change in the law is required to ensure that reports of this nature may be published without fear of legal proceedings. It was for this reason that we decided to establish, on a statutory basis, an Inspectorate of Social Services within the Department of Health. It is proposed that this Inspectorate will have responsibility for quality assurance and audit of child care practice. Moreover, it will be charged with undertaking inquiries on behalf of the Minister. It is our firm intention that the enabling legislation will provide for the privileged publication by the Minister of any report made to him by the proposed Inspectorate.'

[11] In January 2010, Minister Mary Harney in response to a written question provided details of the cost of all reports commissioned in 2007 by the Department of Health and Children to the Dáil. In this reply, a cost of €212,454 was attributed to the Monageer Inquiry.

[12] Dáil Éireann Debates, Vol. 462, No. 7, 7 March 1996 [2004-5]. The debate in the Dáil was prompted by a statement from the Chief Executive Officer of the Western Health Board following publication in the *Irish Independent* newspaper of details of the Kelly Fitzgerald report of inquiry.

The publication of the Monageer Report was delayed by 7 months due to legal challenges and the consideration of legal advice, which recommended against publishing the full report. Ultimately the decision was made to publish a redacted version.[13] Substantial tracts of the report, including 7 recommendations, are redacted in the published version.

The Roscommon Report was published only after the commissioner of the inquiry, the HSE, made an application to the High Court for a permissive order allowing it to publish the report of the inquiry team. The HSE also sought a range of provisions for the continued protection of all the children's identities. Mr. Justice John MacMenamin decided that 'on balance' the report should be published. His judgment emphasized the importance of weighing up, on the one hand, the concerns of the children in relation to future publicity and, on the other, recognising that demands for public accountability and the broad public interest might best be served by publication. The judgment also makes it clear that some, but not all of the children in this case were in favour of the publication of the report.[14] It would be unwise, therefore, to assume the success of similar future application since the balance between the public interest and demands for public accountability and the privacy of the children at the centre of a case might be judged to weigh in favour of the privacy of the children, especially if all of the victims in a particular case opposed publication.

Overall, it would seem that in establishing these inquiries as private non-statutory inquiries, the advantages of a cheaper, faster inquiry were considered to outweigh the disadvantages associated with the inquiries' limited powers and possible challenges to the publication of the reports of inquiry. Although there has been some debate about the legal problems that have arisen in relation to the inquiries, the private non-statutory format has continued to be used. The more formal format of a Commission of Investigation has been used in two instances to investigate child clerical abuse, but as yet has not been adopted to inquire into child protection services in cases of intra-familial abuse. A proposal in the Dáil by an Opposition TD that the Monageer Inquiry be established as an independent commission pursuant to the Commissions of Investigations Act 2004 was not acted upon.[15]

Chair and inquiry team

The Chairs of the five inquiry teams constitute a diverse group. They include a Senior Counsel, who would later be elevated to the position of a Supreme Court Judge (Catherine McGuinness, who chaired the Kilkenny inquiry), and a Junior Counsel (Kate Brosnan, who chaired Monageer), two executives from the charity Barnardos (Owen Keenan, who chaired Kelly Fitzgerald, and Norah Gibbons, who chaired Roscommon), and a management consultant (Michael Bruton, who chaired West of Ireland Farmer). Three of the Chairs had a social work qualification (Keenan, Bruton and Gibbons). No information is provided in any of the reports regarding the basis for the selection of the Chairperson. Speaking in the Dáil after the publication of the Kilkenny Report, Minister for Health Brendan Howlin explained his choice of inquiry Chair as follows:[16]

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[13] *See* Dáil Éireann Debates, Vol. 682, No. 7, 21 May 2009 and Vol. 683, 28 May 2009. *See also* Seanad Éireann Debates, Vol. 195, No. 13, 27 May 2009 [777], during which Minister for State, Barry Andrews stated: '*It was left to the legal advisers to examine the report from a legal perspective and to consider the implications of publishing its full content, cognisant that a delicate balance needed to be found between protecting individual rights and the sharing of knowledge with health professionals and the wider public. In publishing the report, I did what I was legally empowered to do.*'

[14] Neutral Citation Number: [2010] IEHC 360, 27 October 2010. The judgment is available on the website of the Irish Courts Service, www.courts.ie

[15] Deputy Alan Shatter speaking in the Dáil on 27 January 2009: *see* Dáil Éireann Debates, Vol. 672, No. 2 [140-1].

[16] Dáil Éireann Debates, Vol. 431, No. 3, 25 May 1993 [675].

> 'Given the depth of public concern about the case and the questions that had been raised about the role of the health services, I was particularly anxious that the team should have an eminent and independent chairperson. We were indeed fortunate in securing the services of Ms. Catherine McGuinness, Senior Counsel, who combines a distinguished career at the Bar with a long-standing commitment to the whole area of child care.'

Each of the inquiry teams consisted of either three or four team members. Three people (Leonie Lunny, Paul Harrison and Dr. Sheelagh Ryan) served on two inquiry teams. In all, a total of 14 individuals constituted the five inquiry teams.

The reports note the professional status of each member of the inquiry teams. The Kilkenny inquiry team included one member who was an employee of the appointing body, the South Eastern Health Board. While the Roscommon inquiry team included two HSE employees, the report states that these employees '*did not have any previous knowledge of the case and had not worked with personnel involved with the case*' (Gibbons, 2010, p. 7). Six of the 14 inquiry team members were employees of Health Boards or the HSE, and one inquiry team member was a retired Health Board employee. The remaining 7 inquiry team members included two barristers (one Senior Counsel and one Junior Counsel); two employees of the charity Barnardos; a retired Assistant Garda Commissioner; the former CEO of the Citizens Information Board; and a management consultant. Four of the 7 non-HSE/Health Board inquiry team members were non-practising social workers and one was a non-practising nurse.

On occasions, the choice of Chair and the composition of the inquiry team have been criticised. In 1995, Deputy Shatter claimed in the Dáil that the West of Ireland Farmer inquiry team was not appropriate because it was '*chaired by a former health board official*' and its remaining members were Health Board employees.[17] In 2009, the inclusion of HSE employees on the Roscommon inquiry team was also criticised by Deputy Shatter, although in this instance he welcomed the choice of Chair.[18] In the same speech, Deputy Shatter referred to two previous inquiries that had included Health Board members, but claimed that '*there was a key difference in that those involved were from health boards other than the one being investigated. They were truly independent*'.[19] It would seem, therefore, that Deputy Shatter had revised his earlier assessment of the West of Ireland Farmer inquiry Chair and team. The Monageer inquiry team was criticised after the publication of the inquiry report because it did not include a team member from the psychiatric services.[20] The inclusion of a South Eastern Health Board employee on the Kilkenny inquiry team does not seem to have been the subject of criticism.

Terms of reference

The terms of reference of an inquiry define the scope of the inquiry's investigations. Narrow and very specific terms of reference will constrain the work of an inquiry team. Broader, more general terms of reference may allow for more wide-ranging investigations and recommendations. Typically, an inquiry is asked to inquire into the circumstances leading up to a particular adverse event, to make recommendations that would prevent similar events occurring in the future and to present a report with its findings and recommendations.

The terms of reference of the Kilkenny inquiry directed the inquiry team to investigate the health services in the case and in particular the failure to halt the abuse earlier. They could therefore be said to have pointed to an identified failing prior to the conduct of the

[17] Dáil Éireann Debates, Vol. 453, No. 4, Column 1139, 24 May 1995.

[18] Dáil Éireann Debates, Vol. 672, Column 141, 27 January 2009.

[19] Dáil Éireann Debates, Vol. 672, Column 142, 27 January 2009.

[20] Dáil Éireann Debates, Vol. 682, No. 7, 21 May 2009.

investigation. The separate references to the investigation and management of child abuse cases in the terms of reference are considered to be significant in that they invited the consideration of both the role of the various health services staff directly involved in the case and the management structures in the various agencies and organisations within the health services that have a role to play in child welfare and child protection.

The Kilkenny Report explicitly acknowledges on a number of occasions that it went beyond the scope of its terms of reference (McGuinness, 1993, p. 11 and p. 116). It could be argued that the inquiry team interpreted the terms of reference as an imprimatur to consider in a very wide-ranging manner the services and structures necessary to tackle sexual abuse.

Although the Kelly Fitzgerald inquiry was commissioned by a health board (the Western Health Board), the terms of reference were not restricted to the services within the remit of the health board. The inquiry team was asked to make recommendations regarding the protection practices and procedures and '*such other recommendations that are considered relevant*' (Joint Committee on the Family, 1996, p. 10).

The terms of reference of the West of Ireland Farmer inquiry were the narrowest of the five inquiries. They required the inquiry team to conduct a review of the North Western Health Board's (NWHB) involvement in the case and draft recommendations to ensure an 'effective' response by the Board in the event of such cases in the future. The inquiry team was therefore not invited to consider issues that did not directly impact on the services provided by the NWHB.

The terms of reference in the Monageer inquiry were substantially different from those provided for other inquiries and reflected the specific tragic circumstances that led to this inquiry. The terms of reference required the inquiry team to differentiate between the services required and received by the Dunne family and to evaluate whether the services provided were appropriate to the needs of the family; whether there was appropriate interagency cooperation; and whether those providing the services discharged their duties. The latter requirement could be interpreted as requiring the inquiry team to present an evaluation of the work of individual people involved in the provision of public services to the Dunne family. However, the inquiry team's interpretation of its terms of reference was that '*the terms of reference require them to examine the provisions of public and other relevant services rather than the performance of any individual person involved in the provision of such services*' (Brosnan, 2009, p. 6). This interpretation was qualified, however, since the report goes on to note that '*services are provided by individuals or teams of them and it is inevitable that an analysis of service provision will involve consideration of its provision by individuals*'. The inquiry team therefore concluded that in certain instances it was necessary to '*record adverse comment in respect of certain individuals*' (*ibid*, p. 7). Shatter (2009) has attributed the extensive redaction of the contents of the Monageer Report to the inclusion within the report of adverse comments directed at specific individuals.[21]

Only the terms of reference for the Monageer inquiry set out a timeframe within which the inquiry report was to be submitted. The Monageer inquiry team was unable to conform to the timeframe stipulated (of 3 months) and applied for it to be extended on a number of occasions.

[21] While Shatter suggests that the redaction was mainly to protect individuals who may have come into contact with the family, Minister of State Barry Andrews stated in the Dáil that the legal advice he had received indicated that the publication of the Monageer Report in full would result in '*reputational damage*'. Minister Andrews also stated that '*where a conviction has already been achieved, there are fewer constraints on the publication of matters causing reputational damage. The publication of the Kelly Fitzgerald report was facilitated for that reason*'. This suggests that the reputational damage might attach to a member of the Dunne family. *See* Dáil Éireann Debates, Vol. 683, Column 293, 21 May 2009. *See also* Other Questions – Health Service Inquiries, http://historical-debates.oireachtas.ie/D/0683/D.0683.200905210017.html

The terms of reference of the Monageer inquiry did not invite the inquiry team to make recommendations. Despite this, the Monageer inquiry team did make 26 recommendations, of which 7 were redacted in the published version of the report.

The terms of reference of the Roscommon inquiry directed the inquiry team to examine the management of the case and identify shortcomings/deficits therein. In the case of Kelly Fitzgerald, the terms of reference do not extend to a consideration of the protection practices and procedures, or to an evaluation of whether individuals properly discharged their functions in the case of Monageer. The Roscommon terms of reference do not refer to recommendations, but rather to a report on '*findings and learning arising from the investigation*'. This could be interpreted as inviting recommendations that are based on evidence from beyond the particular case.

Inquiry process

The primary methodological approach of all five inquiries was to review the relevant files which provided details of contacts between the child/children and the family with health and social services and to seek to interview all relevant persons. All the inquiry reports note that witnesses could not be compelled to attend the inquiry. The details of witnesses interviewed are set out in Table 2. Four people were asked to attend the Roscommon inquiry on two occasions. All of the inquiry reports, with the exception of the West of Ireland Farmer Report, state that witnesses were permitted to be accompanied if they so wished.

The Roscommon inquiry provided all interviewees with a written outline of the fair procedures that applied to them. Interviewees were provided with the sections of the draft reports that pertained to them and had the opportunity to correct '*any factual inaccuracies*'. They could also request, if they so wished, a transcript of their interview. The approach taken by the West of Ireland Farmer inquiry team was less inclusive, in that they provided *'those who might be perceived as being adversely affected by our conclusions'* an *'opportunity to review the sections relevant to themselves and provide us with their comments'* (Bruton, 1998, p. 6).

In the case of the Monageer inquiry, witnesses who were Gardaí and health service providers were informed in writing in advance of being interviewed that if findings adverse to them were made by the inquiry team, they would have the opportunity to make submissions to the team before the report was presented to the Minister for Health and Children and the Minister for Justice, Equality and Law Reform. The report was circulated to a number of people and the submissions received were considered by the inquiry team before the Monageer Report was finalised. Some of the submissions received are included as Appendices to the report, but these (like parts of the main text) are redacted. Other submissions are not included in accordance with the wishes of the witnesses concerned (Brosnan, 2009, pp. 9-10). Neither the Kilkenny Report nor the Kelly Fitzgerald Report refer to providing witnesses with the facility to review sections of the draft report or transcripts of interviews.

Table 2: Schedule of witnesses

Inquiry	No. of invited witnesses	No. of witnesses who attended	Victims/siblings of victims interviewed
Kilkenny	*not known*	*not known*	Yes
Kelly Fitzgerald	*not known*	52	No
West of Ireland Farmer	*not known*	*not known*	Yes (4 eldest children)
Monageer	55	54	No
Roscommon	41	38	Yes (4 youngest children)*

* The children were interviewed informally by the Chairperson in the homes of their foster families.

Methodological variations

The Kilkenny inquiry held a press conference at the outset of the inquiry during which it was announced that submissions would be invited from interested parties. The 31 submissions received are listed in an appendix attached to the Kilkenny Report. The individuals and organisations that made written submissions to the inquiry include the Chief Executive Officers of six Health Boards, consultant hospital doctors and doctors' organisations, nursing and social workers' representative organisations, academics expert in the area of child protection and welfare, teachers' organisations and a range of other advocacy groups, including the Dublin Rape Crisis Centre and Accused Parent's Aid Group.

The Kilkenny inquiry team also contacted the UK health and social services with a view to reviewing files relating to the family, but no records were available. The team also sought meetings with a senior clinical psychologist (Maureen Gaffney) and a legal expert (William Duncan).

In common with the other inquiry teams, the Kelly Fitzgerald inquiry team interviewed relevant people including many professionals who had been involved in providing health and social care to the family. Prior to conducting individual interviews, the inquiry team held group meetings in Castlebar and Galway with members of staff, including hospital-based staff, who had had contact with the family. At the meetings, the inquiry process was explained and staff were invited to ask questions. The inquiry team also visited London to consult with relevant health and social service personnel, teachers, a Detective Constable from the London Metropolitan Police and some extended family members. A number of extended family members who were invited to meet with the inquiry team declined the invitation. Although the inquiry team did not invite submissions from stakeholders, it received four submissions – from the Western Health Board Psychology and Social Work Departments, the ISPCC and the Children's Rights Alliance. The inquiry team also consulted with two experts on child protection (Harry Ferguson and John Fitzgerald).

In setting out the inquiry procedures, the West of Ireland Farmer Report notes that it analysed the policies of the North Western Health Board in addition to the relevant files. It also notes that no consent was granted to allow the inquiry team access to files maintained by the GP and the GP did not consent to any discussions regarding the two youngest children and the mother. The children's mother also declined to meet the inquiry team.

The Monageer inquiry team had access to Garda files, which included witness statements (198); hospital, social work and GP records; internal Garda Reports; and the social welfare and financial records of the Dunne family. The inquiry team was also provided with an internal HSE review of the circumstances surrounding the tragic death of the Dunne family. In an effort to ensure that all people with information relevant to the work of the inquiry were identified, the inquiry team placed advertisements in local newspapers in the Wexford area during the week commencing 4th February 2008, inviting such people to come forward. The inquiry team was based in Joyce House in Dublin, but as part of its procedures the team visited Monageer. The inquiry team also sought to establish the sequence of events in the immediate period leading up to the death of the Dunne family so that the time of death could be established as accurately as possible. In addition, the inquiry team consulted with Dr. Helen Buckley on child protection issues.

At an early stage of the Roscommon inquiry process, two members of the inquiry team met with senior personnel of HSE West to outline the inquiry procedures and to answer questions. A number of HSE personnel communicated with the inquiry team through solicitors

appointed by their representative bodies, seeking clarification on matters relating to the establishment and conduct of the proceedings of the inquiry. The inquiry team responded in relation to matters that pertained to inquiry processes, but many of the concerns raised were referred to the HSE. Despite a number of unresolved concerns, the HSE personnel agreed to attend the inquiry. The Roscommon Report notes that most witnesses acted on the option to make a written submission in addition to their oral evidence and 15 witnesses opted to be accompanied in presenting their evidence to the inquiry team. The inquiry team also sought expert advice '*from a small number of experts*' (Gibbons, 2010, p. 13).

The Roscommon Report notes that it was guided by the specific objectives of a Case Management Review set out in the *Children First* national guidelines (Department of Health and Children, 1999, 1st edition) and *by Learning Together to Safeguard Children*, which sets out a multi-agency systems approach for case reviews (Fish *et al*, 2008). The 'Methodology' chapter in the Roscommon Report concludes with a section that sets out the 10 guiding principles that underpinned the inquiry's work.

Reports of inquiries

The reports of the inquiries examined range in length from 232 pages in the Kelly Fitzgerald Report to 51 pages in the West of Ireland Farmer Report. The reports do not share a common structure and the number of chapters included varies from 6 (Roscommon) to 11 (Kilkenny).

All of the reports set out a chronological account of the family's contact with health and social services, although in the West of Ireland Farmer Report this chronology of services is set out in an appendix rather than in the body of the main report. In three of the five reports, the chronology of the family's contact with health and social services is very lengthy and accounts for a substantial section of the report. Over 100 pages of the Kelly Fitzgerald Report is taken up by a chronology of the Western Health Board's involvement with the Fitzgerald family. The length of this section is especially surprising in that the period covered by the chronology is just over 2 years (from December 1990 to Kelly's death in February 1993). The chronological account included in the Monageer Report covers 5 years and runs to over 60 pages, while the chronology in the Roscommon Report is a lengthy 50 pages, but covers a period of over 15 years. The chronology within the Kilkenny Report extends to 17 pages and spans a 17-year period. The chronology attached to the West of Ireland Farmer Report covers a time period of 20 years (from April 1976 to March 1995) and is set out over 25 pages.

The Kilkenny Report opens with an introduction and is then divided into two parts. Part I consists of 9 chapters, which broadly speaking could be said to be related to the work of the inquiry in relation to historical events. The chapters cover the background to the inquiry, the terms of reference and procedures of the inquiry team; contextual chapters, which outline the health care system, the legislative framework and the knowledge of child sexual abuse; an account of the family's story and the contact of 'Mary' with health services; analysis; and conclusions. Part 2 of the Kilkenny Report relates to the recommendations of the inquiry team, which are set out in 2 chapters: an introductory chapter and a chapter detailing the recommendations themselves.

The division of the Kilkenny Report into two parts is consistent with the terms of reference of the Kilkenny inquiry, which are also set out in two sections. The approach of the Kilkenny inquiry team to the drafting of recommendations is described in Chapter 5 of this report.

PART 2: Reflections on the inquiry process: 'That's life … that's just life.'

While the main focus of this study is on the recommendations of inquiries, it is inevitable that the value of the recommendations will depend on the perceived worth of the inquiry process generally. The establishment of an inquiry may defuse a crisis, but its effectiveness in restoring public confidence and trust will depend on the fairness and transparency of the inquiry processes and the credibility of the inquiry report. This second part of Chapter 4 begins to report on the data collected through interviews, where respondents discussed qualitative aspects of the process, highlighting elements of it that were considered crucial to its success and others which, in their opinion, detracted from its usefulness.

The data were gathered from 21 semi-structured interviews. As described in Chapter 1, the interviewees are methodologically categorised as 'elite' in recognition of their senior professional status within the sphere of child protection and/or their role in the inquiry process. The participants' reflections are considered below under the following headings:

- role of inquiries in child protection;
- format and procedures;
- Chair and the inquiry team;
- terms of reference;
- opportunities and challenges created by inquiries.

Role of inquiries in child protection

Research participants were generally supportive of processes that review and report on child protection failures and, in this regard, considered inquiries to be an ineradicable element of the child protection terrain. As one interviewee commented:

> 'There are always going to be inquiries … there are always going to be cases that will attract the media attention or political attention and even in the best-run system, where you have a huge system of monitoring and control, there will always be cases where for political or public confidence reasons there will have to be inquiries … Why? That's life … that's just life.'

A second interviewee also used the same phrase (*Why? That's life … that's just life*) to explain why they felt the demand for inquiries would never be eliminated. They also commented:

> 'Some cases attract more attention than others and they're not necessarily the worst … not just in child care … the bureaucratic response is that everything should be treated the same, but you just have to get past that they won't, they won't be treated the same.'

Inquiries were considered by some to be a reasonable response to a crisis. Most agreed that the serious and tragic outcomes for the children involved in the cases warranted investigation, the deficits in the case being described by one former Health Board manager as '*a wake-up call*'. A former HSE manager recalled that when Court proceedings on a case in their area was reported, revealing serious practice weaknesses, the view in the office was that '*Once the case blew, there would be an inquiry of some sort*'. One interviewee, a former social worker who was also a member of an inquiry team, reflected the reality that no professional can consider their work to be exempt from scrutiny at some stage:

> 'You need to enter these things [inquiries] with a considerable amount of humility because you never know the day or the hour.'

However, research participants also noted that inquiries are generally established on the basis of media and subsequent political pressure, rather than the facts of the case. This build-up of pressure is reflected in the reference by a participant to an '*explosion*' which demands a political response to satisfy the demand that '*something must be done*'. As one civil servant described it:

> 'The crisis hits and the politicians have to react; they have to be seen to react.'

A former Health Board/HSE manager described how a case comes into the public arena and gets 'traction':

> 'The Minister will be asked questions in the Dáil and the media will be in a frenzy. They will be out hunting, looking for relatives or neighbours or anyone to talk to them. They will act in a manner that the public wouldn't believe; so they will find members of the extended family who have alcohol problems and they will get them drunk, they will do anything to get pictures, information, stories to keep it running once the frenzy gets going … and that feeds into the political machine, which feeds into the delivery system at the most senior level and the Department … and once things reach a particular level of pressure, an inquiry is the answer to calm that and to bring re-assurance.'

