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Lessons Learned: Public Health Nurses Practice in Safeguarding Children in the Republic of Ireland

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Abstract

The public health nurses' scope of practice explicitly includes child protection within their role, which places them in a prime position to identify child protection concerns. This role compliments that of other professions and voluntary agencies who work with children. Public health nurses are in a privileged position as they form a relationship with the child's parent(s)/guardian(s) and are able to see the child in its own environment, which many professionals cannot. Child protection in Ireland, while influenced by other countries, has progressed through a distinct pathway that streamlined protocols and procedures. However, despite the above serious failures have occurred in the Irish system, and inquiries over the past 20 years persistently present similar contributing factors, namely, the lack of standardized and comprehensive service responses. Moreover, poor practice is compounded by the lack of recognition of the various interactional processes taking place within and between the different agencies of child protection, leading to psychological barriers in communication. This article will explore the lessons learned for public health nurses practice in safeguarding children in the Republic of Ireland.

Keywords

public health nurse, child protection, Ireland, legislation, safeguarding

Introduction

This article reviews issues pertaining to public health nurses' (PHNs) practice in safeguarding children in Ireland using lessons from child protection reviews, legislative and constitutional reform, and relevant multidisciplinary literature. Child protection is a key global public health issue.¹ Like other countries, Irish child protection inquiries have pointed to weaknesses in statutory systems of protection for children. This has resulted in recommendations from serious case reviews in relation to changes in legislation, constitutional reform, and increased clarity in formal responses to child protection. Within these changes, PHNs are identified as key stakeholders.²⁻⁴

Background

The PHN's scope of practice explicitly includes child protection within the role's remit.^{2,5,6} This places them in a primary position to identify child protection concerns as home visiting generally commences with new births and continues at defined intervals.⁷ The role of PHNs has become more apparent in recent years as the statutory obligations of the Child Care Act⁸ have translated into

practice. Nonetheless, Irish studies identify child protection as a reluctant role^{9,10} where concerns relate to the negative impact of "policing" on PHNs' congenial public image, mirroring similar anxieties in other countries.¹¹⁻¹⁴ Yet Hanafin¹⁵ suggests that the PHN has a role in primary prevention and secondary referral, although she argues that tertiary or ongoing care input is limited in child protection, particularly when monitoring rather than proactive intervention is the reality. However, under the Criminal Justice Act 2006,¹⁶ the issue of reckless endangerment is raised that places a requirement on a person with authority or control over a child not to intentionally or recklessly endanger the child by leaving or placing them in a situation of substantial risk of serious harm. This means that the PHN must take reasonable steps to prevent the above, which alters the balance of the parent-professional relationship. These steps have resulted in a major review in recent years regarding child protection

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due to an increasing societal concern regarding scandals that exposed multiple systematic weaknesses as well as the Criminal Justice Act.¹⁶

The focus of Irish historic inquiries,¹⁷⁻¹⁹ and more recently the *Monageer Inquiry report*²⁰ and the *Roscommon Report*,²¹ has been abuse within the family. However, Ireland has also been forced to acknowledge child abuse in other domains such as institutional abuse,²² clerical abuse,²³ and failures in the state's care of children.²⁴ In particular, the lack of cohesive child and family services was highlighted within health board structures (now Health Service Executive [HSE]), which exacerbated substandard responses to child protection and welfare in Ireland.^{25,26} This article examines the state of current child protection responses in Ireland with particular emphasis on PHNs' practice.

Public Health Nurses

Irish PHNs are registered general nurses, with a minimum of 2 years' post-registration experience who undertake a Graduate Diploma in Public Health Nursing and register as PHNs with the Nursing and Midwifery Board of Ireland.²⁷ PHNs work within a geographical population-based caseload with a focus on preventative and curative activities, although the continued feasibility of such a generalist role has been questioned.²⁸ Caseloads can vary in population number from 650 to 6500,²⁹ and child protection concerns may present a greater responsibility in the context of Ireland's high birth rate, which is the highest in the European Union.³⁰

Child Protection

The UK government³¹ defines child protection as

...the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.³²

This encompasses supporting effective functioning in families to promote each child's development and welfare. In the event that family care and protection of the child/children is inadequate, the State has an explicit responsibility to assume care and deliver appropriate care and services.³²

