Review undertaken in respect of death of R
A young person known to the child protection system

December 2011

1. Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care' issued in 2010. Under this guidance, the following deaths and serious incidents must be reviewed by the National review panel:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious incidents involving a child in care or known to the child protection service

2. National Review Panel

A national review panel was established by the HSE and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the national review panel. The National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all

documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

- **Major review** to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review panel should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations

- **Comprehensive review:** to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations.

- **Concise review:** to be held where the involvement of HSE services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.

- **Desktop review** to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

- **Recommendation for local review** to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child death R

This case concerns the death of young person here called R who died in the summer of 2010. The review has been conducted because R was known to the child protection system during the period prior to her death.

5. Level and process of this review

This was undertaken as a concise review as the involvement of HSE services was of short duration during June 2010. It was conducted by reviewing the social work files provided to the review team and through interviews with social work staff of the HSE and R's mother. Each person interviewed was provided with the opportunity to review their contributions to our understanding of the facts.

The members of the review team for the R Case were:-

- Mr Michael Bruton, Independent Management Consultant – Lead Member for National Review Panel in this case
- Mr Hugh Connor, Former Director of Social Work Services Northern Ireland, Member National Review Panel

Neither member had any previous professional or managerial involvement in this case. They were totally independent in conducting this review and arriving at their conclusions and recommendations.

6. Terms of Reference

The review was undertaken with the following terms of reference:-

- To establish the facts with particular reference to the circumstances leading to the death of R and the role played by the HSE and HSE funded agencies in providing services to R
- To review the HSE child protection services in the context of compliance with
    - Existing legislation
    - Policy directions
    - Key professional standards
- To consider issues of interagency and intra agency cooperation and communication
- To prepare an objective report to the National Director of Children and Families Services of the HSE which

- Identifies opportunities for learning from this review
- Makes recommendations

7. Details of R's family

R lived with her mother and a number of siblings. R's parents had separated when R was at an early age. R had lived with her father for a period during this separation before returning to live with her mother

8. Background and reason for referral to services

This case was referred by Gardai to the HSE Children and Family Services in June 2010. R had been removed by the Gardai under s12 of the Child Care Act 1991 from what they considered to be an unsuitable setting. The Gardai became aware of other concerns about R's welfare and subsequently made a report to the HSE Children and Family Services.

9. Services involved with R

The following services were involved with R and her family:

- **HSE Children and Family Services,** who were involved over a short period in June 2010
- **An Garda Síochána** who were involved in removing R under s12 of the Child Care Act 1991 from a house where she was not allowed stay overnight
- The **Principal** of R's school
- **Family GP** who only saw R infrequently

10. Brief summary of child's needs

The social work file indicated that some relationship difficulties existed between R and her mother. It also transpired that she had not attended school for the previous two weeks and had missed, in total, some forty days from school during the year. The Garda report also raised concerns about the relationship between R and her boyfriend. The preliminary enquiry form completed by the social worker recorded that while the social work department (SWD) considered that protective action was urgently required, there were no grounds for legal intervention.

R's mother requested advice from the SWD about arranging counselling for R, whom she felt had an 'attitude' problem. Information about a voluntary counselling service and telephone contact number was provided by the social worker dealing with the case.

11. Chronology of contact between HSE Children and Family Services and R

The involvement of the SWD with R and family began in the early summer of 2010 when the Gardai made a referral to the HSE, having removed R from a house under Section 12 of the Child Care Act 1991. Prior to this, R had not been known to the Children and Family Services. The Gardai also contacted R's family. Her mother was unavailable and could not come to the station on that occasion, but her father attended. A social worker, here called Social Worker A, had been assigned to the case and also attended the station where she met with R and her father.

Following discussions between Social Worker A, R and her father it was agreed that R would return home that evening to her father's house, as it had not proven possible to hold discussions with her mother with whom she normally resided. Three days later, Social Worker A learned that R had subsequently returned home to her mother with her father's agreement but without any discussion with Social Worker A. As Social Worker A had no previous knowledge of any of the family prior to the referral, she was not in a position to form any professional judgement on the parenting capacities of R's mother at the time. In subsequent discussions, R's mother asked Social Worker A for information about counselling for R, which she felt would be beneficial. Social Worker A provided her with the necessary contact details.

Following a review of the completed preliminary enquiry forms, the principal social worker (PSW) decided that the case should be placed on the waiting list for allocation. At the time, there were staff shortages. Cases for allocation were wait-listed in order of priority, and given ratings from 1 to 5, with 1 being the most urgent. The PSW gave this case a priority rating of 2. By the time R died two months later, no contact had been made with her or her family.