This comment suggests that the primary motivation in establishing an inquiry may not be to discharge the explicit functions of fact-finding or identifying lessons for the future from the inquiry's terms of reference, but rather to give re-assurance and provide an opportunity for catharsis. This was considered by some to be less constructive in the longer term than a more managed response. A senior civil servant described the 'knee jerk' response as 'daft' and 'crazy'. As they expressed it:

> 'Once things are in the political domain, people are usually panicking and running all over the place. You need those things out of the political domain and you need a system for doing this sort of thing [that] gets handed to the competent people to do it … according to set procedures based on experience.'

Some participants considered that the significance of the role of inquiries was diluted as they began to recur. While the Kilkenny Report was considered to be seminal, subsequent inquiries were not considered to have had the same impact. One interviewee described what they considered to be the lower profile of the Kelly Fitzgerald and West of Ireland Farmer reports:

> 'I don't think they would have had the same status I suppose as the Kilkenny Report, even though they were both very important reports … There was a review done at some stage and when we looked at it in detail we found that an awful lot more of the Kilkenny Report [recommendations] were actually followed up on rather than the other two.'

A former HSE manager illustrated the different approach that was, in their view, taken when a report was commissioned by the Health Boards rather than the Department of Health:

> 'A report like that would be on an agenda and would be chatted about … I'm using the word 'chatted' about because I think that probably captures [the approach] best.'

A number of research participants suggested that a multiplicity of inquiries could be counter-effective and lead to a sort of systems-overload that might further compromise the quality of service delivery, with little incremental value accruing from each additional report:

> 'To have too many inquiries … diminishes the importance … and I'm not too sure that the inquiries are coming up with anything particularly new … The recommendations I think are broadly the same.'

Another participant shared this view:

> 'I think the value of inquiries as we know it, that value has gone and there needs to be a different system brought into play should there be such a serious case again. And there will be, it's only a matter of time.'

One research participant commented that because of the succession of reports in the area of child protection, each report was '*the report*' for only a fleeting period before it was superseded by a more recent report which demanded attention and resources. In particular, it was claimed that too many recommendations can impede rather than promote standardised practice:

> 'There were an awful lot [of recommendations] and we were constantly being asked about what has happened and like some of the recommendations were completely … detailed so they became kind of irrelevant and we were still having to report on them.'

Format and procedures

Each of the five inquiries examined in this study was established on a non-statutory basis. (The different formats of inquiries are discussed in Chapter 2.) The inquiries were variously commissioned: two were commissioned by Government Ministers, two were commissioned by Heath Boards and one was commissioned by the HSE. The proceedings of all five inquiries were conducted in private. The five inquiry reports are publicly available, although in two instances the published reports are partially redacted.

One of the disadvantages of not putting an inquiry on a statutory basis was pointed out by an interviewee as the lack of legal protection that might result in difficulties later on:

> '… the people with the statutory [basis] have protection and these people [in a non-statutory inquiry] have no protection, and when you go to make recommendations you get all tied up with your legal people … I mean, the Monageer [report] was greatly redacted as a result of a piece of information that [the] legal people insisted came out, and it distorted the whole thing.'

None of the research participants was of the view that these inquiries should have been set up on a statutory basis and it was understood that in the event of non-cooperation, a contingency could be put into play, as evidenced by this quote:

> 'Every non-statutory inquiry, if it can't function, has an implicit threat … that "if I can't deliver on the terms of reference, I'll report back to the Minister and you will have to try Plan B".'

As far as compliance was concerned, the difference between statutory and non-statutory inquiries was considered to be somewhat ambiguous by a number of interviewees. One pointed out:

> 'People confuse the statutory inquiries, where witnesses are compelled to attend, and this type [non-statutory], where it is all voluntary and everybody can just say "get lost" if they want to.'

Two former members of an inquiry team also highlighted an inherent contradiction:

> 'People's cooperation with it [the inquiry] is completely "voluntary", yet they are employed by the commissioning agents … That is an issue … you are expected to cooperate and if you don't, it may have HR [human resources] consequences, which is nothing to do with the inquiry team.'

> 'Some interviewees may feel "I'm only here because I had to be here" type of thing, even though the review team was saying you don't have to be here and you can leave any time you want.'

A former Health Board/HSE manager suggested that it may be unwise to presume that the cooperation of staff with inquiry processes as currently formatted will continue:

> 'I have been amazed that we haven't had more formal hostility and much greater objection from staff and their representatives … that hasn't grown and become much much stronger.'

A number of interviewees commented on the differences between the various inquiry reports and the lack of a structured approach to the process, which they put down to the fact that inquiries have traditionally been 'reactive' rather than 'proactive', which can lead to inquiry teams being hastily assembled and insufficient attention being paid to the drafting of terms of reference. Eight research participants suggested that there should be 'an automatic mechanism' with a standard methodology or template, or a cohort of people with expertise who would give guidance around issues such as the terms of reference and the procedures to be adopted.

When an inquiry is conducted in private, the publication of the inquiry report is the principal means by which the inquiry can defuse public concern and be seen to promote accountability. The publication of the report is also essential if learning is to be disseminated. However, if substantial sections of inquiry reports are redacted (as in the Monageer Report), the reports are substantially devalued, confidence in the inquiry processes may be eroded and opportunities for learning may be lost. The redactions in the Monageer Report were specifically commented on by four research participants. For example:

> 'If you have an inquiry report and so much of the findings and so much of the recommendations are redacted – you know, with a big black line through … and it's for legal reasons … someone took their eye off the ball at some stage in the whole process.'

The Chair and the inquiry team

Most research participants agreed that the inquiry team had to combine independence and competence. The independence of the Chairperson was seen as being crucial to the actual and perceived independence of the inquiry team. Several participants recognised that it can be especially difficult to satisfy demands for complete independence in a small country such as Ireland, where networks of contacts are likely to be multi-layered and dense.

One member of an inquiry team commented that the independence of inquiry teams is especially likely to be under pressure in the period immediately prior to the publication of the inquiry report. This participant stated:

> 'You need to be alert and aware and politically aware … and I think it is really important that inquiry teams and inquiry Chairs make sure that they have done the very best they can to mind the integrity of the process and particularly to be vigilant at the end because that's, I think, when things can go pear-shaped and you can find yourself with a report that's not really the report of the inquiry.'

Two research participants, who were managers or former managers in the HSE/Health Boards, cautioned against the appointment of Chairs that might have:

> '… a vested interest in keeping a foot in the door with the HSE or the Department [of Health] … creating some doubt regarding a person's objectivity or independence.'

A number of interviewees voiced a preference for a Chairperson with a legal qualification because they felt this would ensure that inquiry processes adhered to fair procedures and that the work of the inquiry team complied with the terms of reference. However, others pointed out that the inclusion of a lawyer on the inquiry team might result in the adoption of an excessively legalistic process, which encouraged witnesses to seek legal representation. A former inquiry team member's comments sum up this view:

> 'I think if I was to appear before an inquiry myself that was chaired by a lawyer, I think I would be fairly "lawyered up" going into it.'

Another inquiry team member also noted that the inclusion of a lawyer on the inquiry team could change the dynamics of the inquiry process, but stressed the importance of having legal input:

> 'Formality goes up when a lawyer is present, you know, and sometimes I think it's essential and other times it's not … What is essential is to have a very good legal team behind the review team which is in sync with its thinking and can give advice as the process rolls out. It can't be done without legal input.'

Some Health Board/HSE current and former managers were critical of the composition of some inquiry teams, arguing that they lacked members who were engaged in the delivery of statutory child protection services. It was claimed that:

> 'The actual experience of having been involved in statutory child protection and the actual experience of managing within a statutory context is starkly absent from most of the inquiries, it seems to me.'

> 'The knowledge of child protection within the inquiry team wasn't sufficient … You need to have competence in people who are asking the questions and have that ability and that basic knowledge around the process.'

Other participants highlighted the importance of incorporating the appropriate range of skills, but considered that this had to be assessed on a case-by-case basis. It was also pointed out that the range of issues to be considered is not always clear at the outset, that the relevant skills and expertise may not be known and that a preliminary review might be useful.

Terms of reference

An almost unanimous view was expressed by interviewees with respect to the importance of the terms of reference of inquiries. They were referred to as 'critical' and 'significant'. As one interviewee with experience in a number of sectors expressed it:

> 'Hugely important … and in inquiries I've been involved in since, some of which have gone very well and some of which have been disasters … have brought it home the importance of terms of reference, which I probably didn't appreciate fully then, but I certainly do now and I'd be much more careful.'

Another interviewee described the function of the terms of reference:

> 'In setting your terms of reference, you need to be absolutely clear about what you want an inquiry to tell you … I don't mean what the outcome is, [but] what it is that the inquiry is designed to do. Is it designed to look into the death of a particular child or is it designed to look into an entire system within that particular organisation or part of an organisation?'

Two former inquiry team members considered the terms of reference as important in determining the focus to be adopted by the team. One commented that the terms of reference have to be:

> '… very carefully constructed and I mean one needs to be very careful that they are not presuming that something has gone wrong … or pointing a finger at any particular person or any part of the service …'

The other former inquiry team member cautioned against terms of reference that restricted teams to talking about 'services' to the exclusion of 'servants'. This participant commented that:

> '… to carry out an inquiry like [name of inquiry mentioned] and to restrict yourselves to the services without speaking about those who were providing them [would mean that] the report would amount to nothing. It wouldn't be a comprehensible thing.'

Another interviewee commented on the difference between terms of reference set by different commissioners:

> 'An inquiry commissioned by the Department [of Health] ultimately has to be of policy and legal benefit if it's to fit into our remit. An inquiry commissioned by a service provider should include a specific focus on service for the benefit of the provider.'

Yet, despite the agreement on the centrality of terms of reference, no real consensus was reached on the shape that they should take. Responses varied from:

> 'Broad or tight … each case is different.'

to

> 'I think they shouldn't be too broad.'

and

> 'Better to err on not tying their hands than tying them.'

Two separate former inquiry team members had contradictory views. One observed that:

> 'The terms of reference] should not be used, although they are, to stymie broad-based recommendations … They should be open to being amended as you work.'

as opposed to:

> 'If they [the terms of reference] are loose at all, you are leaving it open to inquiry teams who will choose to meander at will, which isn't the most helpful. I think they need to be very tight and well thought-out.'

Overall, it can only be inferred that, while terms of reference are clearly important, their parameters should be assessed on a case-by-case basis.

Opportunities and challenges created by inquiries

There was general agreement from research participants that inquiries created opportunities to remediate weaknesses in the services that had been profiled in the report. The lack of service development and the paucity of relevant personnel in both the Health Boards and the Department of Health prior to the publication of the Kilkenny Report in 1993 was highlighted by a number of interviewees, one of whom spoke of coming from a '*low base*'. Another pointed out that:

> 'Our structure was highly risky, you know, very dependent on the different personnel that were in positions around the country and how they responded to the different issues and the legal advice available.'

Issues relating to children were dealt with at that time by a number of Government departments, but were not 'owned' by any one department. Child welfare and child protection did not have a political 'champion' so that issues in child care came '*low down in the pecking order*' in terms of attention received and funds to be allocated.

Research participants acknowledged that the Kilkenny Report had placed child protection 'centre-stage' and that the report was championed by the then Minister for Health, Brendan Howlin, who used it to secure a commitment from Government for substantial additional resources, which crucially enabled the Child Care Act 1991 to be implemented within a shorter timeframe than would otherwise have been the case. Given the right context then, inquiry reports were acknowledged as having the potential to be powerful catalysts for change. As one interviewee noted:

> 'I remember one Minister telling me – now he didn't mean it as in he hoped that this would happen but what he said was – what he really needed was another Kilkenny Report so that he could access resources.'

However, successive inquiry reports were not credited with such positive consequences. Although the initial shift of child protection to 'centre-stage' was welcomed, the repeated emergence of 'scandals' and the establishment of inquiries to investigate them was not viewed positively by research participants. Indeed, several reflected on the need to change the current inquiry system. One inquiry team member commented:

> 'I would approach it more and more from a learning perspective. I think you effect better change doing it that way … It's easier to meet in a fora of professional development rather than a fora of management imposition. I think people are more receptive in a place like that.'

A former inquiry team member outlined their aspiration that '*the report might be seen as a contribution to learning*'. However, another participant felt that '*the reactive nature*' of inquiries might interfere with the potential to learn from them, while a third participant pointed out that the principal motive for staff-involved inquiries is to '*survive … which is not conducive to learning*'.

The 'unreal' aspect of inquiries, which are inevitably imbued with hindsight, was commented on by research participants. While it was predictable that interviewees who appeared before inquiries might be critical of inquiry processes, other participants, including inquiry team members, also pointed to flaws and weaknesses in the inquiry format. A former Health Board/HSE manager, who had also been involved in conducting a variety of reviews and inquiries over the years, made the following comment:

> 'You're looking at people's practice through a lens and in a context when you have all the time in the world and you have all the information, and you're looking at it forensically. That tends to be so different from their lived experience that they also then question the value of the insight that comes from it.'

Other research participants also pointed out that failure or adverse outcomes could never be eliminated from the work of child protection, where risk management, uncertainty and inexact processes were central.

The high personal cost of involvement in inquiries was highlighted by a significant proportion of the interviewees. Reference was made to anxiety, trauma and duress. The following comment captures the hurt that can be associated with the inquiry process at an individual level:

> 'Members of staff who have been involved have found their kids getting hassled at school. They have found themselves having comments made to them socially or in the supermarket … You know it's a very small country … particularly in rural Ireland when situations are involved and some people have never functioned properly again after that.'

While it may be possible to point to a small number of individual staff members who have been especially affected by the inquiry process, it is difficult to assess the wider implications of the process on the morale and work practices of professional child protection staff. An example was provided by one interviewee:

> 'I suppose that's the other thing about those inquiries, you know, they weren't all positive. There was all that fear that they generated, the defensive practice … I always remember going to a conference in the aftermath of the [name of inquiry] case and there were social workers there who were actually traumatised by the whole thing.'

The interviews also highlighted that in some instances the experience of being part of the inquiry process has been a difficult and damaging one for people involved on the inquiry teams. One inquiry team member spoke of what they regarded as the '*outrageous*' treatment of the team and of inquiry team members' careers having been '*blighted*' by their involvement in the inquiry process:

> 'We painted the appalling vista and we got punished, if you like, by the system because the system couldn't acknowledge that there was … really bad practice in this instance.'

Conclusions

Research participants expressed disparate views about the inquiries into child protection failings in Ireland. The need to review and report on cases which result in tragic outcomes for children was not challenged, but many participants questioned the value of the continued use of inquiries and pointed to the high personal cost paid by some of the child protection staff involved in inquiries and, indeed, by some inquiry team members. While there was agreement that the Kilkenny inquiry had brought about major positive changes in the area of child protection, the same impact was not attributed to subsequent inquiries. It was felt that the manner in which the inquiries were conducted was not always conducive to learning. The interviews suggest that there is considerable scope to bring about improvements in the inquiry process.

5. Recommendations from the five inquiry reports

This chapter provides an overview of recommendations from the five reports examined in this research. It is based on a study of the reports and also informed by data from interviews with research participants, some of whom were members of inquiry teams and others who were close to the inquiry process in either Government departments or the Health Boards/HSE. A discussion on the content of the recommendations is followed by an account of research participants' views on their various aspects. A detailed list of the recommendations in each inquiry report is provided in Appendix 1, alongside information on their implementation to date.

PART 1: Overview of recommendations

All of the five reports of inquiry examined present recommendations, including the Monageer Report which was not required, under its terms of reference, to provide them. It is difficult to be absolutely definitive about the number of recommendations made by some of the reports since they were not readily quantifiable in certain cases.

The recommendations within the Kilkenny Report are not numbered, but are easily identifiable from the remainder of the text because they are printed in a bold italicised font and organised under 16 main headings with further sub-headings. In a number of instances, several recommendations are 'nested' within one, which has made it difficult to calculate the actual number of recommendations.

Similarly, the recommendations in the Kelly Fitzgerald Report are not numbered, but are set out (without the use of headings) in 44 paragraphs, which for the most part address a single recommendation each.

The recommendations in the Roscommon Report are organised under 5 main headings, with a further 14 sub-headings. They are not numbered, but are easily identifiable as they are printed in bold.

The recommendations in the West of Ireland Farmer Report and the Monageer Report are numbered and organised under headings, although in the case of Monageer, a number of them are clustered together under single headings even though they apply to different sectors. One of the 7 headings used to categorise the 26 recommendations in the Monageer Report is redacted, along with all 7 recommendations under that heading.

The best estimate that this study could make is that the five reports between them offer 187 recommendations, consisting of 25 in the Kilkenny Report, 44 in the Kelly Fitzgerald Report, 34 in the West of Ireland Farmer Report, 26 in the Monageer Report and 58 in the Roscommon Report.

None of the five inquiry reports referenced recommendations to specific sections of the report or to a relevant external source of evidence. Recommendations are not clearly prioritised and do not indicate an expected implementation timeframe. Some were directly related to deficits that were highlighted by the reports and others were equally reflective of more generalised concerns that prevailed at the time. The review of policy reforms in Chapter 3 has demonstrated that many of the issues underpinning recommendations had been identified by the Health Boards prior to the inquiries being established and, in some instances, intended reforms had already been planned or had stalled due to lack of funding.

Kilkenny Report (1993)

The literature reviewed for this study (*see Chapter 3*) and the responses of the individuals interviewed (*see Chapter 4*) all affirmed the significance of the Kilkenny Report (McGuinness, 1993), which was considered to be a watershed, described by some interviewees as a '*game-changer*' that '*almost defined an era*'. As discussed in Chapter 3, the Kilkenny inquiry occurred at a time when the orientation of children's services had only in the previous 20 years shifted from institutional provision to community-based interventions with children and families. Responsibilities of different services in respect of child protection had only lately been delineated and the process of proceduralisation had been relatively light. Referrals to the child protection services were far fewer than currently, signalling a low awareness of child abuse, particularly child sexual abuse. As a consequence, there was scope for the Kilkenny Report to effect significant change.

The recommendations are set out in a standalone section of the Kilkenny Report. This serves to emphasize the different approach adopted by the inquiry team in reaching its findings and conclusions, which included consideration of the historical events that gave rise to the inquiry and the development of recommendations for changes to future practice and policies in that context. The report clearly states that the inquiry team invited submissions from a range of stakeholders to assist them in their task of drafting '*recommendations for the future investigation and management by the health services of cases of suspected child abuse*' (McGuinness, 1993, p. 93). The inquiry team also consulted with experts and referred to evidence assembled on foot of a literature review, prepared by the librarian of the South Eastern Health Board on its behalf. Therefore, in drafting its recommendations, the Kilkenny inquiry team identified key stakeholders and invited them to make submissions to the inquiry. There appear to be 25 recommendations; however, several of them contained multiple clauses (*see Appendix 1*). For example, the recommendation for revision of child protection procedures had 9 further recommendations attached, many of which were qualitatively different from each other. Similarly, the recommendation about mandatory reporting had 6 conditions attached.

The recommendations reflected a number of ongoing legal concerns about the delayed implementation of the Child Care Act 1991 and the perceived need for Constitutional reform to include a statement on the rights of children. The inquiry team highlighted the inadequacy of the current child protection guidelines, information management, the basis for reporting suspected child abuse, the lack of early intervention and family support services. A number of practice issues were addressed in the recommendations, including norms in respect of information-sharing, inter-agency and inter-country cooperation, recording of information, and training and supervision. The team also raised important questions about cultural attitudes to the primacy of the family, willingness to acknowledge issues such as child sexual abuse and domestic violence, and overall awareness and willingness to tackle social issues.

Kelly Fitzgerald Report (1996)

The Kelly Fitzgerald Report (Joint Committee on the Family, 1996) contained approximately 44 recommendations. The inquiry investigated practice in a policy context that was very similar to the one that had been operating in Kilkenny, so it was inevitable that it would identify some similar issues. The report had been officially commissioned by the Western Health Board and contained a mixture of local and national recommendations. Although it is not precisely clear which recommendations were intended for national or local implementation, it appears that 11 of the recommendations were intended for implementation by the Western Health Board, one was intended for the Department of Education and the rest were implicitly or explicitly intended for either the Health Boards or the Department of Health. Responsibility for the implementation of local recommendations was assumed by the CEO of the Western Health Board.

Some of the recommendations were very specific, others less so. For example, the first one was broad-ranging and recommended the '*development in each health board of a perspective which gives corporate recognition to its functions as a child protection and welfare agency*'. It went on to recommend '*the development of a coordinated and integrated approach to the planning and delivery of services and consistency in practices and procedures*'. Recommendations intended for national implementation included the creation of '*a dedicated child welfare manager post in each community care area*', the intent of which was less ambiguous. They further included a Departmental review of the most effective means of delivering child welfare services nationally, more monitoring of child protection and establishment of standards. Other national recommendations reiterated the inquiry team's support of the Kilkenny Report's recommendations in respect of children's rights and reporting legislation and the maintenance of a child protection register that would be externally accessible. Further national recommendations were made in respect of inter- and intra-country exchange of information and record-keeping.

Recommendations at a local level included maximising capacity to identify children at risk; development of multidisciplinary teams; standardisation of records and improving compliance with regulations; procedures about the transfer of cases; access to legal advice; adequate office accommodation and administrative support; improving the quality of case conferences; and the assignment of administrative staff.

West of Ireland Farmer Report (1998)

The West of Ireland Farmer inquiry was established in 1995, but was suspended pending the outcome of legal proceedings. It ultimately reconvened and published its report in 1998. During the three intervening years, a number of policy changes had been implemented in response to the two earlier inquiries (Kilkenny and Kelly Fitzgerald). The authors of the West of Ireland Farmer Report acknowledged that the time lapse had rendered some of their report obsolete.

The West of Ireland Farmer Report (Bruton, 1998) contained 34 recommendations, under 6 headings: Strategy (8), Management (8), Legal (2), Monitoring (5), Information (6), Services (2) and Training (3). The report had been commissioned by the North Western Health Board, but it was not clear on reading some of the recommendations (for example, those in relation to the law) whether they were intended to have local or national implications.