Child protection in Ireland, while influenced by other countries, has progressed through a distinct pathway that streamlined protocols and procedures.^{33,34} A major part of this streamlining was the introduction of the Child Care Act (1991),⁸ which was followed by policy

guidelines in *Children First*.⁶ Although protecting children is a goal of society, it is not a mechanistic process, and even when responses have been appropriate, child protection issues can still arise.³⁵ Similarly, the bureaucratization of processes assumes an accepting clientele, yet practice experience often presents a different reality leading to challenges.³⁶⁻³⁸ Such increases in the application of both bureaucratic processes and governed practice have an impact on therapeutic relationships.³⁹ Furthermore, this increase in bureaucracy may deskill practitioners and ultimately reduce "real" care of skilled practitioners.^{36,40,41} Despite such cautious commentaries, serious failures have occurred in the Irish system, and inquiries over the past 20 years persistently present similar contributing factors, namely, the lack of standardized and comprehensive service responses. Moreover, poor practice is compounded by the lack of recognition of the various interactional processes taking place within and between the different agencies of child protection leading to the "genesis of psychological barriers to communication,"⁴⁰ which can remain a challenge between social workers and PHNs.¹⁰ However, sharing and recording information are not the only issues, and "the time, space, argumentative flexibility, analytic ability and trusting relationships to make sense of what was being seen and recorded"³⁸ are often lacking in child protection work due to a lack of appropriate knowledge, increased governance, disciplinary siloes, and staff shortages. Mulkeen,⁴² for example, observes that the several Irish inquiries demonstrate that, despite formal services' involvement with the families, serious abuse and fatalities occurred due to inadequate responses. Such findings are echoed in recent cases,^{20,21} which emphasize the need for a radical reform of the child protection system in Ireland. For example, the dysfunctional cohesion of services in the Roscommon case was considered as contributing to the child protection issue, rather than ameliorating it, as staff operated in disciplinary silos.²¹ This echoes the findings of Lord Laming⁴³ in the United Kingdom where risks identified within the system of child protection were considered to greatly contribute to the death of Victoria Climbié. The Laming⁴³ review demonstrated that Victoria was on the child protection register, yet cues regarding risk seen by professionals were not acted in a coordinated way.

Positioning the Child's Voice in Case Management

Many child protection reports point to the silence of the child's voice in case management. In the Roscommon Inquiry, the report notes "prior to their admission to care, the voice of the child is virtually silent."²¹ This is

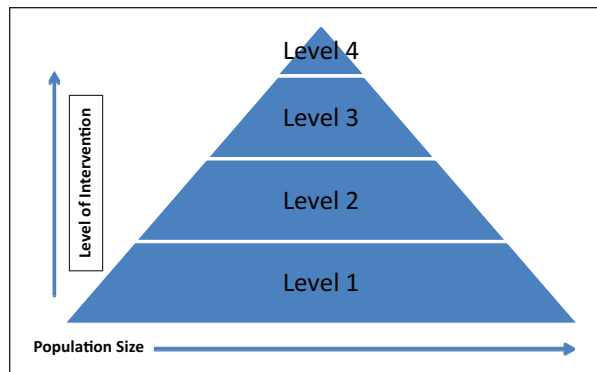


Figure 1. Hardiker et al model.⁴⁵

later reinforced by the child's involvement in the court process.⁴⁴ This silence was justified by a misplaced view held by the professionals that working with the parents would be the singular most important step in protecting the children. This echoes an earlier Irish study by Buckley,⁴⁰ where it was also noted that social workers rarely purposely interacted with the child in safeguarding visits. Such an approach appears to be at odds with policy guidelines,² where the prime focus is that the welfare of the child is paramount and that the views of the child should be taken into account according to age and development. In the Roscommon case, recognition of this major oversight resulted in specific recommendations that case management must include communication with each child and that every case conference should include discussion of the professionals' contact with children.²¹ However, although some advances have occurred in Ireland, additional work is required to enhance the child's voice.⁴⁴

Service Framework

In Ireland and the United Kingdom, the provision of child welfare and protective services is broadly based on the model by Hardiker et al⁴⁵ (Figure 1).