12. Analysis of Involvement of HSE Children and Family Services with R.

12.1 Initial response of HSE to this case

The initial referral was received by duty Social Worker A. This social worker acted promptly in going to the Garda Station to interview R and her father and in making contact with R's mother who was not in a position to attend the meeting. Contact was also made by Social Worker A with the family GP.

A preliminary enquiry form was completed by Social Worker A with respect to R and appropriately signed off by the team leader.

12.2 Assessment

A preliminary inquiry form was promptly and properly completed by Social Worker A and the team leader. However, there is no record of any further assessment protocol being applied, notwithstanding the fact that the review panel identified a range of concerns from the available documentation. No profile of R's needs is recorded on any of the social work department files.

The issues of R's extended absences from school were never the subject of any recorded discussions between the social work department and R's school.

The decision made by the social worker to allow R to leave the Garda Station with her father was appropriate, however some serious issues identified over the course of the initial assessment which, in the view of the review team, clearly established that a full assessment was needed. The identified issues included:-

1) The fact that R had been missing for four days from her own home (it appeared she was staying in her boyfriend's home).
2) The fact that Gardai had concerns about the nature of R's relationship with her boyfriend
3) The fact that R had missed forty days of school. There was no record of a referral to the National Education Welfare Service in this regard
4) The separation of R's parents and its impact on R
5) The fact that R's mother had been unable to come to Garda station to collect R, which meant that Social Worker A had no opportunity to discuss R's future living arrangements with her.
6) The fact that R's sister – with whom R wished to stay – lived in a house that was raided by Gardai and R's sister's boyfriend was found in possession of drugs and was being charged
7) R's mother's request that counselling be provided to R

In the view of the review panel these factors would clearly have warranted a conference to determine the degree of risk to R.

12.3 Compliance with regulations/guidance

The rapid response of Social Worker A in promptly responding to the initial referral from the Gardai when asked to do so by the team leader was a very positive action. The action of the social worker in meeting R and father as well as making contact with GP is consistent with Children First.

However, there is no evidence that information was given to R's parents about contact being made with other professionals e.g. GP or about the intention to do so. This is not consistent with good practice as outlined in Children First.

Under Children First, a child protection meeting should be held in the sort of circumstances presented in this case. It does not appear that a meeting was planned by either the team leader or principal social worker. As a result, no structured assessment was made of the range of possible critical factors pertaining to R's welfare, nor was there any identification of possible sources of protection and support for R, e.g. the school principal and/ or national educational psychology services.

R was not yet 16 years old when she was found in bed in the house of her boyfriend and was identified as having stayed there for four days. Both of these young people were the same age and there was no evidence of exploitation. However, the review team was not reassured that the guidance in Children First which states that consultation must be held between the social work department and the Gardai in cases of alleged underage sexual activity was followed.

12.4 Quality of practice

12.4.1 Interaction with the Child and Family

Good efforts were made by Social Worker A to ensure parental involvement in the care of R, with agreement that she would stay with her father as her mother was unavailable to care for her on the day that she was picked up by the Gardai. It would have been preferable for Social Worker A to have had discussions with both parents about the eventual return of R to live with her mother. This would have ensured that social worker A, who had no previous knowledge of R's mother, was able to satisfy herself that a return to her mother's home was appropriate.

12.4.2 Child and family focus

There was very little contact between Children and Family Services and R and her family beyond the decision made that she should return to her father's care. As outlined above, Social Worker A engaged well with R and her father and sought to ensure a prompt and practical response to the presenting issue. R's mother had advised that she was not in a position to attend at the Garda station and did not in fact do so on the day. Regrettably, the absence of agreement as to the ongoing arrangements as where R would live was not clearly addressed. No harm came to R as a consequence but in practice terms not addressing the ongoing accommodation arrangements created a lacuna.

In the latter stages of social work involvement in the case it was recorded that R's mother requested counselling for her. Information on this matter was appropriately provided by Social Worker A.

12.4.3 Quality of recording

The files were not completed in accordance with the guidance contained in Children First in that, documents were not in chronological order, some documents were not signed or dated, or were missing, and nor was there a summary sheet containing family details.

12.5 Management

12.5.1 Allocation

The case was promptly allocated by the team leader for investigation and assessment, when it presented on a busy morning.