One of the main weaknesses identified in the West of Ireland Farmer case was a failure by different services to be alert to the possibility of child abuse and exchange information with colleagues. Many of the recommendations focused on clarification of roles and responsibilities, different aspects of information-sharing, the need for better quality recording and case conferences, and improved linkages between services. There was a distinct emphasis on the need for improved vigilance and regular review of situations where children were deemed to be at risk. It also advocated for out-of-hours services and services for adult survivors of abuse. The report made recommendations specifically for support and services in respect of the case under inquiry, and its recommendations on training focused strongly on the need for an inter-agency dimension.

Monageer Report (2009)

The Monageer inquiry was commissioned by the then Minister for Health and Children, Brian Lenihan, TD. It ultimately made recommendations to the Minister for Health and Children and the Minister for Justice based on its conclusions, reflecting the range of service provision in the case. The terms of reference focused on the services provided to the family, in particular on the responses made, the way the service providers discharged their functions and the way they cooperated and communicated with each other. In fact, the terms of reference of the inquiry did not specify the development of recommendations, but the view of the inquiry team, as told

to the researchers in the present study, was that making recommendations was considered to be 'part and parcel of the process'.

This report (Brosnan, 2009) was unique among the reports being researched in this study because it spanned a number of disciplines, within and outside the HSE. The recommendations were intended for national implementation and the organisations identified included HSE Children and Family Services, An Garda Síochána, disability services and public health nursing. Two of the recommendations included 'doctors', but did not specify whether the target group were medical practitioners employed by the HSE, hospitals, private practice or otherwise. Although the report was commissioned by, and presented to, Government departments, the implementation was delegated to the HSE, with the exception of the recommendations that were solely relevant to An Garda Síochána.

Recommendations were categorised under 6 main headings, most of which had a number of sub-clauses. The headings were: Out-of-hours services; An Garda Síochána (4 sub-clauses); Early identification (3 sub-clauses aimed at the public health nursing service; 2 sub-clauses aimed at disability services; 4 sub-clauses directed at multiple services); Review of management structures (2 sub-clauses); Training (2 sub-clauses); and Familicide. There was a 7th heading with a number of recommendations, but all of these were redacted in the final published report.

Under the 6 headings, there were some overall recommendations for doctors, other health staff, social work services and An Garda Síochána in respect of training and recording practices, exchange of information and clarity of roles. The recommendations aimed at HSE Children and Family Services mainly concerned out-of-hours child protection services and reform of management structures. Those impacting on An Garda Síochána involved responses to children in unsafe situations and communications within the force, with other organisations and with families. The recommendations for the public health nursing service included a full review of the capacity of the service to identify the needs of children requiring intervention, referral to services, tracking of families that move and transfer of records. The recommendations for disability were focused on standardisation and coordination of early intervention services.

Roscommon Child Care Case (2010)

The terms of reference for the Roscommon inquiry required the team to examine the entire management of the case from a care perspective, identify any shortcomings to the care management process and make a report on the findings and any learning arising from the investigation. It was inevitable within this remit that most of the findings and recommendations would focus on practice and the context in which child protection services were delivered. The learning from the case was expressed in terms of recommendations which reflected this focus. The report (Gibbons, 2010) made 58 recommendations, under 5 headings: Organisational change, Policy change, Practice, Development of services, and Management.

In the section on Organisational change, the report recommended the establishment of a clinical team to support the post of National Director of Children and Family Services in the HSE, which process had already been initiated by the time the report was published. The recommendations in respect of Policy change included measures to comply with the UN Convention on the Rights of the Child, legal and Court processes, audits of neglect cases, quality assurance and escalation of risky cases. The Practice recommendations covered roles and responsibilities, child-centredness, assessment, home visits, working with neglect, working with families and requirement to understand and apply attachment theory. Recommendations about Development of services covered family support services, speech and language, and child sexual abuse assessment. Management recommendations covered HR issues and supervision, quality checks and infrastructural issues, child protection conference protocols and training.

Summary

While many of the recommendations were phrased differently from others, some trends are evident. The requirement for resources to develop standardised services for **early intervention, family support, out-of-hours services** and **staff welfare** were common themes. Recommendations were recurrent in respect of **policies and procedures** that would **clarify roles and responsibilities** of different professionals and **protocols for inter-agency collaboration**, **child protection conferences**, **child protection plans, management and exchange of information**, and **standards for record-keeping**. Various **reforms of management and structures** were proposed in all the reports. **Practice issues** included the need for **better identification**, **assessment and vigilance** of children who show signs of vulnerability or risk, **ability to challenge** the views of other professionals and **training, including multidisciplinary training** on different topics. Various **legal and regulatory issues** were advocated in different forms from the Kilkenny Report onwards and the issue of **children's rights** underpinned all of the reports in different ways.

Each of the reports reflected current concerns of the day, most noticeably the Kilkenny Report's focus on the slow implementation of the Child Care Act 1991. Data gathering for the present study demonstrated that many of the recommendations in later reports took cognisance of other events that were already in train, such as the revision of child protection guidelines, responses to non-compliance with procedures and regulations, plans for an out-of-hours service, the development of Standard Business Processes under the National Child Care Information Project, development of child protection standards by HIQA, the establishment of a National Office for Children and Family Services, and different developments in nursing and disability services.

PART 2: Research participants' views on inquiry recommendations

The remainder of this chapter will present an analysis of the views expressed by the individuals who were interviewed for the purpose of this research. As the earlier part of this report has outlined, interviewees included members of inquiry panels, current and former employees of the Department of Health, the Health Boards or the HSE. All were close to one of the inquiries, some to several and in a few cases to all of them. Some were directly involved in the inquiry process, while others were involved in implementing recommendations.

Process of drafting recommendations

When it came to the point of making recommendations on the findings from inquiries, the different team members interviewed spoke of their aims (which seemed to be similar for all five inquiries) – to promote learning and improve practice. As one inquiry team member described the process:

> 'They flowed or stemmed from weaknesses that we identified … we felt that the recommendations … that we identified would lead to best practice and in particular would hopefully lead to … a better, more caring service to families and in particular to children.'

A member of an earlier inquiry had a similar perspective:

> 'Our hope, at least our aspiration, was that the report might be seen as a contribution to learning.'

Comments by inquiry team members suggest that the task of drafting recommendations was not an especially difficult or onerous one, and that recommendations were perceived as a natural by-product of inquiry findings. One described it as '*not rocket science*'. Authors of three different reports described a similar experience. One commented that '*the recommendations very much flowed from our analysis of what happened in the case*'; another believed that '*they [the recommendations] were jumping out*'; and a third member observed that the recommendations '*fell out of the findings*'.

Members from different inquiries described similar processes for reaching agreement in what seems like a team effort:

> 'We sort of talked among ourselves about it and then began to bullet-point what the big issues were and then work out the main findings from that and then obviously the recommendations fall from those conclusions.'

A member of a different inquiry described a similar mechanism:

> 'We would have had meetings, where we just sat down and discussed recommendations and conclusions and so on.'

One of the inquiry Chairs illustrated the conscientious approach taken:

> 'At the end of all the evidence we had brainstormed … and then we looked … to see what else was there because sometimes … you missed some aspects … I don't think there was anything in the recommendations that wasn't based on what had arisen in the case.'

The importance of transparency was emphasized by another Chair who pointed out that:

> 'If you have the evidence base, you can use that to say this is what is making me do these recommendations.'

Inquiry team members also claimed to have sought to achieve clarity in the manner in which the recommendations were made, as pointed out by one Chair:

> 'The findings were grouped … in a way that we hoped would make sense, so that you weren't repeating recommendations because so much stuff is interlinked.'

A member of a different inquiry expressed similar confidence:

> 'There was no equivocation. It was crystal clear as to whose responsibility it was and where those responsibilities lay [to implement the recommendations].'

Mixed views on the value of recommendations

While a number of interviewees, including some who had been inquiry team members, had reservations about the value of some of the recommendations made by inquiry teams, the highest level of support expressed was for those made by the Kilkenny Report, which were described by a senior civil servant as 'specific' and 'weighty'. Its value was equally endorsed by a former Health Board manager:

> 'You had a very credible investigation … and it made very clear recommendations … and it became almost a strategy of how you could go about it – not only what you had to do, but how you could go about doing it.'

Some of the criticisms about recommendations were not specific to particular reports, but identified more generic concerns, such as their predictability and repetitive nature, their abundance, their perceived unhelpfulness and the way in which they tended to reflect the composition and competence of inquiry teams. These are described in more detail below.

The predictable and repetitive nature of recommendations

Parton (2004), commenting on 30 years of child abuse inquiries in the UK, noted the inevitability of recommendations on inter-agency cooperation, information-sharing and resources. His observations were reflected in some of the comments made by participants in this study, including those made by some inquiry team members, one of whom described the process as follows:

> 'You can seal it in a brown envelope before you start and know that inter-agency cooperation will come up, probably something to do with adherence to policy and procedure, and all these predictable things, the quality of records and so on … You can bet your bottom dollar that they will come out.'

This view was shared by a former Health Board manager:

> 'I think if you put five social workers into a room and you asked them how could you improve child protection work, they would come up with a very similar list to all the inquiries … If you asked them [social workers] that question … What could be done to improve child protection practice? or What goes wrong in child protection practice? or What do you find most frustrating about child protection practice? – they would have talked about lack of access to resources, to specialists, to assessment to mental health and psychological back-up, absence of multidisciplinary working, absence of guidance in very difficult situations, you know, the whole shooting shebang that gets trotted out every time. These are not alien to us … most of us would have said we don't get enough training; we don't get enough support for the difficult cases …'

While the above comments were not particularly intended to be critical of recommendations, the question raised by Parton (2004) challenged the value in such constant repetition since the regularity with which they are repeated seems to indicate their ineffectiveness. This view was reflected by a comment from an interviewee involved in policy-making, who commented that '*the same recommendations seem to get made all the time; there is no learning down into the system*'.

However, one of the inquiry authors believed that reinforcing the message was useful:

> 'There is a lot of sameness about [the recommendations] … but if it hasn't been acted upon, the fact that you're getting it again and again and again must, you would think, add weight to it. You can't not recommend just because it hasn't been done, just because it was recommended before, you can't not say it.'

Others concurred with this view, commenting that the recurrence of recommendations had less to do with their utility per se and more to do with the actions that did, or did not, follow:

> 'Most of the recommendations had a similarity to them and the issue was in how these recommendations were implemented. That's the big one really.'

Similarly, an author of one of the earlier inquiry reports commented that they found the repetition '*depressing*' and concluded:

> 'This is what happens when an organisation or a system doesn't want to learn and keeps repeating the same issues and the same problems.'

Another explanation for reiteration of recommendations could be the relatively short life of a report and the turnover of staff in the years following publication. A member of one of the later inquiry teams expressed their astonishment at the lack of awareness held by practitioners about an earlier inquiry:

> 'With one exception, nobody who had talked to us knew that there was a [name of inquiry] report, had ever read it, had ever had any training or involvement in it, had ever looked at the recommendations.'

Quantity of recommendations

As outlined earlier, this study has estimated that the five inquiry reports made 187 recommendations between them, increasing from 25 in the Kilkenny Report to 58 in the Roscommon Report. A significant number of interviewees felt that whilst the Kilkenny Report had a major impact, the proliferation of recommendations in subsequent reports diluted their value. Two report authors commented that, with the benefit of hindsight, they would now put in fewer recommendations:

> 'One thing that I would change is that I would have fewer recommendations … It's not necessarily that helpful for an organisation to get a long list of recommendations. It's sometimes better to … focus on a smaller number of really key recommendations since if they are implemented, then a lot of other things will happen as a result of that.'

A member of a different inquiry team expressed a similar view:

> 'I would never do anything like that now. There were far too many … I think it's more important to roll them up into sort of bigger hitting recommendations.'

Other research participants suggested that the number of recommendations could have been reduced by amalgamating several of them under one heading or wording them more concisely.

Unhelpful and unrealistic recommendations

A small number of recommendations in inquiries were considered to have been unhelpful because of their far-reaching nature and lack of clarity. For example, a former Health Board manager, reflecting on a particular recommendation that called for the Health Board to 'maximise its capacity to identify children at risk', made the following comment:

> 'What did it mean? It's like a delightful aspiration … but there is no beginning, middle or end to it in terms of what exactly it's getting at. It's kind of a catch-all thing that actually catches nothing.'

Other recommendations were considered to be quite unrealistic for the context in which they were produced, for example, a recommendation in the Kelly Fitzgerald Report for 'the establishment of standards'. A senior civil servant expressed the view that the implementation of this at the time may have caused more harm than good since, in their opinion, the service was still too unregulated and underdeveloped:

> 'Once it's named and the service falls short of those standards, you can be completely exposed … you could do an awful lot of damage.'

Others felt that the recommendation about 'mandatory reporting' in the first two reports was a 'red herring' that distracted from the recommendations that were actually implementable at the time:

> 'There were far more important issues, I felt, than mandatory reporting. People spent a lot more time arguing about that than about improving the services.'

Reflecting the findings of Munro *et al* (2011), recommendations that were produced '*without reference to resources and without reference to legislation*' were criticised, particularly those that were considered by research participants not to be '*legally sound*'. In this regard, one interviewee cited the Monageer Report, which was greatly redacted following legal advice (7 of the recommendations were removed). Others queried how recurrence can be prevented if 7 recommendations are 'excised'.

Panel membership

Some quite sceptical views were expressed about the competence of team members to make recommendations if they lacked the experience of running a service. For example, a former Health Board manager, drawing from their experience of an inquiry, commented on the competence of the author:

> 'A very good [...] and very knowledgeable ... but when [...] had [their] analysis done and began working on recommendations, the absolute poverty of [their] understanding of management became absolutely crystal clear because the consequences of what was recommended were so inconsistent with any sound management practice that it was completely undermining the report ... You get somebody at one level from the professional child care perspective talking about interdisciplinary and inter-agency collaboration and all of that and then coming with recommendations that are much more akin to silos ... The actual experience of having being involved in statutory child protection and the actual experience of managing within a statutory context is starkly absent from most of the inquiries, it seems to me.'

It was also considered that the agenda of individual inquiry team members might dominate:

> 'You will get the background and the interests of the strongest one or two people on the team will tend to influence the emphasis that is made, both in the conclusion and in the recommendations.'

A question of balance

So far, the discussion in Part 2 above has reflected some critical views of the recommendations from the five inquiry reports. One of the objectives of the present study was to ascertain views on the quality of recommendations, with a view to developing a typology or template to guide the construction of effective recommendations in the future. Hence the discussion has focused on responses that question and challenge some aspects of those recommendations contained in the five reports. Overall, however, interview data indicate that the recommendations garnered a high level of support, not least because of their propensity to attract funding to resource services that were perceived to have been neglected.

The following quote from an interviewee who had been close to a number of inquiries outlined their attitude to inquiry recommendations, which is probably more reflective of the general view:

> 'The view I always took of them [the recommendations] was that these people had considered them very seriously. They had invested time and energy in it ... I would also be aware that there was a correlation between the knowledge and competency of people doing them ... where I felt people knew what they were talking about, you definitely would scrutinise those very carefully.'

Recommendations as an influence on policy

As the literature review indicated (*see Chapter 2*), inquiries are but one of a number of competing sources of evidence that influence policy. Some interviewees for the present study, when considering the different elements that impact on reforms, were of the view that inquiry recommendations 'trumped' research evidence in terms of their propensity to shape new developments in child protection. Various reasons were offered for this. It was considered that, in comparison to research, the inquiry reports were '*more accessible*' and provide an '*emotive dimension*' that is lacking in research, which, in contrast, is considered '*not sexy enough … not punchy enough*'. However, it was suggested by one interviewee that the prominence of inquiries as drivers of policy may soon be diminished by the more influential role of inspections and standards, which are gradually becoming embedded in the services.

The potential for consultation on recommendations

In light of some of the consultative approaches cited in the literature review for this study, interviewees were invited to comment on whether they would consider it beneficial for consultation to take place between inquiry teams and policy-makers prior to developing or finalising recommendations. Responses to this question were generally supportive of the idea. A number of the interviewees responded that it would '*make sense*'. As one interviewee involved in policy-making commented: '*It's maddening to get recommendations that are un-implementable*' and it was agreed that engagement would pre-empt that eventuality, as well as gaining '*buy-in*' from those with responsibility for implementation. Concern was expressed, however, that the independence of the inquiry team may be compromised by consultation. The strengths and limitations of such an approach were summarised by the following quote:

> 'There is a balance to be struck there between the dead hand of the civil service … and I can say that … on the one hand, and the freedom of expression of a group of people you bring in to make an independent inquiry … You don't want the situation where people make just outlandish recommendations that lands the whole system in the soup.'

Conclusions

This chapter has provided an overview of the recommendations from the five inquiry reports and identified visible trends that have prevailed over the 18 years between the publication of the first (1993) and last one (2010). It has also outlined the views of the stakeholders interviewed for this study who, while expressing generally positive views of the recommendations, have critiqued some of them. The primary criticism concerns the quantity of recommendations, which are seen to be too numerous. Overall, the responses from interviewees infer that if future reports are to be useful, recommendations must be fewer in number, more inclined towards the promotion of learning and linked to an evidence base that not only contextualises them within the current system, but indicates the likelihood of effectiveness.

Chapter 6 focuses on the implementation of the recommendations from the five inquiry reports and highlights the factors that act as facilitators and barriers.

6. Implementation of inquiry recommendations

This chapter addresses one of the overall aims of this study – to ascertain the extent to which recommendations from the five reports were implemented. The data utilised to answer this question emerged from the review of policy reforms, in addition to interviews with the various participants and informants who were involved with the inquiries and worked in organisations that were implicated in the recommendations. Documents were provided to the researchers in respect of the Kilkenny, West of Ireland Farmer, Monageer and Roscommon reports, which outlined implementation plans in respect of the latter two and progress reports in terms of implementation of the former two. It was also necessary to consult briefly with individuals in different sectors and organisations to check details. This was done by e-mail and telephone, and extended the planned methodology for the study because as the research progressed, the task of establishing whether or not recommendations were implemented became quite complex.

Part 1 of this chapter focuses on the reports. It sets out to establish, as far as possible, which recommendations have been implemented and to identify any gaps. Part 2 reports on the findings from interviews and identifies the factors that influenced the implementation of recommendations.

For the purposes of this research, 'implementation' is understood as the process that gives effect to the recommendations, but it must be acknowledged that the application of that definition has not been straightforward for reasons that will be outlined. Appendix 1 contains a more detailed account of the implementation of recommendations from the five inquiry reports.

PART 1: Implementation of recommendations from the five inquiry reports

While it was not explicit in these reports, it could be reasonably expected that the recommendations carried inherent expectations that they would be implemented within a minimum period of time and that expiration of the timeline without action could be construed as a failure or postponement of implementation. However, it was not considered useful to apply such technical considerations in the present study because the environment within which the recommendations were, and continue to be, addressed is fluid and subject to a number of variables. In some cases, and as Chapter 3 of this report has illustrated, the publication of reports coincided with a number of other events. For example, the West of Ireland Farmer Report was being prepared while measures in response to the Kilkenny Report were being introduced, and the Kelly Fitzgerald Report was published in the interim. The Monageer Report was published 8 days before the *Report of the Commission to Inquire into Child Abuse* (known as the Ryan Report), which was shortly followed by an *Implementation Plan*, published by the OMCYA, which carried a high profile. The Roscommon Report was completed in 2010, but the rate of change in the HSE Children and Family Services has been significant, both before and since that report was published and actions are still being taken that could be seen to address the recommendations.

A number of other complicating factors prevailed. One was the time lapse between publication of the reports and this study. The first three reports were published between 15 and 20 years ago and it has been difficult to separate actions that were taken in their wake from those that were part of a more general policy change, which came with the growth in the economy and increased investment in services during the 1990s and 2000s. It is not always clear in implementation plans if the recommendations were being addressed by measures that had been initiated earlier and separately from the inquiries, and whether they actually fitted with the intent behind the recommendations. Two of the reports from the 1990s were commissioned by Health Boards and many of the recommendations were intended for the local area only.

Very little evidence remains about the specificity of those changes, many of which were eclipsed by further reforms in the intervening years. A number of managers employed in the organisations involved have since retired and many of the interviewees for this project acknowledged limitations in their memory of events.

Another constraining factor in ascertaining implementation has been the limited scope of this project. Establishing whether or not the actions referred to in recommendations were fully operational and impacted on the day-to-day practice of child protection staff would have required a detailed audit, which was outside the remit of this study. As mentioned, some written evidence of implementation was available, but, particularly in respect of the earlier cases, this research relied in part on the recall of interviewees and the data that emerged from interviews, which was not always backed up by documentation.

Finally, while it is possible to ascertain that policies, procedures or guidelines (such as *Children First*) were planned or put in place to *address* the recommendations, this project has not been able to measure the extent to which they were operationalised on the ground, or whether the measures functioned effectively or as intended.

As a result of these limitations, the study has been obliged to take a flexible approach when assessing implementation. While the list provided in Appendix 1 contains more information, it cannot be taken as a definitive account of implementation.

The remainder of this Part 1 will consider the individual inquiries and their recommendations in a general way, and will contextualise their implementation or otherwise with reference to the policy context of the time.

Kilkenny Report (1993)

According to the information provided to the researchers, it appears that, with a few notable exceptions, the Kilkenny Report's recommendations were addressed or implemented by the end of the 1990s. Nonetheless, it would be invidious to suggest that all of the measures put in place flowed directly from the report. Chapter 5 has outlined the reforms proposed some years previously by the 1980 report by the Task Force on Child Care Services and the issues raised in consultations that took place during the drafting of the child care legislation. It has also noted the efforts made during the 1980s to develop services to respond to reported child sexual abuse, as well as prevention programmes that met with some public opposition. As outlined, efforts to promote greater cooperation between the Health Boards and An Garda Síochána were already underway in the 1990s, but had not gained much traction before 1993. It has to be acknowledged, therefore, that the Kilkenny Report provided the catalyst, rather than the inspiration, for a number of the changes that followed it.

The outcome from the Kilkenny Report that is most often referenced and that has had the most far-reaching effect was the **full implementation of the Child Care Act 1991**. The funding released for this purpose subsequently resourced an unprecedented expansion of services, both inside and outside the Health Boards. The next most significant outcome from the Kilkenny Report was the **development of the *Children First* national guidelines** in 1999, 6 years after the report's publication. The 1987 Child Abuse Guidelines were 12 years old at that point and were out of step with legal and administrative changes that had occurred in the meantime. *Children First* covered the majority of policy, practice and case management issues raised in the Kilkenny Report, as well as those raised in subsequent inquiries, although they were not placed on a statutory basis as per the recommendations.