This model is a planning framework for child protection welfare services that match TULSA's (Ireland's Child and Family Support Agency) approach to Irish services. The model demonstrates the increasingly focused services for children with protective and welfare needs. Level 1 includes universal preventative and social development services for all children and also represents community initiatives such as mother and toddler groups or playgroups. Level 2 represents services targeted at children and families who have some additional identified need such as a need in relation to parenting support or welfare support. This level represents a referral to a specific service and parental consent

in service provision. Level 3 represents where children have demonstrated a more serious need and require interdisciplinary support. Within this level, children generally enter formal child protection case inquiries. Level 4 represents where the family context for the child has either temporarily or permanently broken down and the State assumes care. This level can include children who are incarcerated and children who are inpatients due to mental health challenges or disability.

Components of Assessment

The PHN's knowledge of child development processes, parenting, and family assessment are also prominent factors in both preventing and ameliorating child protection concerns. One of the fundamental findings in the Monageer²⁰ and Roscommon²¹ cases was the need to examine parenting and child-parent interactions.⁴⁶ The multiple dimensions of a child's life need to be considered in the context of how such disadvantages cohere in reality and impact on the child's health and well-being. In such an assessment, the child should be viewed within his/her ecological system (development, interconnections, role, and self-identity within in the family and the interconnections both with meaningful others and within the community), reflecting a nested structure.⁴⁷ Therefore, the use of mapping exercises by PHNs, such as genograms and ecograms, can visually represent interconnections and stimulate discussions of child, family, and community relationships. Due to the wealth of considerable knowledge of PHNs regarding parenting and family assessment, they are well placed to address child protection concerns. Furthermore, undertaking activities, such as sharing information, the mobilization of supportive networks, or even simply listening to parents and children, constitute important strategies to prevent families entering the vulnerable or risk group. PHNs are also in a position to consider the gendered nature of child protection and work to enhance the supportive roles of both parents/guardians (if present).^{21,42} For example, dominant male roles have been identified as contextually pertinent in some child protection reviews,^{20,21,38} and the PHN can navigate gender-related issues through a detailed examination of family processes⁴⁸.

In attempting to enumerate the complex factors in a child's life, the Child Assessment Framework as proposed by the Department of Health et al⁴⁹ is a useful lens through which to view the child. Using a 3-dimensional approach, issues related to the status and impact of parenting capacity, family and environment factors, and the child's developmental needs can be reviewed with the focus of promoting optimal health and well-being. Recent Irish commentaries²¹ have supported the use of

such a standardized tool, and relevant research has been undertaken in Ireland⁵⁰ resulting in developing uniform PHN assessment in child protection. This has resulted in the standardization of assessment approaches and an increased focus on specific and relevant dimensions of welfare and protection of children.

An important priority of assessment is to identify the challenges, chronology, and context of the child's well-being. Careful assessment encompasses tracking the antecedents that influence the issue of concern. For example, in the Roscommon case,²¹ the impact of alcohol was not sufficiently considered in the context of the effects this had on areas such as parental emotional and practical availability to the children, dysfunctional attachment patterns, and the ability to provide a secure environment for the children.⁵¹ The PHN is well placed to use family history, family theory, and parenting theory to explore the dynamics of the family, which can identify further possible areas of concern and point to responsive care planning.^{36,52} Factors that can impact on a situation may be hidden; for example, Brosnan et al²⁰ refer to the Monageer Inquiry, in which the family had moved house 7 times within a short period of time, missed multiple hospital appointments, and both parents had a history of special needs. The father was also identified as controlling and the children did not have much community interaction, while the mother's family experienced hostility in relation to maintaining contact with the family. Although such factors in isolation may be considered unproblematic, when clustered, risk increased.⁵³ Thus, assessment and subsequent care planning is a dynamic and reflective process, and each interaction with the family may require subtle reorganization of goals in the context of previous history so that care delivery is contemporaneous to actual need.²¹ Essentially, the focus is on whether the service inputs are working to comprehensively effect positive outcomes and influence the ability of the parent(s) to support change and maximize opportunities to improve the child's life-world. Accordingly, the importance of instigating excellent clinical governance systems is central to potentializing outcomes and successful care planning.³⁹