Whilst a decision was made by the principal social worker that R was to be placed on a waiting list for intervention, (the review team was advised that all social workers had full caseloads at this time), there is no record of what intervention was envisaged or planned. The decision to place R's case on a waiting list at Category 2 level was made by the principal social worker without reference to Social Worker A and the team leader. The criteria on which this decision was based were not recorded. The placing of R's referral on a waiting list demonstrates that service availability was a difficulty in this case. It was not recorded on the file if the decision was communicated to R's mother. Later, R's mother confirmed to us at interview that she had never been told by any social worker of the decision to place her daughter's name on a waiting list. The Gardai were not notified of the social work department decision.

Subsequent to the death of R a local case management review was conducted. This identified staffing difficulties as being the contributory factor in the case being placed on a waiting list. It was also noted that some additional social work staff were taking up duty in the near future

12.5.2 Inter-agency meetings or conferences

No formal interagency meetings were held between any of the organisations involved in this case. The review team considers that a case conference should have taken place to discuss the risk factors that had been identified and plan an inter-agency response.

12.5.3 Supervision

While it is clear from the interviews with staff that regular supervision did occur, this is not documented. The review team was satisfied that there was ongoing availability for telephone discussion between staff and their supervisors. Recording of the supervisory sessions would have been consistent with good practice as outlined in the HSE National Policy on Supervision.

12.5.4 Inter-agency collaboration

While no formal inter – agency meetings or conferences were held there was good informal contact between Social Worker A and the Gardai following the referral made by them.

12.5.5 Policy

Whilst there was a clear acknowledgement of supervision occurring there is no evidence that the HSE national policy on Supervision was in fact operational.

13. Conclusions

This is a case with which the HSE had an extremely short professional involvement concerning a young person who died shortly afterwards. The case presented a range of issues entailing inter agency work; intra agency communication; the management of responses within a resource constrained environment and the making of judgements consistent with best practice, local and national guidelines. The review made the following findings:

- The initial assessment appears to have been a short term response to an incident where R was found in an unsuitable setting. On the positive side R was seen quickly by a social worker and contact was made directly with her mother and father. Contact was also initiated by the social work department with the family's GP. Interagency communication between Gardai and HSE complied with the best practice.

- The decision to return R to the care of her parents was an appropriate one. However, a number of potentially serious issues were identified by the review panel over the course of the initial assessment and information sharing between the different agencies which clearly established that a full assessment was needed. In the view of the review team, these factors would clearly have warranted a conference to determine the degree of risk to R.

- A separate and distinct issue is that of the prevailing staffing levels which caused the case to be placed on a waiting list instead of receiving immediate intervention. It is unclear to the review team what, if any, managerial advice was given to staff where a case is placed on a waiting list.

- While R's referral was prioritised by the principal social worker as on the higher end of risk, there was no evidence on file to explain the basis for this categorisation, the reasons on which it was based and no detail of the evidence used to determine the prioritisation level. No other social work staff was involved in the prioritisation decision. Neither was there any evidence that any consideration had been given to the management of the case should an urgent matter arise pending the allocation of a social worker. Furthermore, there was no identified process in place for ensuring that new information about the case would be reviewed or shared with relevant agencies.

- There were undoubted significant staffing and other resource issues arising in this case as it presented to the HSE in mid 2010. These factors require robust assessment by management to ensure that staff are provided with clear guidance as to the processes and actions they must undertake in such cases.

- Having given full consideration to all the evidence made available, the review team have formed the view that there is no basis for believing that the placement of R on a waiting list for social work services contributed in any way to her death. Nonetheless, the practice and policy issues highlighted in this review require to be addressed.

14. Key Learning Points

Four key learning points emerge from this case. The first is the need to ensure that a structured review of all available information is undertaken on receipt of a referral, leading to assessment and an agreed future action plan. The second key learning point emerging from this case is the requirement for a legible, chronological documentary file that allows for review. Thirdly, the review team noted that the managerial processes used, for example, in making decisions regarding placement on a waiting list were not clearly evident from the review as they were not an integral element of recording practice. Finally, there is a need for management to develop a process that ensures new information is shared so that the original decisions can be reconsidered.

15. Recommendations

- The criteria used to determine where a case is being placed on a waiting list should be clearly outlined. This decision and documentation showing the process should be placed on file.
- A standard assessment framework should be implemented by the social work department

- Frontline staff should be provided with clear guidance as to the processes and actions they must undertake where staffing, financial or other resources are insufficient to meet identified need.

Signed: Helen Buckley

Professor Helen Buckley

Chairperson National Review Panel

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