By the time *Children First* was launched, a certain amount of restructuring of services had taken place in line with the *Putting Children First* policy document published in 1997, partially in response to the mandatory reporting debate that followed the Kilkenny Report. The **development of family support services** had been initiated around the country, with the

launch of Springboard and other projects. **Training** departments had been established in all of the Health Board areas and these were later expanded in order to assist the implementation of *Children First* and provide training for relevant community-based organisations. Increased funding was provided for **domestic violence services** and the *Report of the Task Force on Violence against Women* was published by the Office of the Tánaiste in 1997, which made a number of proposals for the development of coordinated services for women who are threatened with, or have experienced, violence. The **Child Abuse Prevention Programme** was expanded nationally as a result of the Kilkenny Report's recommendations, all previous obstacles to its implementation in schools having been eradicated by the shift in awareness created by the report and surrounding media coverage.

A certain number of recommendations were considered to be the responsibility of Departments or organisations outside of the Department of Health, namely the Department of Education, the Department of Justice, Equality and Law Reform, the Office of the Director of Public Prosecutions (DPP) and An Garda Síochána. These recommendations concerned child protection inputs into teacher training; the law regarding sexual intercourse with people with intellectual disability; extension of Barring Orders legislation; expediting child abuse cases through the DPP; contact with the DPP regarding prosecutions; and the appointment of designated Gardaí to deal with child abuse. A document provided to the researchers in the present study indicates that cross-departmental communication took place and these recommendations were implemented by 1995 (Department of Health, 1995b). An exception appears to be the recommendations in respect of communication between the Health Boards and the DPP, and measures to expedite child protection cases. These may have been implemented at the time, but there is no evidence of their current operation.

Three of the recommendations from the Kilkenny Report were ***not*** implemented, although attempts were made to address them. The proposal for **Constitutional reform** was referred to the Constitutional Review Group and was kept on the political agenda by advocacy groups, but was not acted upon for another 19 years. The recommendation in respect **of mandatory reporting** was examined by the Government during 1996 and 1997 (Department of Health, 1996a and 1997) and a decision was made not to introduce it at that time. The other significant recommendation that was not acted upon was for **child abuse 'registers'**, which could have been accessed by staff in hospitals and other relevant organisations. The *Children First* national guidelines proposed a notification system that could, if it had been fully implemented, fulfil the required criteria, but it was never fully developed.

In some other cases, parts of recommendations were implemented, while other parts were not, but may have been implemented locally or for a limited time. For example, there was an extensive recommendation concerning liaison between the Health Boards and An Garda Síochána. In response to this, a protocol for joint notification between the Gardaí and Health Boards was introduced, but other parts of the same recommendation (in respect of annual reviews of the operation of policy and protocol and systems for informing each other of changes in personnel) were not. It was not possible to examine whether recommendations in respect of family doctors were implemented since there is no way of establishing this with a group whose contractual arrangements with the State are so varied. The time lapse between 1993 and the present means that policies may have been put in place locally at first and then discontinued.

Kelly Fitzgerald Report (1996)

The Kelly Fitzgerald Report had 44 recommendations, some of which were intended for national implementation and some exclusively for local implementation. As has already been demonstrated for the Kilkenny Report (*see above*), a number of national recommendations were addressed by virtue of the implementation of the Child Care Act 1991, which commenced before the report's publication and provided extra resources. Recommendations were also

addressed by *Children First*, which covered many of the policy and practice issues. It appears that most of the national recommendations were addressed through the aforementioned processes. The exceptions were those referring to Constitutional change, mandatory reporting, a recommendation for the regulation of the Guardian ad Litem service, a recommendation for the establishment of a system for monitoring child protection standards and a recommendation that the Department of Health explore a modular approach to child protection training. It was not possible to measure whether a recommendation that 'judges and officers of the courts be informed of the indicators of emotional abuse and neglect' had been implemented. It may have occurred at the time or at local level, but there is no evidence of its implementation as a recurring process.

Interviews with staff who had worked in the area following the publication of the Kelly Fitzgerald Report indicated that the Western Health Board was committed to the implementation of the recommendations and had regular meetings over a 2-3 year period to monitor progress. The researchers saw no documentary evidence of an implementation plan and relied on the accounts of interviewees. It appears, therefore, that many of the reforms were actually put in place before the publication of *Children First*, with the impetus for implementation of the local reforms coming from the Western Health Board. Exceptions included one which proposed the development of multidisciplinary child protection teams. In the words of one of the interviewees, this failed because '*other disciplines didn't want to touch child protection with a barge pole*'.

West of Ireland Farmer Report (1998)

The terms of reference of the West of Ireland Farmer Report, commissioned by the North Western Health Board (NWHB), made it clear that the focus was on the work of the Board and the recommendations were made accordingly. Inevitably, however, many of them had national implications and to some extent were dependent on national policy decisions, for example, the establishment of standard practices and out-of-hours services. As with the earlier inquiries, both the passage of time since the report was published and the number of changes that have taken place in the interim have made it difficult to separate some of the reforms made in response to the West of Ireland Farmer Report from those that occurred as a result of *Children First* and ensuing developments during the 2000s. Neither is it possible to say with certainty that the reforms that were put in place at the time are still effective since many of the staff that promoted them have now moved or retired.

Interviews with senior HSE staff indicate that the NWHB was committed to the full implementation of the recommendations and it appears from the information received by the researchers that most were addressed, albeit over a number of years. Data from interviews indicate that a number of meetings were held to discuss the report and its recommendations. While it was acknowledged by a former senior manager that no one individual had responsibility for implementation, the researchers were given an internal 'progress' report from 2001 and an internal 'update of the recommendations' from 2003 (5 years after the report's publication), both completed by the same senior manager. After a slow start, it appears that much progress was made between the time the two reports were issued, which coincides with the early dissemination of *Children First* and the appointment of *Children First* trainers and advice officers.

Some implementation appears to have taken place earlier: an interviewee reported that prior to the delayed publication of the report, informal discussions took place between members of the inquiry team and senior management, where it was pointed out that certain matters required urgent action. As a result, two training posts had been created and a process of training and dissemination of information about procedures and responsibilities was commenced. It could be assumed that this initiative addressed some of the recommendations in advance of the report's publication as well as afterwards. It is not possible, from this remove, to measure the comprehensiveness with which it met them or the length of time that the learning and other

benefits endured. The matter of communications between hospital and community staff was addressed in detail and systems were set in place to monitor the repeated admissions of children to hospitals. These systems are still in place and, as far as this study could ascertain, are unique to the former NWHB area.

Recommendations that were not implemented at the time or since included the development of an out-of-hours service. It was also pointed out to the researchers that effective inter-agency collaboration has been very difficult to maintain, despite efforts to promote it, and that efforts made in response to the report were more successful in some areas than others.

Monageer Report (2009)

By the time the Monageer Report was published in 2009, 11 years had elapsed since the publication of the most recent intra-familial child abuse inquiry. The changes that had taken place in the interim facilitated a clearer process of implementation. The most significant change in this respect was the establishment of the HSE as a national organisation, which would have made the process of national policy formation more straightforward than previously. The development of management structures within the HSE, including Integrated Service Areas and a Serious Incident Management Team, meant that it was possible to identify specific senior managers to lead the implementation of recommendations within different sectors.

The Monageer Report was unique among the inquiry reports being researched in this study because of the number of disciplines it spanned within and outside the HSE. The recommendations were intended for national implementation and the organisations identified included HSE Children and Family Services, An Garda Síochána, disability services and public health nursing. Two of the recommendations included 'doctors', but did not specify whether the target group were medical practitioners employed by the HSE, hospitals, private practice or otherwise. Although the report was commissioned by, and presented to, Government departments, the implementation was delegated to the HSE, with the exception of the recommendations that were solely relevant to An Garda Síochána. Within the HSE, the report was received by the Serious Incident Management Team and responsibility for responding to it was delegated to lead managers in disability, nursing and Children and Family Services.

Although the recommendations had a national focus, the local area (Wexford) appears to have acted quickly to address the recommendations, particularly in respect of nursing services. At a national level, implementation appears to have been more complicated. The researchers were able to ascertain that HSE Children and Family Services had fully implemented the recommendation on **management structures** and had addressed, though not fully implemented, the recommendation for **an out-of-hours service** by piloting and evaluating two projects in separate areas and initiating a plan to introduce the service nationally. The researchers were told that a national plan for out-of-hours services had been developed prior to the inquiry, but had not been actioned because of lack of resources. In common with some previous inquiries, Monageer therefore served to release resources to advance a development that had been planned, but had stalled for financial reasons.

The researchers were told that all actions in response to the recommendations on nursing services have been completed locally. The national picture is less clear. One HSE region has piloted a framework for the assessment of vulnerable children by public health nurses (PHNs) which, if implemented nationally as planned, will address the recommendation on early identification of vulnerable children. A protocol for transfer of records has not yet been introduced nationally, although it is in place in Wexford. A national record-keeping policy for health staff has been published, but it had not, at the time of writing, been implemented nationally by PHNs. The researchers were informed that the national review of public health nursing that was recommended had not proceeded because of internal problems.

The researchers were told that much progress has been made in relation to standardising and coordinating Early Intervention Teams and new policies have been developed, but that local divergence in the disciplinary make-up of teams and employment and retention issues in different areas has posed some obstacles to complete implementation. The recommendation in respect of record-keeping has been addressed for social workers by the introduction of Standard Business Processes in 2011 and 2012 in the HSE; a local policy on record-keeping and case transfers for nurses was introduced in Wexford. It has not been possible to establish the response of doctors to this recommendation. The report recommended the establishment of a central index to ensure information-sharing between different disciplines within the HSE; this recommendation has not been progressed. The document provided by the HSE indicated that approval for this had not been given by the Department of Finance. The HSE was unable to comment on whether the recommendation for medical specialists to provide updates to general practitioners has been addressed.

The documents provided by the HSE to the researchers indicate that recommendations on training for nurses, doctors, social workers, Gardaí and HSE staff have been addressed in part by the development of *Children First* training and joint Garda/HSE training since 2011. It was not possible for the researchers to establish how many staff had received the training at this point, although the projected figure for the end of 2013 is 1,000 staff from each organisation.

The recommendations for An Garda Síochána were received by the Garda Commissioner and delegated to the Crime, Policy and Administration Division. Information was provided to the researchers to the effect that the recommendations were given attention, but no specific group was given responsibility for implementation. It was considered at the time that existing and planned policies would address them. At this point, all the recommendations have been addressed through legislation, which gives Gardaí extra powers under Section 12 of the Child Care Act 1991[22]; the establishment of the post of Family Liaison Officer; and a new programme of joint Garda/HSE training, which references findings from the report and relates them to practice.

A project on suicide and familicide, which had already been commissioned by the HSE National Office for Suicide Prevention prior to the inquiry, has since been completed (HSE, 2011a) and is regarded as having fulfilled the relevant recommendation.

From the documentation provided to the researchers, it appears that a number of the measures cited as responses to the Monageer recommendations had already been initiated in the different services prior to the inquiry or the publication of the report. While it is likely that many of them would have met the objectives of the recommendations, they were not all formulated in response to them.

Roscommon Report (2010)

In common with the Monageer Report (*see above*), the implementation of the Roscommon Report's recommendations was partially eclipsed by reforms that were occurring in parallel, some of which fitted with the actions advocated in the report and others which had been in train either before the inquiry started or the report was published. The report was published in October 2010 and by that time it had been preceded by the *Implementation Plan* for recommendations from the Ryan Report (OMCYA, 2009b); an interim revised version of *Children First* had been published online pending final revision (DCYA, 2011); the National Office for Children and Family Services was in the early stages of formation and the newly appointed National Director was due to take up office within weeks of the report's publication. A template to standardise child protection tasks on a national basis, known as the Standard Business Processes, had been in preparation for a number of years and a change programme

[22] Childcare (Amendment) Act 2011, Section 7.

was underway in Children and Family Services. To that extent, it has been hard to identify the degree to which the Roscommon Report's recommendations influenced change, although it is very likely that they expedited some aspects of it and some measures may have been amended to provide a better fit.

The challenge of responding to the recommendations in the midst of other reforms was expressed by a HSE senior manager:

> '[Implementation of the recommendations was] dependent on the change programme … and we were caught in the process of trying not to make an interim change while there was a more substantive change coming.'

The researchers were given a copy of the implementation plan that had been drawn up in the National Office after the publication of the report in 2010. While this report has not been formally updated, a HSE manager from the National Office expressed assurance that the recommendations had been largely addressed:

> 'The formal review of it is not ongoing … my understanding is that pretty much most of it has been implemented … In terms of the national piece of it … we're confident that we met all the requirements that we were obliged to meet under that … we'll keep a watching brief on it.'

This manager was aware, when speaking to the researchers, that a detailed audit of the recommendations was being conducted in HSE West, some of which was picking up information on national implementation. The report of the audit has since been finalised (HSE Quality and Patient Safety Directorate, 2013). It employed a comprehensive methodology. Questionnaires were circulated nationally, local site visits were conducted, a random sample of case files was examined, semi-structured interviews were conducted and local and national documentation was reviewed. The audit excluded the 7 recommendations that related to human resources (HR) or finance issues. It grouped some of the remaining recommendations and made findings in respect of 26 recommendations or groups of recommendations. It found that 10 had been fully implemented, a further 12 had been partially implemented or were in progress, and 4 were not implemented. Those that were fully implemented included policies on organisational change, family support and home management services, Court processes and clarification of staff roles, as well as some practice issues such as working with fathers, providing feedback and recording observations on home visits. A number of the recommendations that were partially implemented had a more multidisciplinary aspect, including the involvement of speech and language therapists, review of nursing records, specialised child sexual abuse units, child protection conference processes and training. This reflects a theme noted in respect of previous reports – that recommendations in respect of more than one discipline are more challenging to implement. Those that were not implemented were concerned with victim impact statements, documentation of home visits, outcomes measurement and staff's awareness of attachment theory and testing of their assumptions in supervision. The audit team noted that the introduction of Standard Business Processes has addressed a number of the recommendations. This finding mirrors the outcomes of previous inquiries, where recommendations often get absorbed into policies that were already planned.

While the HSE West audit provided information on national actions taken to address the recommendations, the data it gathered through site visits and interviews applied mainly to the region. Where the recommendations on practice are concerned, there is evidence of a robust national response by the HSE. Dissemination of practice messages was achieved nationally by two means: (1) a series of standardised 'briefings' was delivered to social workers in all the HSE areas in early 2011 with key messages for practice, and (2) the practice messages were further

reinforced in the HSE's *Child Protection and Welfare Practice Handbook*, published in 2011 (shortly after the revised version of *Children First* had been published), which also referenced the Kilkenny, Kelly Fitzgerald and West of Ireland Farmer reports (HSE, 2011b). The Children and Family Services National Office is in the process of producing a *Child Protection and Welfare Procedure Manual*, which will contain all their procedures and policies, including a protocol on the conduct of child protection conferences. These policies have not yet been audited for compliance with the UN Convention on the Rights of the Child as per the recommendations.

PART 2: The implementation process

Although the HSE response to the Ferns Report and the Ryan Report *Implementation Plan* (OMCYA, 2009b) are still audited and reported on regularly, the response to the five reports in this research was less transparent. The Kilkenny Report was received by the Minister for Health at the time (1993) and an internal plan was drawn up, which was reviewed at intervals for a number of years. The Kelly Fitzgerald and West of Ireland Farmer reports were the subject of internal Health Board plans, which, according to verbal accounts given to the researchers, were the subject of numerous meetings and were reviewed periodically. Overall responsibility for implementation was with the Chief Executive Officers, but it is not clear whether this was delegated to one person or to whom. Although interview data suggest that there was frequent contact between the Department of Health and the Health Boards during the 1990s, when the three earliest reports were published, other comments by participants imply that reporting on the implementation of recommendations was very largely an internal organisational affair. However, some participants noted that if questions were raised in the Dáil, Ministers would be required to report on progress. So, although no formal structures were put in place to publicise advancement of implementation, reports could be, and intermittently were, demanded through the Dáil. The absence of formal published and reviewable implementation plans did not therefore signify a lack of anticipation that progress would be reported.

As might be expected, there was a perceived difference between the way that earlier and later reports were handled. As one of the research participants expressed it:

> 'Nowadays you talk of an action plan … you build it in … but early on, none of that was built in, not in the '90s. You produced a report, you circulated it and people were expected to get on with implementing the recommendations. There was no established system for follow-up or re-assessment.'

Responses to the later reports were more formal, in line with management structures that had started to evolve in the meantime. The response to the Monageer Report was drawn up by the HSE Assistant National Director for Integrated Services and delegated to the Serious Incident Management Team. No one individual was assigned overall responsibility at national level for overseeing the implementation. Aspects of the plan were updated in early 2010 and the next review of progress was conducted by the HSE when contact was made with managers in respect of this study.

As already outlined, the HSE drew up a response to the Roscommon Report and responsibility for implementation was undertaken by the newly established National Office for Children and Family Services. Certain actions were taken immediately, for example, the series of national briefings on practice messages and the inclusion of recommendations in the *Child Protection and Welfare Practice Handbook* (HSE, 2011b) that was published with *Children First* in 2011. As far as the researchers could ascertain, no formal review of its implementation occurred on a national basis, apart from a detailed audit of its implementation in HSE West (*see above*).

Overview of implementation

The foregoing account indicates that the majority of recommendations appear to have been at least addressed, if not implemented. As mentioned earlier, in some cases the local areas took immediate action, but the national response was slower and seemed more cumbersome to effect. It is not possible to be definitive about which recommendations were or were not implemented for a number of reasons, which will be elaborated upon below, but certain trends are apparent. For example, of the recommendations that appear not to have been successfully or consistently implemented, those in respect of non-social work/social care disciplines (i.e. health and disability staff) and those involving inter-agency issues (including exchange and management of information) appear to have been the most difficult to address. This is not surprising given the frequency with which recommendations of this type re-appear in inquiry reports and raises questions about the propensity of recommendations to engage with such issues. Recommendations connected with the law, or with legal processes, standards and regulations, were the next most challenging category. Certain national policy recommendations appeared in more than one report and seem to remain difficult to implement, for example, the development of a national out-of-hours services.

An earlier section referred to the difference between the process of *addressing* recommendations and *implementing* them. To put it simply, a policy may be developed, published and even publicly launched, but unless it is put into action at management and front-line levels, it cannot be considered to be implemented. The inconsistent implementation of *Children First* as noted by the OMCYA (2008b) and the Ombudsman for Children (2010) is a case in point. The report of the Garda Inspectorate (2010) provides another example of ostensible implementation that was found to be deficient when closely examined. Even when policies are embedded at a local level, their adoption in the practices of front-line workers may not be automatic or visible. Availability and take-up of training is rarely comprehensive for pragmatic reasons. As such, implementation of recommendations about training and practice are difficult to measure without a detailed audit, such as that conducted on the Roscommon Report's recommendations in HSE West.

Factors influencing implementation

The question of whether or not the full implementation of recommendations was a realistic expectation was explored in interviews with research participants, who also provided insight into the factors that influenced it. There was a general view that either the Minister and their Department or senior management in the HSE, depending on who received the report, would normally be positively inclined towards total implementation. However, full commitment was not always seen as obligatory. One interviewee explained it as follows:

> 'Well, I think a kind of pragmatic view would be taken. I mean, mandatory reporting would be a case in point. It was recommended in the Kilkenny Report and Kelly … so I mean that would have been one of the ones that didn't happen because there was all kinds of fairly legitimate reasons raised. So I think politicians are fairly pragmatic people … if there are 32 recommendations and there are two or three they think are problematic, you can do a lot of good in implementing the 30 and you slow-pedal on the other three or whatever.'

Interviewees were also invited to comment on why some, but not all, recommendations are implemented. Their responses suggest that the key determining factors are policy fit, political and professional 'buy-in', resources, congruence with social and cultural norms, and attitude to change. A former HSE/Health Board senior manager commented:

> 'I think recommendations that were implemented, generally speaking … if the fit was right with other issues that were going on in the system … if there was a broad direction of policy … if a Minister was particularly interested … if there were other pressures at force. But if those other pressures weren't there, I would have seen limited impact.'

It was perceived that:

> 'If, for instance, they don't fit, [for example] like the recommendations … for out-of-hours services, if they don't fit, then it's unlikely, certainly in the short term, that [simply] making them … will lead to them being implemented.'

The question of 'fit' also applied to synchronicity between the key stakeholders. An interviewee who was involved in policy-making over the period in which all of the inquiries were published commented that:

> 'It will only happen if you have a common ground between the political system, the administrative management system, whether that be the Department, the HSE or the Health Boards … and the relevant professional disciplines. If you don't have them all pulling in the same direction, then it won't happen, it won't happen.'

This notion of 'common ground' underpinned a pragmatic view taken by a HSE manager, whose view was that, given the changes in the child care sector in the past few years and the reform programme currently underway, there is potential for confusion if recommendations were to be taken literally. As the manager pointed out:

> 'We would end up with multiple processes kind of running alongside of each other, you know, and … by default creating more disaggregation between standardised and non-standardised practice.'

The fit between recommendations and economics was also identified as central, as a senior civil servant explained:

> 'A recommendation will only work if [it] stands up to scrutiny and if the recommendation can be implemented given the resources you have available. So if you don't have the resources, and can't get the resources, it won't happen. If it doesn't stand up to scrutiny and there isn't buy-in, it won't happen.'

The views expressed echo the findings of Stutz (2005) who concluded that to be implementable, recommendations should be both feasible and affordable. The importance of a key political advocate to drive implementation was also noted by participants, again reflecting Stutz's finding about the positive effect of 'champions' on the implementation of recommendations. A former inquiry Chair emphasized the importance of political back-up:

> 'An awful lot depends too on what kind of Minister you have in whatever Department it is. It happened that [name of Minister] was willing to make changes and to say, well, we have got to be able to afford these changes.'

In addition, the importance of having civil servants on side was pointed out:

> 'It depends to some extent on how it is sold to the Department and to whom it is sold … [if it] has the ear of somebody in the Department … it will get legs.'