Stage Management by Parents and Guardians

When visiting the home environment, PHNs predominantly communicate with parents/guardians. In child protection cases, home visiting is a complex, negotiated space that involves "bodies, emotions, information and power."³⁶ Rather than a dominant focus on the protection of the child being paramount, there may be a metaphorical "tango," where care is negotiated care with

parents rather than being consciously driven by the best interests of the child. The social presentation of families can essentially be "stage managed" so that a particular version of "reality" is presented. Perpetrators of abuse rarely want to be discovered and may employ diversionary tactics to distract health care professionals. These tactics may include frequently moving home without giving forwarding addresses,³⁶ using multiple phone numbers,²⁰ avoiding contact with health care professionals,¹² distracting from the child protection issues,²¹ coaching children,⁴³ managing availability,⁴⁰ or fabricating reality.²⁰ Even the atmosphere commanded by parents can make home visiting uncomfortable and lead to the health care professional losing focus.³⁶ The practice challenge of stage management was identified as early as 1985 in the United Kingdom⁵⁴ in the Jasmine Beckford case. This case records how the parents distracted the social worker on one home visit and superficially the child appeared "well and happy," despite having sustained a fracture. Similarly, in the case of Victoria Climbié, Lord Laming⁴³ noted that visits to the home were planned, which gave the opportunity to tutor the child on what to say and to direct both observation and case focus. To use the analogy of theatre, the parents can stage manage what the professional observes. In the Roscommon case,²¹ health care professionals were generally directed into one room of the house, thus avoiding the impoverished state of the rest of the house. Furthermore, in related case conferences or home visits, peripheral issues were highlighted and emphasized by the parents who diverted attention from the children. Similarly, diversionary tactics were used in the Monageer case²⁰; the father controlled communication with external services and made all appointments, which were frequently missed with false excuses of having other engagements.

This stage management activity may be enhanced by an awareness of the culture of social care services. For example, in the Baby P case, it was observed that experience of the culture of social services could lead to knowledge of how to deceive professionals.³⁵ Moreover, the Haringey Local Safeguarding Children Board³⁵ suggests that health care professionals believed the mother's accounts of the care of her children too easily and did not question its self-serving potential.

Reviews of child protection scandals have the advantage of hindsight bias; however, it is a lack of establishing interconnections, a lack of knowledge of when to employ appropriate legislation, and a lack of serving the best interests of the child that are the overwhelming factors that can lead to negative consequences and fatality in some cases. Therefore, in all child protection cases, information needs to include a merging of subjective

and objective knowledge, critical, reflective professional practice, and the integration of accounts, reports, and information from others, such as family and community members. The consideration of information from community sources may be particularly pertinent for PHNs, as informants may feel comfortable disclosing concerns due to the previous confidence built up through practice within the community.

The Irish Constitution and Protecting Children

The Irish Constitution⁵⁵ was heavily influenced by the Catholic Church and placed the family in a sacrosanct position. As early as 1993, McGuinness¹⁷ noted the rights of the child could be usurped by the rights of the family as stated in the constitution. More recently, Ryan²² pointed to a failure of state and religious orders to prioritize the best interests of the child and surmised that this may be linked to the invisibility of children's rights in both the constitution and legislation.^{22,56} This ambiguity in the Irish Constitution was tested in the Roscommon case,²¹ which notes, as discussed previously, that there was an absence of any child's voice, and even if there had been submissions from the children, their independent voices could not be evenly matched with the parents' constitutional rights. The child's views are given legislative value in the Child and Family Agency Act³²; although this is a useful stepping stone the word "consideration" of the child's voice is used and so limits its value as professionals ultimately have more powerful voices.

Issues related to the constitutional rights of children were also raised in terms of adoption rights⁵⁷ and in relation to parental refusal for a child to have metabolic testing.⁵⁸ In response to these mounting concerns, Ireland held a referendum on November 10, 2012, which resulted in providing additional clarity to protect the individual rights and best interests of children as well as addressing the concerns raised through various Irish child protection inquiries.