The importance of Governmental authority was highlighted:

> 'I mean, the history of implementation in public bodies is … unless you're driven from the top … there is a history of sabotage. People just carry on doing the old stuff.'

The resistance to change implied in the last quote was also identified by a senior HSE manager, who described a national divide:

> 'There is heroic resistance … to standardisation, particularly if it's coming from Dublin … there is going to be a better way of doing it in Cork north Lee or Donegal south!'

Such reluctance was seen to come not just from front-line staff, but from those at the top as well, including those responsible for implementation. An interviewee with experience of a number of inquiries noted a tendency whereby senior management sometimes 'minimise' the recommendations and 'swoop' them into something that is 'tangentially' being done:

> 'You get some individual somewhere near the top who says 'Ah, this will do', 'That will do', 'That's going on over there, put that in with that.'

In another example, a senior civil servant recalled a particular period in the 1990s when recommendations were being addressed by new national child protection procedures:

> 'We had a couple of big rows on *Children First* … I remember one in particular was with an acting CEO with one of the Health Boards … he told me on the phone that there was no way they were going to accept national guidelines because they had their own … I just couldn't believe the attitude.'

This orientation towards a local idiosyncratic approach to child protection appears to have been consistent with a view held at the time – that the recommendations of reports of inquiries were optional rather than mandatory and could be tailored to suit particular local dynamics.

A small number of recommendations appear to have been written without the expectation that they would be implemented in the short to medium term, in that they were not consistent with social or, in some cases, professional norms. One interviewee commented:

> 'There have been some that were probably way ahead of themselves in the sense of the country wasn't ready for them.'

The most typical example of this is the recommendation regarding Constitutional change, which was included in the Kilkenny Report and again in the Kelly Fitzgerald Report. This recommendation was written in 1993 when the issue of children's rights figured far less prominently on the political agenda and when there was still a great deal of resistance to initiatives that could be framed as challenging the position of the family in Irish society. It seems unlikely that either the Kilkenny or the Kelly Fitzgerald inquiry teams expected this recommendation to result in immediate efforts on the part of the Government to bring forth a referendum on the issue of children's rights. Indeed, a senior Government legal adviser is reported by an interviewee as having responded to the recommendation in the Kilkenny Report by saying, '*You're out of your mind if you think you will ever get that*'. It may be, therefore, that sometimes recommendations are framed as a vehicle to promote debate on an issue around which there is an absence of consensus, rather than with the expectation that they will be acted upon. The recommendations on mandatory reporting provide a further example of this. Two separate interviewees who had been members of inquiries that had recommended it acknowledged that there were many divergent opinions on its merit. One commented that:

> 'There would appear to be fairly strong evidence that mandatory reporting isn't necessarily the best way forward.'

The other interviewee pointed out that:

> 'They haven't implemented that recommendation, but I was always aware of the fact that a lot of people whose views I would respect thought it was not a good thing.'

The above quotes are illustrative of a political and public ambivalence about reporting legislation, one that would last two decades.

Implementation in operation

The impression given by interviewees for this study was that a programme of implementation would run for a limited period immediately after the publication of the report and then it would tail off. As one participant explained, a group might be set up that has to report regularly initially and then:

> '... tends to run for a while and then something else comes along ... and it slips away ... You nearly forget what you're tracking ... Life moves on and other things happen and you're stuck with recommendations that are no longer relevant.'

In some instances, measures were taken to address the recommendations, but they were partial and short term. For example, child protection training was introduced into teacher education following the Kilkenny Report, but research has found it to be of very brief duration and considered to be quite inadequate (Buckley and McGarry, 2011; McGarry and Buckley, 2013). Joint Garda/Health Board child protection training was conducted in 2001 and 2002, some 8 years after the Kilkenny Report, but not repeated until 2011. Changes in front-line practice following a set of recommendations also had 'a shelf-life', according to two former Health Board/HSE managers in different areas. One of them described:

> 'A great push ... a great reactive push to effect changes ... but once the dust begins to settle ... the changes slowed down.'

The other recalled:

> 'It sort of happens in bursts, you know. You [implement a new practice] for three or four months, and then it will start slipping again.'

Interviews with some members of inquiry teams illustrated the distance between those making the recommendations and those implementing them, where, in certain cases, inquiry teams would have been open to further involvement. This would have served the dual purpose of, firstly, ensuring that the recommendations were understood as envisaged and, secondly, by encouraging mutual ownership and a conjoint approach which may have facilitated more effective implementation. One former inquiry Chair commented on the lack of opportunity to communicate with commissioners about the intention behind the recommendations and their appropriateness, using a particular initiative as an example:

> 'There wasn't an opportunity to engage in a process of discussing these recommendations and even from the point of view [of] "Do you really mean that?" ... "How implementable is the other?" And even if you take [a particular recommendation], it was implemented but not in the way that we had envisaged it ... it ended up becoming worse than the original problem.'

This view was shared by another inquiry Chair, for similar reasons:

> 'Being able to be involved and maybe involving members of the inquiry team if it is appropriate ... at least talking about, you know, "Where does this come from?", "What's it about?", "What's the thinking about?" ... When you look at how recommendations are implemented and you've been involved in it ... you know that was never the intention at all ... that wasn't what that was about.'

This reflected the notion, referred to in Chapter 5, that consultation between stakeholders in an inquiry process may assist in effective implementation, a point which will be developed in the concluding chapter of this report.

Conclusions

Two objectives of this study were to ascertain the degree to which recommendations had been implemented and to examine their impact on policy and practice. The research was unable, for a number of reasons, to do more than estimate the degree of implementation, given the complex and dynamic context in which the five reports have been published. It appears that most recommendations were addressed, but the extent to which they have exclusively impacted on policy and practice is far less clear. Reviews of the various documents provided to the researchers, together with consultations with HSE managers, indicate that implementation plans were normally developed, but not vigilantly reviewed. It was also evident that implementation was subject to a number of variables, some of which were pragmatic. These included political and local enthusiasm and acceptance; the degree to which proposed reforms slotted into ongoing service development; and their fit with the social and cultural norms of the time. The research also revealed that some recommendations were not implemented as intended by the inquiry teams that developed them.

The next and final chapter of this report summarises and distils the findings from the research. It concludes by considering the current role and function of inquiries into child protection and offers a new approach to the drafting of effective recommendations.

7. Concluding Summary: A new approach to inquiry recommendations

Lord Laming, the Chair of the Victoria Climbié inquiry, has contended that inquiries:

> '... provide an assurance that the facts surrounding an alleged failure will be subjected to objective scrutiny. They are expected to reach judgments on why terrible events happened. They often make recommendations on how such events might be prevented in future. They may give relief to some and allow the expression of anger and outrage to others. They are often disturbing and painful events. They should improve our understanding of complex issues. At best they change attitudes, policies and practice. That being so, they occupy an important place in our society.' [Extract from evidence of Lord Laming to Public Administration Select Committee, cited in PASC, 2005, p. 9]

Laming's observation was made in respect of the UK, but recent history shows that inquiries also occupied an important place in Irish society over the past two decades. As this study has illustrated, the reports that followed inquiries have been regarded as weighty and influential, and have enjoyed a privileged authoritative status not necessarily proffered, for example, to empirical research or to other types of evidence. They also carry an inherent expectation of implementation, which seems to be based on the assumption that they always 'get it right'. In presenting a compelling authoritative version of the facts and the promise of solutions, reports of inquiries offer coherence and an alluring certainty, which makes them attractive to policy-makers. These factors make a study of inquiry recommendations particularly pertinent in the current context, where the child protection system is in the midst of a developmental phase.

The present small-scale qualitative study, which was commissioned by the Department of Children and Youth Affairs, focused on the recommendations made by five Irish inquiries conducted between 1993 and 2010, all of which were concerned with perceived failures of child protection services to intervene effectively in relation to intra-familial child abuse and neglect. As well as reviewing relevant research, the study examined a range of literature and documents, including internal HSE/Health Board reports, Departmental memorandums, Ministerial briefs and Dáil reports. Semi-structured interviews were conducted with 21 current and former senior professionals and specific information was also provided by 21 key informants. The study does not claim that the views expressed in this research report are representative of the wider body of child protection policy-makers, managers and practitioners; it simply presents the views and perspectives of a small group of professionals who were closely connected to the inquiry process, including the implementation of inquiry recommendations.

The study adopts an interpretative stance in arriving at its final assessment. The researchers have sought to conduct it in a rigorous, sound and trustworthy manner, and to present results which are credible, dependable and transferable. The research findings are summarised below and the report concludes with the key lessons identified.

PART 1: Summary of study findings

The overall aim of this project was to examine the recommendations of five Irish child abuse inquiry reports, to ascertain the degree to which they were implemented in the context of concurrent reforms and to develop a strategy to improve the relevance and achievability of recommendations in future reports. It had five specific objectives, as follows:

- To examine the recommendations from the five reports.
- To produce an overview of policy and practice developments in child protection and welfare over the past two decades and demonstrate the degree to which recommendations were directly and indirectly responsible for reforms.
- To evaluate the recommendations in terms of their relevance to the report findings.

- To establish a template for recommendations that will inform the design and terms of reference for future reviews, be capable of comprehensively addressing the complexity of child protection practice and policy, and
  - be realistic and measurable;
  - promote learning;
  - reflect the principles underpinning the National Children's Strategy; and ultimately
  - enhance practice and produce better outcomes.
- Through the course of the research, identify key issues for policy and practice development.

In order to fulfil the objectives of the study, it was considered necessary to first provide a context on which to base the fact-finding, analysis and discussion that followed. The process and structure of inquiries, as well as their role and function, were examined in Chapters 1 and 2. *Chapter 1* provided information on the role of inquiries in public policy in Ireland and elsewhere. *Chapter 2* reviewed available literature on the background to different types and legislative backgrounds of commissions and inquiries, and elaborated on their explicit and implicit functions. The literature illustrated how inquiries serve as vehicles for addressing deficits not only in services, but in the trust and authority of institutions that had been regarded as pillars of society. Focusing particularly on child abuse inquiries, Chapter 2 went on to describe the use of inquiries in different jurisdictions. Research that debated the usefulness of child abuse inquiries was reviewed and while the opportunities for change and development created by them was acknowledged, a number of perverse and unintended consequences flowing from the self-perpetuating nature of inquiries was identified.

Chapters 3, 4 and 5 addressed the **first three objectives** of the study between them. The evolution of the child protection and welfare system over the time span of the five inquiry reports, including the emergence of different policy directions, was traced in *Chapter 3*. The shift in focus from the narrow concept of 'child battering' by parents to the assumption of responsibility by the State for preventing child harm and upholding children's rights was mapped through four decades. The expansion of services, which was matched by the accretion of legal measures, regulations and guidelines, was tracked in terms of the different policy orientations that the system tried to adopt at various times, including early intervention and family support. The rise of child protection as a political issue, from its minor role in 1970 to its prominent position today, was profiled.

The inquiry process

Chapter 4 continued to develop the inquiry theme, focusing in particular on the five reports under study. The private and non-statutory nature of the five inquiries was noted and it was inferred that the advantages of a cheaper, faster, non-statutory process were considered to outweigh the disadvantages associated with the inquiries' limited powers and possible challenges to the publication of the reports. However, it was noted that even when inquiry proceedings are not publicly accessible, the inquiry report assumes a particularly important role in terms of providing re-assurance, allaying public concerns and restoring trust in the capacity of the public sector. The difficulties in relation to the publication of three of the five reports, which led to the substantial redaction of one, were noted.

The composition of the different inquiry teams was also described and compared, along with the terms of reference used by each. The methods adopted by the inquiries, including the sources of information and numbers of witnesses, were examined. The reports were compared in terms of their length and presentation style. The views of interviewees, reported in Part 2 of Chapter 4, affirmed that inquiries have become an inevitable part of modern life, a development which is not without problems. Some interviewees were critical of the perceived lack of experience and expertise of some inquiry teams, their potential for bias and

the separation of their deliberations from the 'lived experience' of day-to-day child protection work. The utility of inquiries as catalysts for change was affirmed, but a number of research participants reflected on the need to re-orientate the process away from policy reform and more towards learning. While the role and function of inquiries received general support, it was considered that they came at a high price in terms of the personal trauma experienced by participating staff and the defensive practice that was seen to ensue.

Recommendations from the inquiries

Chapter 5 began by examining the 187 recommendations produced by the five inquiry reports. It was noted that the Kilkenny inquiry team based their recommendations not only on the findings of their investigation into the case, but also on evidence provided to them through a submission process and a search of relevant literature. This broad-based approach enabled them to comment on the inadequacy of the child protection framework that existed at the time, but also provided them with an opportunity to comment on societal reluctance to acknowledge the prevalence and impact of child abuse and family violence. The significance of the Kilkenny Report's recommendations was acknowledged by research participants and it was observed that the recommendations of later reports had a lesser impact, partially because their focus was slightly narrower.

Recurrent themes in the recommendations were identified. These included the need for improved vigilance and identification of children at risk, better inter-agency cooperation, record-keeping and exchange of information, and protocols for child protection conferences. The need for revision and consistent implementation of guidance featured in the Kilkenny Report, and as it gradually became known that *Children First* and other guidance were not being fully implemented, this recommendation was reiterated in later reports. Each report cited the need for training on different topics and the need to prioritise child-centredness and children's rights was implicit in all of them.

Part 2 of Chapter 5 reported on the perspectives of interviewees on the recommendations from the five reports. Former inquiry team members described the process they employed to construct recommendations, emphasizing the conscientious efforts made to link them with findings from the cases. Interviewees who had, in their professional roles, been tasked with responding to the various recommendations expressed mixed views about their value. While most had found the recommendations relevant and useful, some were also critical of their quantity and predictability, the vague and aspirational tone of some, occasional lack of clarity of others and the lack of congruence with recognised principles of best practice perceived in a few of them. The recommendations of the Kilkenny Report were held in the highest regard, but the repetitive nature of subsequent recommendations was noted and interpreted by inquiry team members in particular as depressing and symptomatic of resistance to change in the organisations concerned. It was considered that some level of consultation between inquiry team members and policy-makers prior to finalising the report would be beneficial in pre-empting recommendations that would 'land the whole system in the soup' and could ultimately promote ownership of them. The strongest theme to emerge from Chapter 5 was the need to modify the process of developing recommendations and the aim to have fewer in number in the future.

Implementation of recommendations

Chapter 6 addressed one of the **overall aims** of the study – to ascertain the degree to which recommendations had been implemented in the context of concurrent reforms. This proved to be a challenging task. The inquiries span the period from 1993 to 2010 and the inevitable development of policy and restructuring of relevant organisations over the past 20 years has altered the child protection system to the point where some recommendations from early inquiries have become irrelevant.

The passage of time presented further obstacles to measuring implementation and meant that the research had to rely in part on the recall of interviewees, who acknowledged limited memory of events.

The study findings indicate that, with few exceptions, recommendations from the Kilkenny Report were implemented. Most of the exceptions were in respect of actions that were not considered to be appropriate at the time, but have since been addressed. From the available documentation, proceedings from Dáil debates and data from interviewees, it can be concluded that while the majority of the recommendations from the other two earlier inquiries (Kelly Fitzgerald and West of Ireland Farmer) were addressed by the development of some national, but mostly local policies and protocols, it was not possible to assess whether the changes were fully operationalised at the front-line of practice. In some instances, parts of recommendations were implemented, while other parts were not. Some recommendations were implemented locally, but not nationally. Others were implemented for a limited time, followed by reversion back to the former status quo. It appeared that a number of recommendations from the different reports acted as triggers for the implementation of policies and measures that had been planned and aspired to, but had not been fully operationalised due to lack of funding or lack of readiness on the part of society.

The later reports received a more formal response. However, subsequent action in respect of the policy, organisational and management recommendations seems to have been partially obscured by other developments and the degree to which the new measures were deliberately intended to address the recommendations is not always clear. In some aspects, implementation is still underway. It appears that the present study actually became part of the process of implementation by, in the case of the Monageer Report, triggering a review of progress to date.

There was a trend whereby certain recommendations made by each of the inquiries appeared difficult to implement in full or with any lasting effect. Those involving disciplines which one interviewee described as outside the 'sphere of child protection' appeared to founder, while the recommendations on management and exchange of information between disciplines by use of central registers or indexes also appeared complex to address.

One of the more significant points that emerged from this study was the separateness of inquiry teams from commissioners and other stakeholders whose responsibility it was to respond to recommendations. This was a cause of regret to some inquiry team members, who felt that on occasions the intent behind recommendations was misunderstood, thus affecting their implementation. The idea of consultation between all relevant parties prior to finalising recommendations received positive, if slightly conditional support, with some reservations being expressed about a threat to the independence of the inquiry.

Moreover, the research drew a distinction between *addressing* and *implementing* recommendations. The limited scope of the study, which was not intended to be an audit, could not ascertain whether all the measures recommended to improve practice have been put into day-to-day operation. The findings made in previous reviews and investigations in respect of non-compliance with *Children First* and the Garda/Health Board protocols would suggest that caution should be applied in making any assumptions in that regard.

Template for recommendations

The **fourth objective**, which was central to the overall aims of the study, was to establish a template for the development of recommendations which takes account of the findings of this study. The template is presented at the end of this chapter and is based on the data from interviews as well as some recent international perspectives on the most effective use of inquiries and child death reviews. It outlines a collaborative process, which produces fewer

prescriptive recommendations. It reflects the principles and goals of the National Children's Strategy by emphasizing the importance of an evidence base, promoting learning and providing greater clarity about desired outcomes and the process of reaching them.

PART 2: Implications for policy and practice

The final part of this chapter will consider the **fifth objective** of the study, which was to identify key issues for policy and practice development. The issues identified are relevant to the inquiry process, but have implications for the child protection and welfare system in general.

The use of inquiries

The study has determined that inquiry recommendations, particularly those from the Kilkenny Report, have acted as a mechanism for positive change. However, it has also demonstrated that they have become too numerous, predictable and repetitive. It has been suggested that the incremental contribution of more recent inquiries to developments in child protection practice has been less significant. The findings of this study have revealed a type of 'recommendation fatigue', which has developed following the succession of inquiries which, including the five reports on which the research was based, have produced over 550 recommendations in Ireland alone. It is inevitable that the capacity of the child protection system to withstand the unlimited expectation of reform will soon be exhausted. It could be inferred that a critical mass has now been reached and the benefits from inquiries have succumbed to the law of diminishing returns. The privileged status previously afforded to inquiry recommendations in the policy sector may no longer be sustainable. This was recognised by interviewees in the present study and has led other jurisdictions to reduce the use of inquiries and adopt an alternative, but rigorous system of internal quality assurance in the area of child protection.

In Ireland, **internal quality assurance procedures** in child protection have only recently emerged, but are developing rapidly. These mechanisms include the **National Review Panel**, which reviews deaths and serious incidents involving children in care or known to the child protection services, and the **National Standards for Child Protection**, which provide benchmarks for inspection by the Health Information and Quality Authority (HIQA). The **Quality and Patient Safety Directorate** conducts audits in the health services and the **Child and Family Agency** will also have an in-built quality assurance process. None of these systems existed when the inquiries in this research were commissioned and they can now provide the competence and consistency that some interviewees believed was previously lacking. If public trust in the credibility, reliability and rigour of the internal quality assurance system can be fostered, it could reasonably be inferred that demand for inquiries into child protection failings will reduce. This will have the additional advantage of reducing the personal distress associated with the more adversarial process.

A fresh approach to recommendations

At this point, the repetition of a number of core themes in the recommendations of inquiries on child protection failures suggests the need to re-evaluate the process of drafting and disseminating them. Attention is now turning internationally to the potential for learning from reports and attempts are being made to change the focus from individual deficits in policy and practice to systems-wide approaches and strengthening of organisational elements that promote good practice (Brandon *et al*, 2011; Fish *et al*, 2008).

The key question here is how the current approach in Ireland can be modified so that the inquiry process and inquiry recommendations become more effective resources. This question is addressed in the final part of this chapter, which suggests that inquiry teams should adopt a process similar to that used by Laming (2003) when making recommendations. It is proposed that recommendations should be drafted in a separate *forward-looking* phase of the inquiry process, using a different methodology to the fact-finding *backward-looking* initial phase of the inquiry. The approach will be based on an underpinning principle of collaboration (*see below*).

Protocol for collaboration

The collaborative approach suggested is consistent with the position that an inquiry should be viewed primarily as a form of qualitative social research (Walshe and Higgins, 2002). Like other forms of qualitative research, the work of the inquiry should be evaluated in terms of its credibility, dependability and trustworthiness, and in the rigour and depth of its approach (Golafshani, 2003). A collaborative approach to drafting inquiry recommendations would include a consultation process with key stakeholders following the finalisation of the inquiry's findings. The adoption of such an approach would address a number of concerns raised by the interviewees in this study. It would provide the inquiry team with access to a range of local and expert knowledge, and link the findings and proposed solutions to an evidence base. It would strengthen methodological rigour of the inquiry process and reduce the likelihood that the inquiry findings and recommendations will be unduly biased by the values and perspectives of the inquiry team. Consultation about recommendations would also ensure that the intention behind them is clearly understood and promote the likelihood that they will be feasible and realistic. It would increase ownership of recommendations by policy-makers and service providers, and potentially reduce the negativity and resentment that sometimes follows inquiries.

Collaboration could be achieved in a number of ways that would not greatly add to the cost or duration of the inquiry process. Cognisant of the reservations expressed by some interviewees – that consultation might compromise the independence of the inquiry team – it is proposed that a protocol be drawn up. This could usefully be included in the terms of reference of the inquiry. The protocol should be comprised of the following sequence of actions:

Under the terms of the protocol, it is proposed that an advisory group should be established at the start of the inquiry, to assist the inquiry team. The members should be selected following consultations between the commissioner and the Chair, and should be drawn from a range of relevant disciplines. The role of the advisory group would be to provide the inquiry team with expert advice, including written advice, as required.

In developing recommendations, the inquiry team should invite and consider written submissions from relevant stakeholders. Once the recommendations are drafted, the inquiry team should conduct a workshop with invited participants to discuss them. It is also suggested that the inquiry team should be involved in a series of briefings when recommendations have been finalised. Importantly, in order to protect the independence of the inquiry, the consultation processes will be managed, directed and controlled by the inquiry team.

Template for drafting recommendations

The final part of this report presents a template for drafting recommendations that are primarily oriented towards the organisation, management and delivery of professional public services. The template consists of 5 individual and interlocking CLEAR components, as described below.