Relevant Legislative and Policy Change

Part of the role of the PHN is to be acquainted with relevant child protection legislation, yet a lack of HSE familiarity in this domain was a significant issue in relation to the handling of the Roscommon case⁵⁶ and other inquiries. The principle legislation is the Child Care Act,⁸ which gave the HSE and the gardai (police) specific responsibilities to protect children where a child has, is, or is likely to be assaulted, ill-treated, neglected, or

sexually abused. Additional legislation has also focused on strengthening safeguarding. The Children Act⁵⁹ of 2001 makes it an offence for any person in charge of a child to either perpetrate abuse or allow abuse to occur "in a manner likely to cause unnecessary suffering or injury to the child's health or seriously to affect his or her well-being."⁵⁹ Previously, parents may have used the defense of reasonable chastisement in relation to corporal punishment of children.⁶⁰ The limits of reasonable chastisement are, however, not defined and this means such boundaries are decided by the courts in individual cases, which complicates the judgment of health care professionals, such as PHNs. The Children Act⁵⁹ also provides a framework for the juvenile justice system and gives legal status to the establishment of Family Welfare Conferences. Further legislation has also addressed systematic weaknesses. For example, in response to one of the initial clerical abuse cases,²³ where abusing clergy were found to have been moved from parish to parish rather than being held fully accountable for their actions, the Criminal Justice Act¹⁶ now incorporates an offence of reckless endangerment of children, although it can be argued that this needs to also take account of children placed in danger due to information being received on suspected abuse rather than substantiated abuse.⁶⁰ Thus if a health care professional, such as the PHN, observes abuse and does not ensure the continued safety of the child as well (as reporting this) this could result in criminal proceedings and professional consequences.

Other legislative advances have underpinned responsibilities of reporting child protection concerns. For example, Criminal Law Act 1997,⁶¹ Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act (2012),⁶² and the Offences Against the State Act (1998)⁶³ make those who are aware of criminal offences liable to prosecution if they do not report this. However, for those who do report in good faith, protection is given from liability.⁶⁴ The National Vetting Bureau Act (Children and Vulnerable Persons) (2012)⁶⁵ mandates all persons working with children to be screened by the gardai and this includes an examination of "soft" information.⁶⁰

*Children First*² represents the national policy on child protection and provides guidance for PHNs' practice with children. However, as a policy, the guidance lacked legislative teeth and contributed to uncertainty and a lack of standardization in child protection procedures. However, child protection has recently been enhanced by a suite of legislative reforms that include the separation of the remit of children from the Department of Health and Children to the Child and Family Support Agency (CFSA) known as TUSLA, meaning beginning of the day. Established under the

Child and Family Agency Act (2013),³² TUSLA will provide “comprehensive, early and multidisciplinary responses to the needs of children”⁶⁶ in the context of prevention, early intervention, and ongoing therapeutic and care interventions for children in need of support.

In April 2014, the Heads of Bill to place the Children First Guidelines on a statutory footing were finalized and published in 2012, although due to complexities it was not until 2014 that the Children First Bill (2014)⁶⁷ was published. This bill in effect establishes mandatory reporters for child protection and their responsibility to cooperate with TUSLA. Organizations that interact with children have a requirement to comply with best practice and develop organization-specific safeguarding statements.

Practice Development

Recognizing the need for additional guidance, the Health Information and Quality Authority (HIQA)⁴ published National Standards for the Protection and Welfare of Children to support continuous improvements in care and protection of children in receipt of HSE child protection and welfare services. Two themes are delineated within the Standards: child centeredness and safe and effective services. Within these themes, capacity and capability need to be fostered within 4 domains of practice: leadership, governance, and management; the optimum use of resources; appropriate and effective workforce planning; and the use of information to meet service needs and direct quality improvements. The importance of these guidelines are that service delivery by the HSE will be monitored by an external, independent body, who will have the authority to ensure child protection proceedings are conducted appropriately and with a determined focus on the child’s best interests. However, care must be taken so that health professionals such as PHNs do not become submerged in complying with regulation at the expense of good practice.⁶⁸

Another major practice change has been the publication of the Child Protection and Welfare handbook.⁶⁹ Reports such as Gibbons et al²¹ and Brosnan et al²⁰ reflect a situation whereby professionals were seen to be working in environments and with material that was unstandardized and lacking in clarity in case management. The HSE handbook supports the guidelines in *Children First*² and provides information that is very much practice based. The advantage of these recent publications is that they cohere together and complement Irish legislation to provide persons working with children, such as PHNs, a firm foundation in the roles and responsibilities in relation to child protection. In particular, within the HSE⁶⁹ document, the role of the PHN is described under

18 domains of information generation. These domains range from eliciting information on development history, attachment patterns, and information on home environment to information on parental upbringing and extended family and community networks.