Case for change: A convincing case for change needs to be outlined as change may require modification of norms, perspectives and behaviours, as well as structures and policies.

Learning-oriented: Identify key learning points and any training/skill gaps that need to be addressed.

Evidence-based: Recommendations must draw on an evidence base when identifying solutions to policy and practice deficits identified in the report.

Assign responsibility: Each recommendation should identify the discipline, directorate or organisation with responsibility for implementation, recognising that some recommendations will require a collaborative response.

Review: Recommendations should be written in a manner that facilitates review. This can be achieved by clearly specifying desired outcomes and time lines, and any additional resources required to achieve them.

Case for change

Evidence from this study, together with reviews and investigations by the OMCYA and the Ombudsman for Children, illustrates that resistance to change can pose challenges to the implementation of recommendations and policies. Given the rate of development in services in Ireland over the recent past, an inquiry that proposes further change or amendments will need to make a strong case for it. Inquiry teams should draw on evidence from the case under review and clearly identify the issues that give rise to the need for change, outlining the likely consequences should no change occur. Importantly, the proposed change should be contextualised within current policy, or that which is known to be in preparation. This will indicate the level of congruence between current or planned policies and change proposed by the recommendation. Such a process should also minimise the potential for recommendations to be, as one interviewee for this study warned, 'swooped' into existing policies without consideration of whether or not they fit.

Learning-oriented

Research on the Serious Case Review process in the UK indicates an intention to shift the focus of inquiries towards the promotion of learning and away from more superficial actions that may be easy to implement but may side-line the type of change that needs to be made at a deeper practice level (Vincent, 2010; Devaney *et al*, 2011). A similar aspiration was expressed by participants in the present research.

Recommendations should highlight key lessons for practice revealed by the inquiry process and should promote the transfer of learning. Deficits in knowledge or practice skills are not always attributable to lack of training, but can be linked with inadequate information and guidance. Such deficits may need to be addressed through additional research, expanded databases and practice guidance on specific topics. Messages for practice could be elaborated in a separate section of the report, which can reference research and theory.

Evidence-based

Recommendations should draw on different types of evidence. First, they should flow from evidence of any deficits in policy or practice revealed by the inquiry. Secondly, they should demonstrate knowledge of the context in which recommendations are to be implemented, for example, current and planned policy developments. Thirdly, recommendations in respect of policies, programmes or interventions should only be made if evidence exists and can be cited, indicating that their implementation will effectively address and remediate the deficits identified by the inquiry report.

Assign responsibility

Recommendations should clearly specify which discipline, directorate or organisation is implicated in their implementation. If a multi-agency response is required, each individual discipline or organisation required to respond should be identified, as well as a leader to carry responsibility for coordinating and overseeing implementation.

Review

A set of learning points and recommendations that follow the format proposed in this template should be amenable to review. It should also be feasible to link recommendations to regulatory processes, such as the HIQA standards for child protection, as well as the quality benchmarks that are planned for the Child and Family Agency.

However, caution needs to be applied to the process of measuring progress. The reforms that are easiest to quantify are likely to be those that are most superficial. Improvements in practice as a consequence of new learning are not amenable to the type of review or progress update that has been utilised to date in respect of the five inquiries in this study. An effective review of implementation will necessitate a methodological approach which captures the more nuanced aspects of child protection practice. The audit conducted by the Quality and Patient Safety Directorate on the implementation of the Roscommon recommendations in HSE West (described in Chapter 6 of this report), involved a multi-methods approach and provides a good exemplar (HSE Quality and Patient Safety Directorate, 2013). Using questionnaires, qualitative interviews, reviewing case files and studying proceedings of meetings, it comprehensively assessed not only the degree to which national and local policies have been amended, but also the way that learning was reflected in the practices of front-line staff.

Conclusions

The key messages from this study were, in summary, that inquiries in the future should take a fresh approach which minimises the number of prescriptive recommendations and focuses instead on key learning points which may be disseminated within and across organisations. It is proposed here that a consultative, collaborative approach is taken to the development of recommendations and a protocol for this process has been suggested. It is argued that a consultative approach would provide clarity, prevent misinterpretation and promote ownership. It should also ensure that the recommendations are informed by all relevant sources of information, knowledge and expertise, and it should ultimately render them more feasible and cost-effective. It is further suggested that recommendations should be framed in a way that illustrates the rationale for change, promotes learning, cites evidence, identifies the organisation or sector responsible for their implementation, and outlines them in such a way that progress in their application will be easy to evaluate. The proposed template for CLEAR recommendations has been designed to incorporate these messages and takes account of the difficulty of measuring outcomes in areas that involve the exercise of professional judgement.

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S.I. No. 259/1995 – Child Care (Placement of Children in Residential Care) Regulations, 1995

Appendices

Appendix 1: Implementation of recommendations from child abuse inquiries

Kilkenny Incest Investigation (Kilkenny Report, McGuinness, 1993)

Report recommendations	Implementation
Child Care Act 1991	
We cannot recommend too strongly the urgent need to provide the necessary resources and to implement the remaining sections of the Act (Child Care Act 1991) and in particular Parts III, IV, V and VI which deal with the taking of children into care, court proceedings and the powers and duties of health boards in relation to children in their care.	All sections of the Child Care Act 1991 were implemented by the end of 1996.
Prior to the introduction of these parts of the Act it will be necessary to provide detailed briefings and, where necessary, training for those likely to be dealing with child care under the new legislation. Training programmes must address individual discipline needs, in addition to multi-disciplinary training.	Training posts were created in the Health Boards over the following two years.
Constitutional change	
Consideration be given by the Government to the amendment of Articles 41 and 42 of the Constitution so as to include a statement of the constitutional rights of children.	This was not implemented for a further 19 years, although it was kept on the political agenda during the interim. A decision was made in 2006 to hold a referendum, which took place in November 2012.
Child abuse procedures	
We recommend that the Minister for Health prepare revised procedures for the identification, investigation and management of child abuse to replace the current guidelines. These procedures should be given statutory effect under the provisions of Sections 68 and 69 of the Child Care Act 1991. We further recommend that revised procedures should include: › a mandatory system of reporting; › a standardised notification system; › precise and workable definitions of physical abuse, emotional abuse, sexual abuse or neglect; › guidelines on interviewing, history taking, indices of suspicion, incorporating recent theoretical developments in this area; › standardised criteria for the clarification of the outcome of investigation; › written protocol on inter-professional and inter-agency collaboration, including a policy on access to records; › protocols for the conduct of case conferences, with specific reference to the format, chairing and recording of minutes; › protocol on parental participation; › guidelines on case management, including: » recognition and investigation » assessment and planning » implementation and review › protocols for the maintenance of child abuse registers.	The Garda/Health Board guidelines were launched in 1995 and *Children First: National Guidelines for the Protection and Welfare of Children* were launched in 1999. The guidelines addressed all the identified issues, but were not given statutory effect and did not include a mandatory system of reporting, although there was a prolonged debate on the matter. There was a general view that society was not ready for it at the time.

continued

Report recommendations	Implementation
We recommend that a regular system of evaluation of the Procedures (Child Abuse Guidelines) be established.	The *Children First* guidelines were formally reviewed in 2007/08. This is the only review that was held. To that extent the recommendation was partially implemented.
There should be written agreed protocols for the investigation and management of child abuse within each health board. The roles and responsibilities of all staff should be outlined. There should be clear guidelines for inter-programme collaboration between hospital and community care staff on matters concerning the identification, notification and follow-up of child abuse.	This was addressed in *Children First*.
We recommend that the role and responsibility of the DCC/MOH in regard to child abuse be appropriately assigned in the event of the abolition of that post. In view of the increased responsibilities assigned to health boards in the Child Care Act 1991 and because of the increased reporting of cases of child abuse, we recommend that consideration be given to the creation of a separate post of child protection co-ordinator within each community care area.	The Child Care Manager post was established in 1998, with responsibility locally for the investigation and management of child abuse cases. However, later reviews found that there was a lack of clarity and inconsistency in the way the role was administered (*see* PA Consulting Group, 2009) and it may not have been what was intended by this recommendation. Later inquiry (Monageer) recommended a review, which was carried out in 2009.
Child abuse registers	
We recommend that standardised child abuse registers be maintained by the DCC/MOH in each community care area. Prior to the introduction of such registers, certain safeguards and procedures must be agreed: › there must be a precise and standardised system of clarification of outcome; › parents and guardians should have the legal right to be informed of any entry, or change of entry to the register in relation to their child; › procedures for the removal of names should be established; › a system of regular review of data must be in place; › procedures must be established concerning the disclosure of information from the register.	This was not implemented as intended. The term 'register' was not used. The Child Protection Notification System was set up under *Children First*, but has not been accessible by any person other than the HSE local area staff to date.
To facilitate the speedy dissemination of information regarding children at risk, we recommend the computerisation of the child abuse register. Access to this information should be provided to appropriate health care personnel, including hospital staff.	The National Child Care Information System was established in the late 1990s, but to date no standardised or interlinked information management system exists.
Reporting of child abuse	
We recommend that there should be mandatory reporting of all forms of child abuse by designated persons to the DCC/MOH (or other nominated person within health boards). These designated personnel should include doctors, nurses, social workers, psychologists, community welfare officers, child care workers, teachers, probation officers and other professionals responsible for the care of children.	Mandatory reporting was not introduced in response to the recommendations, but was given extensive consideration. Concern was expressed about the impact it would have on the system.

continued

Report recommendations	Implementation
A clear definition of what is to be reported should be provided in guidelines to such designated personnel, i.e. observed abuse or its effects, disclosures or specific risk factors which give reasonable cause for concern. There should be immunity from legal proceedings for such designated persons, who report suspicion of child abuse to an appropriate authority, provided they do so in good faith and in accordance with guidelines set down. Failure by designated persons to report child abuse should become an offence. All designated personnel should be required to caution clients about their reporting obligation under a mandatory reporting law. Persons other than those 'designated' should also be entitled to report abuse and receive the same immunity provided they do so in good faith.	
We recommend that the confidentiality of persons who make reports should be protected, if requested, so long as this does not adversely affect the investigation of the case. The duty to protect the child from abuse must override the duty to respect family privacy or personal freedom.	This was addressed by *Children First*.
Confidentiality	
We recommend that the Medical Council should ensure that all doctors are circulated with ethical guidelines governing medical practice on a regular basis and that it should be made clear that, if a doctor has reasonable grounds for believing that a child is being abused, not only is it permissible for the doctor to disclose information to a third party, but it is the duty of the doctor to do so. Where a client admits to child abuse or discloses child abuse, clinical responsibility to that client cannot take precedence over a doctor's responsibility in relation to child protection and the client should be so advised.	This was implemented by the Medical Council.
Case conferences	
We recommend that the DCC/MOH take all reasonable steps to facilitate the attendance of relevant persons at case conferences. There must also be an equal obligation on all those required to attend to facilitate the DCC/MOH in arranging the case conference.	*Children First* outlined responsibilities of different professionals in the child protection network in respect of child protection conferences.
We recommend that accurate minutes are kept in regard to decisions reached at case conferences and that these are distributed to participants within a reasonable time and are properly corrected where appropriate. Appropriate secretarial services must be provided in this regard. We recommend the attendance of parents/guardians at case conferences unless there are substantial grounds for their exclusion. Where parents or guardians are to be excluded, they should be advised in writing of the reasons for their exclusion. This will require careful preparation and training for those involved.	The conduct of child protection meetings was comprehensively addressed by *Children First*.
Because of the central importance attached to the task of chairing case conferences, we recommend that those likely to be charged with responsibility for chairing case conferences should be suitably trained for the task.	It could be assumed that this was covered in *Children First* training in the early 2000s.

continued

Report recommendations	Implementation
The role of chairperson of case conferences has never been properly defined. This role should be clarified to include: › ensuring that proper arrangements are made for the calling of the case conferences; › arranging for the minutes to be taken and circulated; › allowing all members of the conference sufficient time to present their information and opinions and a point of view, while recognising that it is important that contributions do not become repetitive or argumentative; › ensuring that the meeting keeps the interests of the child as its primary focus; › probing the information and opinions being proffered and, where necessary, challenging statements being made; › ensuring that a plan with immediate and long-term aims is formulated at the case conference; › ensuring that all those at the conference are clear on the decisions reached and who has responsibility for their implementation; › deciding on when, and in what circumstances, the case conference may be reconvened; › the chair will remain the focal point for the circulation of information before and after the case conference and will remain a central point of contact in regard to the case until it is satisfactorily disposed of.	The role of the chairperson was addressed by a protocol in *Children First*.
Inter-agency cooperation	
We recommend that responsibility for ensuring that inter-agency reviews are carried out should be assigned to the health board.	This was addressed by *Children First*.
We recommend that the DCC/MOH should notify the Garda Superintendent of all allegations of child abuse. Each Superintendent should notify the DCC/MOH of all allegations of child abuse received by Gardaí. We further recommend that a standardised format be used for initial reports on child abuse passing between the DCC/MOH and the Gardaí.	A protocol for joint notification was published in 1995 and further elaborated within *Children First*.
We recommend that formal contact be established between senior health board and Garda management whose areas of geographical responsibility overlap; roles and responsibilities of each agency regarding all forms of child abuse be discussed and clarified; an agreed policy be derived for the effective inter-agency communication, liaison and working at all levels in each organisation to meet the needs and responsibilities of each agency; written protocols for implementing this policy be devised and circulated to all relevant staff in each agency; arrangements be put in place for consultation between investigation personnel from both agencies prior to action on an investigation taking place; explicit criteria be agreed for cases that require joint investigation – all approaches to be agreed in advance and from which neither agency can pursue independent investigation.	A protocol for joint notification and action between the Gardaí and the health boards was outlined in *Children First*.

continued

Report recommendations	Implementation
We recommend that the Garda Authorities should designate one or more officers at regional level as contact persons in child protection cases. These officers could be attached to the Office of the Chief Superintendent and provide services to a number of Garda districts. Such officers should be trained in matters relating to child abuse and protection. As designated contact persons such officer(s) should attend all relevant case conferences, accompanied by the officer dealing directly with the individual case. The DCC/MOH should notify the Garda Superintendent of the outcome of the health board's investigation of any/or agreed cases of child abuse within his area. Each Superintendent should advise the DCC/MOH in relation to the progress and outcome of Garda investigations into cases of child abuse.	
Where a file is to be sent by the Garda Authorities to the Director of Public Prosecutions, we recommend that DCC/MOH be advised of this decision and that a report from the health board professionals be included in the file forwarded. This shall include a report to the DPP on the impact a prosecution may have on the welfare of the child. In view of the possible adverse affect on child welfare of delays in decision-making, every effort should be made by the Office of the DPP to process files on child abuse cases speedily and as a matter of priority. The decision of the DPP should be conveyed to the health service personnel.	This was not formally implemented on a national basis.
An annual review of the operation of the policy and protocol should be arranged to include relevant personnel from both agencies. Opportunities for joint training of staff, particularly those involving investigation, follow-up and support should be actively pursued by both agencies. A system should be developed by each agency to advise the other of changes in key personnel.	This was not nationally implemented, but may have occurred locally under the *Children First* protocol.
We recommend that appropriate training on the identification, investigation and management of child abuse should be developed and introduced at pre-service level for all teachers. In addition, a programme of appropriate in-service training should be provided for all teachers. These programmes should be reviewed and updated at regular intervals and be provided on a rotating basis to include new staff on appointment and to update more experienced staff from time to time.	Teacher education courses have had very limited inputs on child protection since the early 2000s. Teachers who were Designated Liaison Persons were trained in 2002 and 2003, but training ceased after that with only new DLPs trained until 2012, when another round of DLP training was conducted. New teachers are not routinely inducted and all teachers are not trained (Buckley and McGarry, 2011).
We recommend that guidelines issued by the Department of Education should be reviewed in consultation with the Department of Health on a regular basis. If changes or revisions of guidelines are proposed by either Department, these should be carried out in consultation to ensure uniformity in approach in dealing with suspicions or allegations of child abuse. All such reviews or changes must be brought to the attention of all teachers, health services and other professionals dealing with child abuse.	Department of Education guidelines were revised in line with *Children First* in 2001 (primary) and 2004 (secondary) and were later revised in line with the re-launch of *Children First* in 2011.

continued

Report recommendations	Implementation
We further recommend that there should be formal liaison between health boards and schools at local level to align respective guidelines on child abuse into a joint protocol for effective action.	The matter of formal liaison between health boards and schools was handled on a local basis, therefore it is not possible to state whether this recommendation was implemented.
Inter-country cooperation	
We recommend that a formal liaison between the Department of Health and the UK Departments of Health and of Social Services be established to explore opportunities to develop and support maximum inter-agency cooperation in relation to children at risk.	This occurs on a case-by-case basis.
Recording of information	
We recommend that guidelines be prepared regarding the retention by family doctors of written records of all attendances and that in group practices where there is more than one centre of practice that one central record is maintained.	No evidence that this was implemented.
We recommend that linkages be established for all hospital attendances. They should be kept in summary form and should preferably be computerised.	This was established in the North Western Health Board following the West of Ireland Farmer Report, but not nationally. To date, there is no system of data linkage between hospitals that could identify multiple attendances/ child protection concerns in respect of any individual child.
We recommend that common guidelines be prepared in regard to the retention of the files of social workers, public health nurses and other professional staff who deal with child care. We recommend that records should be accessible to professional workers who need them. This is particularly so in relation to new staff taking over a case and also to staff providing cover while a colleague is on leave. In order to ensure the proper management of child abuse cases, agency policies should promote the maximum amount of information and record-sharing between personnel and departments. This would encourage a holistic approach to cases and would help to eliminate the possibility of contradictory or conflicting stories being told to individual workers. We would stress that all agencies, including voluntary agencies dealing with children, should have a policy of cooperating with the DCC/MOH and his/her staff in making records and information available in promoting the welfare of children.	Record-keeping was addressed by *Children First* and later for social workers and social care workers by the Standard Business Processes. Record-keeping by other professional staff has not been standardised. Information-sharing was addressed by *Children First*. The review of compliance with *Children First* (OMCYA, 2008) showed that it was not happening as envisaged.
Where child abuse victims move from one area to another, the records should be transferred to the new area. In some cases, personal contact between the team who have had responsibility for the care of the child should be established with the team who will be assuming this responsibility in the new area. Where the transfer of a case file might be impractical or unworkable, it is recommended that there should be a summary of the known information supplied to the new area when the case is transferred.	Addressed by *Children First*.

continued

Report recommendations	Implementation
Prevention	
We recommend funding for the promotion of primary prevention programmes for children and young people, family support services, public education programmes.	The Stay Safe and SPHE programmes were made available nationally.
We recommend the introduction of the Child Abuse Prevention Programme (CAPP) in all classes at primary school level and recommend that a child abuse prevention programme be devised and introduced into second-level schools at the earliest possible date.	
We endorse the recommendations of the Second Commission on the Status of Women in relation to the introduction of age-appropriate life skills programmes in primary and second-level schools. These programmes should cover such issues as relationships, parenting, sex education, nutrition, hygiene.	
We recommend the extension of family support community-based schemes and suggest that family support services for men should be promoted as their participation in such programmes is low.	Springboard was launched in 1998 and funding made available for other programmes. Many services include elements specifically for fathers.
We recommend that education programmes should be devised by the Health Promotion Unit, Department of Health, to increase society's awareness and knowledge of child abuse.	Funding was provided to advocacy groups who work to promote awareness.
Treatment	
We recommend that appropriate treatment resources and facilities be developed in each health board area to deal with the victims of child abuse.	Each health board made their own arrangements.
We recommend that health boards should employ a comprehensive range of expertise in the provision of diagnostic, treatment and support services for children and families, and that these be available in each area. This includes child and adult psychiatrists, psychologists, social workers, nurses, family and play therapists.	This was addressed by the increased funding made available to implement the Child Care Act 1991 and over the following decade. It is not possible to document precisely how the funding was utilised, but it could be assumed that this recommendation was implemented in terms of increased staff and improved accommodation.
Health boards should provide suitable and appropriate accommodation for the investigation and management of child abuse, including facilities for observation, video/tape recording and secretarial back-up, and play equipment.	
Health boards should also be obliged to evaluate the effectiveness of their intervention programmes and share this information with other agencies.	National Reviews of Adequacy are published annually since 2006. Different areas commissioned evaluations. It is not possible to say if this recommendation was fully implemented.
We recommend that a treatment service be made available for perpetrators of child abuse and research be carried out into the most appropriate forms of treatment. We also recommend that inter-agency co-operation between the various sections of the Department of Justice (i.e. prisons, Gardaí, courts and court welfare services) and of the health services be developed to facilitate a co-ordinated approach. Furthermore, where a perpetrator has commenced a treatment programme while in custody a continuation of this programme should be available on release.	This was implemented on an area-by-area basis. Programmes were gradually introduced in prisons and catered for a small number of offenders.

continued

Report recommendations	Implementation
Training and supervision	
We recommend that the health boards provide a systematic training programme for all professionals working in the area of child abuse.	Training departments were established following the recommendation. Each health board ran individual programmes up to 2012, when a national approach was developed.
We recommend that newly qualified staff should have additional support and supervision when working in this area.	There is no evidence that this was implemented nationally at that time. It was reiterated in the Ryan and Roscommon reports, but not implemented consistently.
Domestic violence	
We recommend that: › Health boards should provide directly or in association with voluntary agencies a minimum number of refuge places within their geographical area for victims of domestic violence. Refuges should have back-up facilities, including access to professional counselling, information and advice on entitlements and on practical help available to victims of abuse. › Counselling support services for adult survivors of child abuse and incest. Particular attention should be paid to the need to provide specialised services for adolescents who are victims of abuse. › A free phone service to facilitate contact and the provision of information and counselling for victims of domestic violence. › Protocols should be developed for use by general practitioners, hospital and other health care staff for dealing with cases of domestic violence presenting for treatment or care. These protocols should include arrangements for the notification of such cases to the Gardaí and subsequent co-operation and liaison between health care and Garda personnel. › Health care, Gardaí and staff of voluntary organisations dealing with victims of domestic violence should receive adequate training in the recognition, investigation and recording of cases of domestic violence. › A community and professional education programme should be provided to dispel current ambiguity and tolerance regarding domestic violence and to highlight the services available to victims of such violence. › Support groups for men overcoming violence should be supported and encouraged by health boards.	Funding was provided to the health boards and to voluntary organisations for this purpose. Different initiatives have been developed over the past two decades, including COSC which has a coordinating and awareness-raising function. The National Counselling Service was established in 2004, CARI was established in 1995, other services have been funded around the country and the Family Support Agency also funds a number of support services. Helplines were established in different services. This was addressed by hospitals on an individual basis. It is not clear if all hospitals complied. Training is provided from time to time on this topic with health care staff and Gardaí. *Children First* training covers it and *Children First* Advice and Information Officers train voluntary organisations. Funding was provided for this following the Task Force on Violence against Women. Funding was made available and the response varied between areas.
We support recommendations by the Second Commission on the Status of Women for the amendment of the law in relation to barring orders and in addition recommend that barring orders should be available in certain cases of family relationships other than spouses or co-habitees.	The Domestic Violence Act was enacted in 1996 and addressed this recommendation.
We recommend that in cases where the welfare of the child is an issue, a health board should have the statutory authority to apply to the court for the barring or protection order. Such an application should not be made unless and until a full case conference has been held on the case, which the parents have been given the opportunity to attend. It should not be made without the explicit authority of the DCC/MOH.	This was addressed by the Domestic Violence Act 1996.

continued

Persons with mental handicap	
We support the LRC recommendations in relation to sexual offences against mentally handicapped persons and in general terms we recommend that it should be an offence to engage in unlawful sexual intercourse with persons suffering from mental handicap to such a degree that the person is incapable of guarding himself or herself against exploitation.	This was addressed by the Criminal Law (Sexual Offences) Act 1993.
We recommend that appropriate guidelines on procedures for the identification, investigation and management of sexual abuse of people with disabilities as recommended by the National Rehabilitation Board in 1992 should be prepared by the Department of Health and issued to health agencies and other organisations dealing with people with disabilities.	*Children First* had a specific section on children with disabilities.