Discussion and Conclusion

Child protection in Ireland has been subject to major reform in recent years, primarily due to the findings from serious case reviews. Such practice and legislative reform have an important impact on the work of health care professionals, particularly PHNs, whose job encompasses family and child practice. PHNs are in an ideal position to observe children in their own home and use expert skills in assessment. However, the PHN does not operate in a disciplinary silo and overcoming inter- and intradisciplinary challenges is key to successful teamwork 70. Interdisciplinary teamwork needs to be fostered in order to be firmly focused on the paramount welfare of the child *in context*, and the child’s voice needs to be central in case management. This means building up a rapport with the family yet also being aware of the possibility of stage management by parents or others. Therefore, at each home visit, the PHN needs to use professional expertise in picking up cues, negotiating, and critically appraising information to elicit challenges for each child. The PHN can prevent or intervene in child protection issues, through therapeutic relationships, mobilization of family, voluntary and community support systems, and this may avoid the child/children entering the child protection system. In using a comprehensive assessment framework, the PHN can generate a holistic picture of the child’s lived reality and decide if referral is merited. In terms of tertiary care, the supportive and continuing intervention role of PHNs is essential within a team focus, where reflective case management is fundamental. However, although tools, procedures, and protocols can assist standardization, caution should be noted in relation to an overreliance on such processes. The prime focus of the child should override bureaucratic processes and case inertia, which can stifle professional judgment.^{1,7,39}

In Ireland, child protection has focused on working with parents, which eclipsed the child’s voice, and this was further exacerbated by the explicit constitutional imperative of “the family.” Within current new legislation such as the Criminal Justice Act (2006)¹⁶ and policy and the recent constitutional amendment, the child is enabled to have specific and individual rights that cannot be usurped by parents. However, similar to other countries such as the United Kingdom, Irish PHNs experience a conflict in the conduct of balancing for child

well-being and the risk of damaging congenial relationships with the family.¹⁰ However, this reluctant role is required by both policy and legislative imperatives and protection of children is central to the primary health care ethos of promoting optimum health. Within the context of such change, a focus on continuing professional development is crucial in order that PHNs can update their skills and draw on them in this delicate balancing act.

Yet, as noted by Appleton,¹ staffing shortages must be acknowledged as posing a threat to child protection and PHNs may struggle to provide adequate care for vulnerable children, particularly with high child protection caseloads in Ireland.⁷¹ In light of practice, policy, and legislative changes, impoverished PHN numbers and a complex caseload will have the potential to increase PHN stress levels, particularly with high caseloads with multiple and competing demands. Within the United Kingdom, health visitor shortages were identified as reducing the potential of positive health for children, leading to a major health visitor recruitment drive.⁷² Similar workforce increases are required in Ireland, with some calls for a specialist child protection PHN.⁴⁸ This is particularly relevant in the context of changes presented in this article, as PHNs are fundamental in safeguarding children.

This article has highlighted the important role that PHNs play in child protection. This role compliments that of other professions. PHNs are in a privileged position as they form a relationship with the child's parents/carers and are able to see the child in its own environment, which many professionals cannot. PHNs are centrally placed in child protection and are ideally located to act as a conduit for child protection concerns due to their privileged position. They have an opportunity to feed into the interdisciplinary team and can unlock resources. Child protection has often been likened to a jigsaw⁷³ with each profession holding a piece of the child's life. The jigsaw can be incomplete without the input of the PHN. The TUSLA considers the PHN as fundamental to its new service⁶⁶ and in tandem with the ethos of the HIQA⁴ and parallel to the reorientation of services in the United Kingdom,⁶⁸ the establishment of this child-centered service is considered central to comprehensive welfare and protection care delivery.

Author Contributions

AP substantially contributed to conception or design; contributed to acquisition, analysis, or interpretation of data; drafted the manuscript; critically revised the manuscript for important intellectual content; gave final approval; agree to be accountable for all aspects of the work in ensuring that questions relating to the accuracy or integrity of any part of the work are appropriately investigated and resolved. MD contributed to

conception and design; contributed to acquisition; drafted manuscript; critically revised manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of Conflicting Interests

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