Kelly – A Child is Dead (Kelly Fitzgerald Report, Joint Committee on the Family, 1996)

Report recommendations	Implementation
We recommend most strongly that the Government make a commitment to the continuing development of services for children over a seven to ten year period.	The first part of this recommendation was addressed by continued development of services.
The implementation of the Child Care Act 1991 in full will increase the statutory powers and responsibilities of the eight health boards for the protection and welfare of children. Essential to the exercise of these powers is, we believe, the development within each health board of a perspective which gives corporate recognition to its functions as a child protection and welfare agency. This will require the commitment and leadership of senior health board managements, supported by the Department of Health, and the harnessing of relevant facilities and services in support of this statutory function. It will also require the development of a co-ordinated and integrated approach in the planning and delivery of services and consistency in practices and procedures, both within and between each health board. In order to ensure that these requirements can be met, we recommend the creation of a senior professional post with responsibility for child welfare within the headquarters management staff of each health board.	The Child Care Manager post was established in 1998, but it is not clear if this is what was intended.
We recommend that a dedicated child welfare management post be created in each community care area to provide the leadership and direction necessary for the effective discharge of the board's statutory child welfare functions, including child protection. We recommend that these posts be filled by professional staff with a relevant qualification, frontline child welfare experience, post-qualifying training and a clear interest in managing this function. We further recommend that these child care management posts include a developmental function and responsibility for children in care, fostering and adoption, and family support services.	The Child Care Manager post was established in 1998.
We recommend that the Western Health Board establish an internal, consultative process with relevant staff and services with the objective of maximising its organisational capacity to accurately identify children at risk in the region and to intervene effectively to eradicate or to reduce the degree of risk to which children are exposed.	It is not possible to measure how far this was implemented by the Western Health Board at the time. The researchers were told by former staff that managers met regularly to review and progress recommendations from the report.
We recommend that the Western Health Board review its current deployment of community care staff.	The researchers were advised that this occurred.
We recommend that the Western Health Board give consideration to the development of multi-disciplinary child protection teams covering a geographical area.	The researchers were informed that this was not achievable.
We recommend that the Department of Health examine, in consultation with the relevant interested parties, the most effective means of delivering child welfare services nationally.	Numerous consultations took place between the Department of Health and Children and the health boards in the following decade, principally in relation to *Children First* and its implications. To that extent, the recommendation was implemented.

continued

Report recommendations	Implementation
We recommend that the Department of Health take appropriate measures to protect resources for preventive, support and treatment services, thus avoiding resources being directed exclusively towards investigation of instances of abuse and neglect.	The expansion of family support services, including Springboard, addressed this issue, but the extent to which it was successful is debatable (*see* PA Consulting Group, 2009).
We recommend that the Department of Health adopt a proactive approach in monitoring health boards' child care developments in order to ensure consistency on a national scale, both in provision and of procedures and practice.	Data collected from interviews indicate that a lot of communication between the Department of Health and the health boards took place during the following years.
We recommend the establishment at national level of a system for the setting and monitoring of child protection standards, to promote examples of good practice and to inquire into serious failures of practice.	This was not implemented at the time. HIQA standards were published in 2012, following recommendations in the OMCYA's 2009 *Implementation Plan* from the Ryan Report.
We recommend that all Government actions in respect of children and, in particular, in respect of children who are vulnerable due to abuse or neglect be founded on the principles and articles of the UN Convention on the Rights of the Child.	The National Children's Strategy was developed in order to comply with the UN Convention's requirements. The strategy was published in 2000.
This inquiry supports and echoes the recommendation of the Kilkenny Incest Investigation Report that consideration be given by the Government to the amendment of Articles 41 and 42 of the Constitution so as to include a statement of the constitutional rights of children. We further recommend that the body currently reviewing the Constitution give consideration to ensuring consistency between Ireland's ratification of the United Nations Convention of the Rights of the Child and the constitutional provision in this regard.	Not implemented at the time. Not implemented for a further decade.
We recommend the development of national standards in the provision of an advocacy or guardian ad litem service to children who are the subjects of legal proceedings.	Not implemented.
We recommend that judges and officers of the Courts be informed of the indicators of emotional abuse and neglect and of their particular risks to individual children.	It is not possible to measure how far this was implemented.
We recommend that the reporting of actual or suspected child abuse or neglect become a legal requirement for relevant designated staff, including health board personnel, general practitioners, the Gardaí, teachers and staff of voluntary and private child care services.	Not implemented at the time, although the issue was extensively addressed by the Government between 1996 and 2000.
We also recommend that this mandatory reporting requirement be accompanied by guidelines to these staff, who should have immunity in any legal proceedings.	Mandatory reporting was not introduced, but the Protection for Persons Reporting Child Abuse Act 1998 provided immunity for persons reporting suspected child abuse to State agencies.
We recommend that the Irish Government take the initiative in establishing European Union protocols for liaison and sharing of information between Member States in the interests of protecting children.	This matter is now covered by EU legislation.

continued

Report recommendations	Implementation
We recommend that the Department of Health establish bilateral arrangements with other jurisdictions for the sharing of information between relevant authorities where children are, or are suspected of being, at risk.	This matter is now covered by EU legislation.
We recommend that any authority where it knows that a family whose children are, or are suspected of being, at risk has moved to another area, take all steps to ascertain the family's new address and to provide the equivalent authority in the new area with all relevant information. This should include the extent to which the family was known to the services in the former area and their motivation for moving, where known.	*Children First* addressed this. However, the problem of slow transfer of public health nursing records was highlighted in the Monageer Report.
We recommend that the receiving authority adopt a proactive approach in seeking information on any family which has recently moved into its area in relation to whom an allegation or referral is made.	*Children First* addressed this.
We recommend that a national agreed standard and format be established by the eight regional health boards for the transfer of information from one board to another.	Addressed by *Children First*.
We recommend that health boards support in principle and facilitate where necessary relevant staff from two or more authorities meeting, even where this involves travel to another jurisdiction.	Health boards operated separately at the time, so it is not possible to say how far this was implemented or whether policies changed.
We also believe that it should be possible to establish national standards with regard to the structure of child protection files. In particular, we recommend the adoption of a standardised case summary sheet similar to the format used in the chronology included in this report. This should be located at the front of all files, should include details of family history and be continuously updated with factual summaries of new information and events.	*Children First* addressed this and it had already been addressed at a local level following the report.
We recommend that all allegations be recorded on a special colour-coded form to be used for this purpose by all disciplines in all health boards.	*Children First* contained a standard reporting form and stipulated that all allegations should be investigated urgently.
We recommend that where a completed investigation indicates that a child is indeed 'at risk', his/her name should be entered on an 'At Risk' Register. The operational aspects of this Register, including protocols for the registration, maintenance and removal of a name, should be enunciated by the Department of Health following consultation with the health boards, voluntary organisations and other interested parties.	The Child Protection Notification System was developed as part of *Children First*, but was not implemented consistently on a national basis (OMCYA, 2008).
We recommend that the Western Health Board assess the current level of knowledge and compliance of staff with the Department of Health Guidelines and establish and address reasons for non-compliance.	Addressed in *Children First* training from 2001 onwards.
We recommend that the Western Health Board ensure that all of its child protection staff are aware of the importance of assessment and that all relevant staff receive training in the identification of abuse, including indices of abuse, and in risk assessment.	Addressed by *Children First* training from 2001 onwards.
We recommend that in each case the Western Health Board develop a plan of intervention based on its assessment of the risk involved to the child.	Addressed by *Children First*.

continued

Report recommendations	Implementation
We recommend that the Western Health Board take all necessary steps to ensure that the arrangements for the holding of case conferences be substantially overhauled and that appropriate training be provided to relevant staff to ensure that the case conference becomes a significantly more effective element of the Board's child protection strategies.	The researchers were informed that this was addressed locally and implemented.
We recommend that the Western Health Board clarify the status of legal advice given at case conferences and whether any such advice which indicates that a Court application will not be successful should be followed in every case, irrespective of the views of relevant staff.	Implemented locally at the time.
We recommend that a key worker be appointed in each case and that all those with an involvement in the case are aware of the key worker's identity and share information with him/her.	Addressed by *Children First*.
We recommend that the Western Health Board, in the interests of strengthening collaboration between agencies in support of the child protection function, give serious consideration to reversing its policy of requesting representatives of other agencies to leave case conferences once they have given their report.	Addressed by Child Protection Conference Protocol in *Children First*.
We recommend that a comprehensive training programme be developed in consultation with staff to include, inter alia, assessment; dynamics of abusing families; case conference management; roles, etc., corporate responsibilities under the Child Care Act 1991; team development; the psychology of inter-disciplinary and inter-agency collaboration; communication – its dynamics and processes; investigative techniques.	Training departments were established in all the health board areas to undertake *Children First* training, which should have covered these matters.
We recommend that the Department of Health explore the development of a modular approach to the expansion of child protection training.	Not implemented. Training was managed by health boards.
We recommend that the Western Health Board take the steps necessary to ensure an adequate level of administrative support to child protection staff.	Addressed at local level at the time.
We recommend that the Western Health Board ensures that all professional staff remain accountable for appropriate administrative tasks, such as the writing, signing and dating of case notes.	This was addressed by *Children First*.
We recommend that the development of child protection services be matched by the provision of appropriate accommodation and facilities.	Addressed at local level, with extra resources provided to implement the Child Care Act 1991.
We recommend that responsibility for communicating health board child protection policy and provision to schools should be one of the responsibilities of the new post of Child Care Manager in each community care area.	Not possible to establish if this was implemented since Child Care Managers worked independently in local areas.
We recommend that each school nominate a teacher to develop special expertise in the identification of child abuse and neglect, and function as its liaison officer with local health board staff. Special joint in-service training programmes should be provided and this will assist in developing collaborative relationships locally.	Addressed by requirement in *Children First* for Designated Liaison Persons.

continued

Report recommendations	Implementation
We recommend the development by the Department of Education of a new sex education and life-skills curriculum for primary and post-primary school students, which should address issues of child abuse and neglect. In-service training for teachers of this curriculum should include the development of skills in identifying and facilitating pupils who wish to make a disclosure.	The Social, Personal and Health Education (SPHE) Programme was instituted in schools.
We recommend that the Western Health Board initiate a process to consider all aspects of inter-disciplinary and inter-agency communication and collaboration involving staff from each discipline and agency.	Addressed at local level. Data from interviews suggest that it was a difficult process.
We recommend that the Western Health Board investigate measures used in other employments to provide support to workers who may experience trauma in the conduct of their professional duties.	Occupational health services were established. It is not clear if this was in response to the recommendation.

West of Ireland Farmer Case (West of Ireland Farmer Report, Bruton 1998)	
Report recommendations	**Implementation**
Strategic	
The child protection responsibilities of the Board [North Western Health Board] impose a corporate responsibility which transcends any one discipline, department or programme; hence a multidisciplinary and integrated response is required from all sections and staff of the Board.	Considered to be more of a statement than a recommendation.
Child protection practices operated within the Board should conform to a standard Board policy. A quality assurance programme is essential in developing child protection services and should be a key responsibility of the accountable child protection manager.	It was considered that the appointment of child care managers and a senior researcher provided quality assurance. Ultimately addressed by *Children First*.
The issue of emotional abuse must be systematically addressed through appropriate training, assessment and operational procedures.	Training on this topic was developed at the time by two Children's Services Officers who were specially appointed to address issues raised by the inquiry. It was continued through *Children First* training.
Where there is no formal out-of-hours arrangement for dealing with child protection cases, the necessary steps to formalise an out-of-hours service should be taken and these arrangements notified to relevant hospital, community and Garda personnel.	Not implemented.
The Board should develop a strategy which enables information to be shared with school staff in relation to the contribution which they can make in identifying and monitoring children at risk.	As above, training developed at the time to address this. It was noted that by 2003 not all schools had appointed designated teachers and sharing of information was on a case-by-case basis.
The Board should develop a policy clearly stating the nature of the services which it will provide for adult survivors of sexual abuse.	A regional counselling service was established in 2001 as part of the National Counselling Service.
The considerations of safety and personal protection for Board staff, who may be subjected to actual or threatened abuse while pursuing their duties as officers of the Board, should be addressed at a policy level by the Board in the context of its child protection responsibilities and the corporate responsibilities it has as an employer under health and safety legislation.	An Occupational Health Unit was established. All services were required to develop safety statements and anger management courses were organised regionally for staff.
The review of national guidelines, now being undertaken by the Department of Health, should take the opportunity to provide a national perspective on the classification of cases, definitions on assessment of risk, accountability in relation to decision-making and defining the gold standards of good practice by which services and outcomes can be evaluated.	Addressed by *Children First*.
Management	
Assignment of the operational medical officer of health functions in regard to child abuse, and necessary steps to ensure the medical exchange of information between doctors. [Follows the abolition of the posts of DCC and Medical Officer of Health]	Principal Social Workers in the region were given this responsibility and it was incorporated into the North Western Health Board's guidelines.

continued

Report recommendations	Implementation
The Board should satisfy itself as to the specific responsibilities that it can assign under existing legislation or under the Child Care Act 1991 to personnel who are not its direct employees.	Addressed by *Children First* and *Our Duty to Care*. Voluntary organisations and GPs were involved in *Children First* training, The health board GP unit was involved in discussions.
Maintain the practice of actively seeking legal advice and involvement of the Board's legal advisor in case conferences.	Continued and role of legal advisor clarified.
Specific policies as to the role of the child psychiatric team in the sphere of sexual and emotional abuse in particular are required and must be communicated fully to all relevant staff.	The Child and Adolescent Mental Health Services (CAMHS) were expanded and a service for adolescents involved in sexual behaviour was set up. *Children First* addressed the issue of responsibility. CAMHS still regarded as 'outside the sphere' of child protection.
If necessary, appropriate statutory protection should be provided where non-Health Board staff are enjoined in assisting the Board discharge its statutory duties.	This was considered to have been addressed through service agreements that incorporated compliance with *Children First* and *Our Duty to Care*, and also covered by the Protection for Persons Reporting Child Abuse Act 1998.
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 convening a case conference should have access to all previous information on contacts with the child or children's family, especially previous case conference notes. This will require adequate secretarial and data retrieval facilities being readily available.	Addressed by *Children First* and subsequent training.
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 for not doing so should be recorded and circulated to appropriate personnel.	Addressed by *Children First* and local policies on closer collaboration with hospitals. A progress report from 2003 indicated that several projects had been set up in the Board area to improve the information system and develop a strategy for information-sharing. The continuing lack of a coherent system for collecting information on medical contacts for each case was noted in the report.
There is a need to have appropriate and systematic medical input into decision-making regarding children at risk. The general practitioner has a key role and if his/her attendance at a case conference is not possible, alternative methods of consultation with the GP must be found to ensure a comprehensive assessment monitoring and plan of action.	Efforts were made to implement this which were generally successful, but difficulties remained in certain parts of the area.
Legal	
The right to interview and/or medically examine a child who is not in care, in school or elsewhere, without parental consent, remains unresolved and requires proper legal structures.	Addressed by *Children First*.

continued

Report recommendations	Implementation
Notwithstanding the improvements in legislation, there are still issues to be resolved relating to the rights of children, the rights of professionals to interview children without parents present and the sharing of information between professionals.	Addressed by *Children First*.
Monitoring	
In situations where staff are alerted to a possible situation of a child being at risk and refused access to a child, all other strategies for monitoring children, for example, through school, should be explored as a matter of policy.	Addressed by *Children First*. The Child Protection Notification System was considered to be the appropriate mechanism.
In all cases where the Board is exercising statutory responsibilities, it is essential that specific monitoring arrangements are installed, managed and regularly evaluated.	Addressed by *Children First*.
A review system should be established between the hospital and community settings to ensure that the totality of contacts by children aged under 18 years deemed to be at risk are collated and monitored to ensure regular review and actions as required. This could be undertaken by a delegated person who would formally report on all such contacts to the relevant clinician and the proposed accountable child protection manager. Detailed clinical information on these contacts could then be requested through reports to a case conference by the accountable manager or designated medical officer so that decisions can be made and action taken.	Specific protocols were put in place in the local area and have been maintained.
The review group recommend that where any child is taken into care, either on a voluntary or a statutory basis, that immediate monitoring and support is given to the remaining siblings at home.	Addressed by *Children First* and by training in response to the report.
In providing a Board response to allegations of child abuse, it should be standard policy to undertake a multidisciplinary overview, especially where there are other children in the family.	Addressed by *Children First* and particularly by the Child Protection Notification System. Problems were experienced in some parts of the local area in getting GPs to attend child protection conferences.
Information	
All field staff must make contemporaneous notes of their contacts with service users. It would be desirable to have modern recording systems made available by the Board with appropriate clerical support, especially in cases where the Board is exercising statutory responsibilities.	Addressed by *Children First* and local administration. The Public Health department instigated a project on sharing information. The 2003 progress report indicated that the use of computers had increased.
The linkages within a hospital, and between hospitals, need to be developed to ensure that the indices of suspicion, as regards non-accidental injury, operate smoothly, particularly within a casualty department. The new appointment of a full-time accident and emergency consultant within this department presents an ideal opportunity to review the operational systems and linkages that are necessary to provide an appropriate organisational response to children at risk.	This was comprehensively addressed in the local area.

continued

Report recommendations	Implementation
The establishment of appropriate hospital record systems that can readily identify repeat visits by those under 18 years of age, especially from families where there is already suspicion of an at risk situation, is required. Access to, and managing this information is a critical phase.	Addressed locally by the appointment of a dedicated nurse in Letterkenny Hospital to screen frequent admissions to the Emergency Department. The Principal Social Worker is informed of frequent admissions.
An effective system of circulating child protection guidelines and procedures, within and without the Board, should be established and form part of the quality assurance programme.	Addressed by the local *Children First* team.
The concept of confidentiality should be positively stated by the Board in clear operational terms such that professionals from different backgrounds have a common framework for the sharing of information on child protection issues.	Clarified in *Children First*.
The new standard procedures for the notification of suspected cases of child abuse between health boards and Gardaí, published by the Department of Health in April 1995, must be actively implemented. The development of strong managerial and operational links with the Gardaí which have been initiated by the Board are essential and must be maintained in the future.	This was addressed by *Children First* and was considered to be operating well in 2003.
Services	
We recommend that counselling services acceptable to the children in this case should be funded by the Board.	Implemented locally.
The Board should develop a framework to provide support in a manner which the family will find acceptable.	Implemented locally.
Training	
Training for Board staff, GPs and school teachers to enable them acquire the skills and knowledge necessary to deal appropriately with child abuse should be regularly reviewed, monitored and provided as necessary. Training in the chairing of case conferences is an example of such specific training.	Training programmes were established locally and expanded. The 2003 report noted that attempts to include GPs in training had not met with much success to date.
The Board in providing training should also ensure that GPs and other non-Health Board staff, such as school teachers, are skilled in appropriate aspects of identifying, reporting, monitoring and supporting children at risk.	Training was developed locally at the time, which included schools. The North Western Health Board's training team liaised with the Department of Education in respect of local teacher education courses.
In its role as promoter of child welfare, the Board has a responsibility to ensure that all healthcare staff recognise and explore situations in which adults presenting with problems may also signal the possibility of risk for children.	Addressed by *Children First* training, which at the time incorporated domestic violence and its implications for children.

Monageer Inquiry (Monageer Report, Brosnan, 2009)

Report recommendations	Implementation
Out-of-hours social work service	
The provision of a national out-of-hours social work service structured and resourced to ensure an appropriate response to all serious child protection and welfare concerns.	Out-of-hours services have been piloted and evaluated in two areas. It is planned to implement the service nationally during 2013.
An Garda Síochána and the protection of children	
Where a member of An Garda Síochána receives a report and has reasonable grounds for believing there is an immediate and serious risk to the health and welfare of the child, he/she should take immediate action in order to ensure the safety of the child and where necessary invoke Section 12 of the Child Care Act 1991. Where a member of An Garda Síochána receives information concerning the safety and welfare of a child, he/she should immediately bring the matter to the attention of their line manager. Where a member of An Garda Síochána receives information concerning the safety and welfare of a child, such information should be brought to the attention of the HSE social work service as soon as possible and in appropriate circumstances to members of the child's extended family. Where a tragedy has occurred, particularly in the case of a fatality, the senior Garda officer at the scene should ensure that on discovery of body/bodies, the next of kin are identified and informed as soon as possible.	All these recommendations have been addressed, firstly, through Section 7 of the Childcare (Amendment) Act 2011, which gives Gardaí extra powers under Section 12 of the Child Care Act 1991; secondly, through the establishment of the post of Family Liaison Officer; and thirdly, a new programme of joint Garda/HSE training, which references findings from the report and relates them to practice.
Early identification of children at risk and vulnerable families	
The public health nursing system currently in place should be reviewed in order to ensure that a high standard of service is provided and that resources are directed at those children who are in greatest need. Where a public health nurse recognises delayed developmental milestones, disability and any other issue of concern, a referral should be made in respect of the provision of appropriate family support services regardless as to whether those services currently exist or not. It is important that children are identified as requiring services as early as possible. Where vulnerable families with young children move home, immediate steps should be taken by the public health nursing service to identify their new address. Failure to identify the new address of such families should be brought to the attention of their line managers.	All recommendations in respect of nursing have been implemented locally, but not all the new measures taken have been introduced nationally at this point. A national review of public health nursing (PHN) was planned for 2010, but has not yet taken place. A review of local PHN services in Wexford had been conducted in 2008 following the Monageer incident, but prior to the report's publication. Following the local review, a number of Management Operating Procedures and Standard Operating Procedures were introduced in the area. These included procedures for referral to an Area Medical Officer if a child is not reaching developmental milestones and referral to a specialist PHN and multi-disciplinary team. It also included record-keeping and transfer of records when a family moves. It has been noted that some PHN posts are vacant, which means that new policies cannot be implemented in certain areas. A framework for the assessment of vulnerable children has been introduced in parts of Dublin Mid-Leinster and there are plans to implement it nationally.

continued

Report recommendations	Implementation
The early identification of children with complex developmental needs is crucial to the individual child's potential development. The role of the early intervention team is central to this approach. The service provided by the early intervention team should be standardised throughout the country.	Recommendations in respect of early intervention have been addressed locally through the appointment of a local project worker. A national change programme, which aims to standardise the approach, is ongoing.
A coordinator should be identified for each early intervention team. This person should take responsibility for the collection and dissemination of all relevant information concerning the child/family and monitor and report on the delivery of the different professional services to the early intervention team.	A coordinating group has been introduced as part of the change programme, as well as local implementation groups, which are led by a team manager/coordinator. Not all teams are integrated as yet because disability services in each area have a different history and are therefore at different stages of forming plans and restructuring services. There will not be a clinical coordinator.
Protocols regarding the transfer of records when a family moves to a new address outside their area of responsibility should be strictly adhered to by public health nurses and other professionals as necessary.	A protocol on transfer of records has been implemented in Wexford to deal with this, but not nationally as yet.
Accurate and contemporaneous records should always be kept by all health professionals, including doctors, nurses and social workers. Records should be dated and signed, and should include details of all contacts, consultations and actions taken.	A document was produced by the HSE in 2011 (HSE, 2011c) and is available on the HSE website. It recommended practices for healthcare records management. However, it does not reference the Monageer Report and it is not known how extensively these practices has been implemented nationally.
To ensure that accurate information is shared, an index of all children and families who are being provided with services by the different disciplines within the HSE should be established and maintained.	No shared index has yet been developed; permission has not been received from the Department of Finance to progress it.
Medical specialists should provide updates in respect of children receiving treatment to family GPs and local Directors of public health nursing at intervals no greater than yearly.	The HSE was unable to determine if progress has been made on implementing this recommendation.
XXXXXXXXXXXXXXXXXXXX	
[All 7 recommendations in the next section are redacted.]	
Review of management structures	
The HSE should review its management structures in respect of the child care manager post, social work staff, public health nursing staff and staff of the early intervention team. Absolute clarity of these roles is required to ensure the highest level of professional practice. The head of each discipline should be responsible for the management and professional practice of their team and should undertake regular audits in this regard.	A review of social work management structures was conducted shortly after the publication of the report and changes have been implemented. A proposed review of public health nursing did not take place. A change programme on disability services has been initiated and restructuring is underway.
Professional working with children in State agencies and agencies supported by the State must be absolutely clear regarding their individual responsibility for any duty of care owed to families to whom they are offering services. Responsibilities must be set out clearly in job descriptions and reviewed annually by line managers as part of a performance review and in accordance with best practice.	The Task Force appointed in 2009 to look at arrangements for a Children and Family Support Agency clarified the relevant professional roles. This has been further elaborated in the HSE *Child Protection and Welfare Practice Handbook* (2011). It has not been possible to ascertain if duty of care responsibilities are set out in all the job descriptions of professionals working with children in State and State-funded agencies, nor whether they are reviewed annually.

continued

Report recommendations	Implementation
Training	
Relevant in-service training should be provided to all relevant staff, including nurses, social workers, doctors and Gardaí. Such training should include child protection and mental health issues. Such training should also include encouraging the self-assurance to question as appropriate the opinion/judgement of other professionals/more senior professionals. Inter-disciplinary and inter-agency training should be provided on a regular basis.	A national training strategy is being developed with the intention of standardising training. A second round of joint Garda/HSE training is being delivered currently and some *Children First* training includes doctors. Training of hospital staff is arranged locally. The term 'doctor' in the recommendation is non-specific and it is not possible to ascertain if the recommendation has been addressed as intended. According to information received by the researchers, the issue of self-assurance to question the opinion of others is not specifically covered in training, but is considered to be integral to most courses.
Familicide	
The inquiry team note the increased incidence of familicide both nationally and internationally and believe that this area needs to be carefully reviewed.	A guidance document had already been commissioned by the HSE in 2008 and produced by the National Office for Suicide Prevention. It was designed as a planning tool to prepare a response to events such as suicide clusters. It was published in 2011 and references the Monageer Report.

Roscommon Child Care Case (Roscommon Report, Gibbons, 2010)	
Report recommendations	**Implementation**
Organisational change	
It is recommended that the post of national director for child and family services be supported by a clinical team (professionally qualified and experienced social workers and other suitably qualified staff) to drive and support practice in child welfare and protection services and ensure that national standards are set, monitored and delivered.	The National Office was established in 2010 and a team has been appointed.
Policy change	
It is recommended that the HSE ensure that all appropriate policies and procedures are compliant with the requirements of the United Nations Convention on the Rights of the Child for children to be heard in all matters that concern them. This should include all stages in the child welfare and protection system, from the initial assessment stage where a child's welfare and protection are being considered.	The recommendation on compliance with the UN Convention on the Rights of the Child has not been implemented nationally as yet. Standard Business Processes covering all stages of child protection and welfare have been implemented.
Victim impact statements	
It is recommended that the HSE engage with the Office of the Director of Public Prosecutions to determine how best the identities and personal information of children involved in child protection cases can be better protected, particularly where victim impact statements are supplied in relation to criminal cases.	This has not yet been implemented nationally.
Guidance should be issued to HSE staff regarding the preparation and presentation of victim impact statements, and the rights of children in care to privacy.	This has not yet been implemented nationally.
Quality-assuring the child welfare and protection system	
It is recommended that: The HSE should develop and implement a national policy of audit and review of neglect cases. An audit of current practice of chronic neglect cases should be undertaken in County Roscommon in the first instance. Experienced senior practitioners from another HSE area, undertaking practice audits within an agreed national audit of practice framework, could identify cases where drift rather than active planning and management had occurred and recommend any appropriate changes. It would identify best practice models for dealing with these cases and develop national standards to guide practice in these cases.	This has been partially addressed by conducting audits in three areas, but not nationally. It has been decided not to extend the audit to all areas, but the methodology is to be disseminated nationally.
The Q-mark should be relinquished and replaced with a nationally appropriate quality assurance system that considers the practice issues as well as the technical aspects of each case.	This has been addressed. A Director of Quality has been appointed in Children and Family Services. HIQA is inspecting child protection services nationally against the HIQA Child Protection Standards published in 2012. The Q mark has been relinquished. A number of other methods are in operation, including monthly *Measuring the Pressure* returns.

continued

Report recommendations	Implementation
The procedures that are in place in the HSE for the reporting up of escalating risks and cases of public importance should be reviewed to ensure they are fully understood and that they are applicable in the wide range of possible situations that arise across child welfare and protection work.	Children and Family Services are now included under the HSE National Incident Management Policy and a separate process is planned for the Child and Family Agency. The National Review Panel has been established.
Court process	
The HSE should take steps to ensure that specialist legal services in child care matters are available at all times. Law agents/legal advisors should be consulted, and their views elicited, regarding any possible legal remedies at an early stage, when there are serious concerns around child welfare and protection. The likelihood of success should not be used as a criterion for determining whether or not relevant and appropriate legal remedies should be pursued. Where a legal matter arises in a case that is unfamiliar to personnel involved, it is recommended that a wider consultation process is undertaken within the HSE to ensure the experience of colleagues who have dealt with similar matters is considered.	Children and Family Services have appointed their own legal advisor and a national procurement process for legal services has taken place. A legal advisor is based in the National Office and provides consultation to staff in addition to the contracted legal firms. It is not possible for this study to discern whether the likelihood of success is used as a criterion for pursuing legal remedies.
Practice	
Staff roles	
Greater clarity should be articulated on the roles of each staff member in cases where there are child protection concerns, so that everyone is clear on the exact concerns for each child and understands their role both in terms of their professional expertise but also as part of the team working together on each case. Each person visiting the home should be clear on the outcomes established for each case. Involved professionals who never/seldom attend conferences or reviews should be communicated with on an ongoing basis and it should be agreed who has responsibility for doing so. 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. 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.	The HSE published its *Child Protection and Welfare Practice Handbook* in 2011 (shortly after the revised edition of *Children First* was published) and addressed the practice issues raised. It is not possible for this research to determine how far these recommended practices have been implemented. The HSE West audit by the Quality and Patient Safety Directorate (2013) found that, in most cases, the recommendations had been implemented in the West.
Assessment	
It is recommended that a national common assessment framework be introduced without delay for all child welfare and protection cases. The framework needs to identify core components while allowing for flexibility. It is recognised that any such framework will need to be reviewed and updated as knowledge and practice develops and changes.	A framework for initial assessment has been included in the Standard Business Processes. A national framework for further assessment has not yet been produced.

continued

Report recommendations	Implementation
Home visits	
It is recommended that: Where there are ongoing concerns of child neglect, as in this case, the appropriate frequency of home visits by the family social worker should be agreed and carried through. All workers should be clear about the purpose of each home visit and all staff should be alert to parents or guardians constantly guiding the conversation away from the welfare of the children and on to practical issues. Home visits should include observing hygiene, warmth, provision of food and clothing for each child in cases where these are identified as a deficit for the children involved. It should also include general observations on the well-being of each child. Those observations should be recorded by each discipline and shared with other disciplines. Care should be taken to work with both parents and in particular workers should be proactive in seeking to engage fathers.	This is addressed in the HSE *Child Protection and Welfare Practice Handbook*. The HSE West audit found partial implementation of the recommendations relating to documenting the frequency and purpose of home visits. The audit team found sufficient evidence of implementation of recommendations in relation to observations made on home visits and working with fathers. It was not possible for this research to ascertain whether the recommendations had been implemented nationally.
Chronic neglect	
It is recommended that: › 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. › The case management plan should include how progress on each key element in these chronic neglect cases is to be measured. › 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 is guiding the work for the child and family. 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. 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.	These recommendations were addressed in the HSE *Child Protection and Welfare Practice Handbook*. The HSE West audit found sufficient evidence of implementation of recommendations relating to child protection plans; partial evidence of implementation of recommendations relating to alternative plans; and insufficient evidence of implementation of recommendations relating to outcomes measurement. It was not possible for this research to ascertain whether the recommendations had been implemented nationally. The HSE West audit found that this had been implemented in the region. The extent of national implementation is not known at this point.
Concerns of relatives and others	
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 *Children First* as revised.	Addressed in the HSE *Child Protection and Welfare Practice Handbook*. The HSE West audit found sufficient evidence of implementation in the region. The extent of national implementation is not known.

continued

Report recommendations	Implementation
Working with parents	
It is recommended that the views of parents should be taken into account and checked against the facts and the views of concerned others. It is recommended that all personnel be alert to parents and carers who consistently try to divert attention away from the primary concern with the well-being of the children.	Addressed in the HSE *Child Protection and Welfare Practice Handbook*. The HSE West audit found partial evidence of implementation of the recommendations; they appear to be implemented in Children and Family Services, but not to the same degree in ISA services. The degree of national implementation is not known.
Attachment	
All staff involved in child protection and welfare work should be knowledgeable about, and alert to, attachment theory and test their assumptions in supervision.	Addressed in the HSE *Child Protection and Welfare Practice Handbook*. The HSE West audit found insufficient evidence of implementation. The degree of national implementation is not known.
Development of services	
A system should be devised and implemented for the equitable distribution of HSE resources based on assessed need. This system should be agreed and communicated to relevant managers and staff.	Researchers were informed that a resource allocation model has been introduced.
A targeted family support service aimed at working with families with young children should be developed for this part of County Roscommon. Any model introduced needs to be appropriate to a rural/town setting. It is of course acknowledged that any such service must work actively with families, communities and local services. Some elements of services already in the area could be subsumed into such a service.	This has been implemented locally.
There should be full involvement of the HSE Speech and Language Department in the development of support and treatment services for children and families where this is an issue for children's well-being. All systems should be organised in a way that maximises the possibility of children getting the services they require.	Speech and language therapists are named in the HSE *Child Protection and Welfare Practice Handbook*, but their role is not elaborated upon. The HSE West audit found evidence of partial implementation of this recommendation. There is no evidence of whether this recommendation has been implemented nationally.
Within the context of the development of such a service, there should be a review of the effectiveness of the Home Management Service in respect of working with families where chronic neglect is an identified issue.	This was addressed in the West, but not nationally.
A specialised Child Sexual Abuse Unit or Team should be put in place in each HSE region to build up expertise and experience in assessment and to act as a centre of excellence when frontline workers require advice. Therapeutic treatment services must also be available for children who have been sexually abused.	This has been addressed. A plan to standardise existing child sexual abuse assessment services nationally was initiated in response to the Ferns Inquiry.

continued

Management	
Staff management	
Accredited management training should be provided to all new managers who are managing frontline health and social services staff.	This has been addressed and training has been provided to some, but not all new managers nationally.
Managers providing supervision to staff should receive training in supervision theory and practice.	This has been addressed by the implementation of a revised supervision policy in 2013.
Systems should be in place for supervisors to review and sign case files, and to endorse or disapprove actions being taken.	As above.
Systems should be in place for senior professional managers at local/regional level to quality assure the overall child protection and welfare system.	This has been addressed by the implementation of policies, e.g. Measuring the Pressure, Supervision.
Management, in order to fulfil their role, needs to have available the necessary resources in terms of appropriate offices, clerical support, computers, etc. for every member of staff to allow the work of the department to function to an optimum level.	It has not been possible to ascertain if this has been implemented.
Decision-making	
The HSE should ensure that, as the revised *Children First* Guidelines are implemented locally, all systems of decision-making are well linked and provide for the decisions to be fully carried through and reviewed for effectiveness.	This is addressed by the national implementation of *Children First* and the HSE West audit found that the recommendation had been fully implemented in the region.
The Chair of case conferences should be trained for, and alert to, the demands of this role. This includes interrogating the facts and opinions presented at case conferences and reviews. It also includes reviewing cases where numerous case conferences are held on a child/family where the same issues are repeated from case conference to case conference, with little evidence of change. The Chair should also ensure that the voice of the child is heard at all case conferences and that their welfare and safety are paramount. The purpose of each case conference and review should be clear and where it is proposed that a course of action agreed by a case conference should be changed, the case conference group should be reconvened to agree the new course of action as soon as possible. The record of each case conference should be clear and easily accessible, with a clear record of those invited, those attending and those providing an apology. The minutes of each case conference should be approved by the Chair and contain a clear plan, with responsibility for each task assigned and the plan for how each assigned task is to be monitored should be outlined. The review meeting should be alerted when the agreed outcomes are not achieved and alternative action should be undertaken. The minutes should go to all those invited to the case conference, including those unable to attend. Standardised file recording and file management systems should be devised and introduced. It should be clear what records are specific to each case and the case file should be complete. The decision reached and guidance given at staff supervision in respect of individual cases should be recorded on the file.	These recommendations have been addressed by the development of a new Child Protection Conference Protocol, soon to be finalised. The HSE West audit found that the recommendation had been partially implemented and a standardised approach was required.
The nature of Public Health Nursing records in respect of children where there are child protection concerns should be reviewed to ensure their adequacy.	This has not been implemented nationally.

continued

Staffing	
A human resource recruitment and retention plan should be developed and implemented.	A recruitment campaign was conducted in 2011. There is a current pause on recruitment. A study was commissioned and conducted on staff retention, but it is unclear if any of its recommendations were implemented.
Systems should be in place to ensure that anyone employed in the area of child welfare and protection is accredited and is competent to undertake the work.	Accreditation and competence have been addressed by the registration requirements for social care workers.
A standardised supervision system should be implemented and sustained.	All the recommendations on supervision were addressed by the development of a (revised) supervision policy circulated in 2013.
Supervision of frontline staff should be no less than monthly and may need to be more frequent for new and inexperienced staff.	
Newly qualified workers should have a protected caseload and receive additional supervision and support.	This has been addressed in some areas, but may not have been implemented nationally.
Although it is difficult to be entirely prescriptive in relation to caseload size, it is recommended that attention is paid to caseloads so that each worker can function fully and work proactively with every case for which they have responsibility.	According to the information provided, this has been addressed in some areas, but may not have been consistently implemented nationally.
Procedures for job-sharing should be in place to ensure that such jobs are actually shared and that cover is available at all times, particularly in key management positions.	No measures have been taken nationally to implement this.
Staff welfare should be a corporate responsibility, reflected in policies and procedures that value, respect and support the individual worker.	A staff welfare system is in place. It has not been specifically implemented from the recommendations.
Debriefing arrangements should be put in place as an option for all staff exposed to personal or vicarious trauma.	
Continuous professional development	
Learning from other case reviews, legal cases and judgements, and emerging practice initiatives should be systematically embedded into practice, through multi-disciplinary training and opportunities for professional reflection.	These recommendations are being addressed by the Workforce Development Programme, which is standardising training nationally and has developed detailed work plans. The inquiry recommendations have been a specific focus of training in HSE West, although not nationally at this point. The HSE West audit found partial evidence that the recommendations were implemented there.
A training needs analysis should be periodically undertaken with staff and relevant training put in place.	The researchers were told that local need and the skill set of local trainers are still determining factors and not all the issues within the recommendations have been covered in each area. Issues such as worker assertiveness are generally more implicit than explicit. Training is available to a certain proportion of staff and is subject to financial restraints.
Specific training should be regularly delivered on child care legislation, national strategy and policy, and developing international best practice.	
Other areas where training should be considered depending on assessed need could include assessment, abuse and neglect, involuntary and resistant clients, worker assertiveness and authority.	
In addition in this case the following issues were also identified where additional training could have supported the work of the frontline staff: new developments and understanding of attachment theory, drug and alcohol dependency and in particular its effects on parenting, and working directly with children. Particular attention should be given to report writing and the need to evidence opinions provided in reports.	
Management development training for first and second line managers.	

Appendix 2: Members of the Research Advisory Committee for this study

Michele Clarke	Social Work and Child Care Specialist, Department of Children and Youth Affairs (DCYA)
Annie Callanan	Head of Quality, Children and Family Services, Health Service Executive (HSE)
Vick Blomfield	Regional Operations Manager, Health and Information Quality Authority (HIQA)
Maria Corbett	Legal and Policy Director and Deputy Chief Executive, Children's Rights Alliance (CRA)
Dr. Paula Mayock	Children's Research Centre and School of Social Work and Social Policy, Trinity College, Dublin (TCD)
Dr. Eoin O'Sullivan	School of Social Work and Social Policy, Trinity College, Dublin (TCD)

Appendix 3: Consent Form

Interview Consent Form

School of Social Work and Social Policy

Please read the statements below and tick in the right hand column to confirm your agreement.

I confirm that I have been provided with and have read an Information sheet which explains the purpose of this research and that I understand my role in the research.	
I confirm that I have voluntarily agreed to be interviewed.	
I understand that I may withdraw from the interview at any time, for any reason, without penalty.	
I understand that I can choose not to answer particular questions.	
I understand that an audio recording of the interview will be made and I consent to the audio recording of the interview.	
I understand that I will not be identified by name if the information I provide is used in oral or written reports.	
I understand that I can request a copy of the interview transcript.	
I understand that the audio recording and interview transcripts will be stored securely.	
I understand that audio recordings of interviews will be deleted when they have been transcribed and verified and that interview transcripts will not be retained for more than three years.	
I understand that I may seek additional information regarding the research from the researcher.	

Signed: _____

Print name: _____

Date: _____

Appendix 4: Research Information Sheet

Research Information Sheet

School of Social Work and Social Policy

This research project is examining the recommendations in a number of specific child abuse inquiry reports in Ireland.

The Principal Investigator is Dr. Helen Buckley, School of Social Work and Social Policy, Trinity College Dublin.

The research is funded by the Department of Children and Youth Affairs.

The project will involve documentary research and interviews with 15-20 key informants involved with child protection and welfare policies and practices and inquiries into child protection failings in Ireland over the last two decades. Informants' participation in the research is entirely voluntary and may be withdrawn at any time.

The overall aim of this project is to examine the recommendations of a number of specific Irish child abuse inquiry reports, ascertain the degree to which they were implemented in the context of concurrent reforms and to develop a strategy to improve the relevance and achievability of recommendations in future reports.

The information generated by this research will contribute to a report to the Department of Children and Youth Affairs and will also be used for publications and presentations. Direct quotations from interviews will be anonymised and will only be included in reports with the prior consent of interviewees. Information provided by informants is confidential and will be only be used in a manner which ensures the identity of informants is protected. Interviews will be recorded with the consent of informants. Audio recordings of interviews will be destroyed on completion and verification of transcripts. Interview transcripts and interview consent forms will be stored in a secure location and destroyed after three years.

Participant data likely to be generated includes contact details and current and past employment position. Participants have a right under the Freedom of Information Act to access their data at any time. Participant information will be destroyed after the completion of the project.

It is not anticipated that participation in this research will result in participants being at risk. Participants have the opportunity of contributing to a report which may influence future inquiry reports.

Participants who have any further questions at any stage of the research process are very welcome to contact the lead researcher. Dr. Buckley can be contacted at hbuckley@tcd.ie and 01 896 2065.

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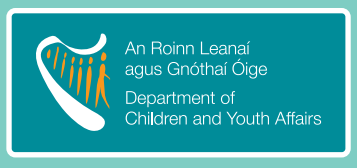

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