National Review Panel

Review of the Accidental Death of O

November 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 in May 2010 and began its work shortly thereafter. 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 consisted 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 was to be produced which contained 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:

I. **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.

II. **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 Panel 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.

III. **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 Panel 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.

IV. **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.

V. **Recommendation for internal 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 Children and Family services is implicated.

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

4. Death of O

This review is concerned with a young person, here called O, who in the summer of 2010 was involved in an accident in which he tragically died. O was a middle child in a large family. At the time of his death he had just turned 15.

His family had been known to Children and Family Services since 1991, although the case had been closed and reopened on several occasions. O always lived with his parents. In the weeks prior to his death he was made the subject of a supervision order which was granted to the HSE.

5. Level of Review, Period to be considered and Process Undertaken

This was conducted as a comprehensive review. It involved reading all the Children and Family Services' records, which in this instance comprised of three substantial social work files, which included all correspondence and case notes and two files of notes made by the child care worker who had worked directly with the four older children between 2000 and 2002. The public health nursing file was also reviewed.

Interviews were held with the social worker, team leader and principal social worker, who had responsibility for O's case in the period leading up to his death. The public health nurse and a coordinator of a voluntary organisation also were interviewed. O's parents and two of his older brothers also agreed to meet us.

This family were known to HSE and HSE funded organisations for a period of almost 20 years. From 1998 until O's death in 2010, there was almost continuous, if at times episodic contact with the family. However, as the children grew older, problems arose in terms of the parents' ability to manage and control them as the behaviours of some of the older children resulted in them increasingly putting themselves at risk.

As a consequence, it was agreed that this review would concentrate on the years 2006, when these problems first began to emerge, and O's death in 2010. Reference will be made to earlier intervention by HSE and HSE funded organisations, to put the period 2006 – 2010 into context.

This review was led by Mr Michael Bruton, Independent Management Consultant. He was assisted by Mr Hugh Connor, retired Director of Children and Family Services (Northern Ireland). Neither, had any professional or managerial involvement in this case, and were therefore independent when conducting this review and arriving at their conclusions and recommendations.

The Review Panel is appreciative of the help and support provided to them by all the people with whom they met. Each person interviewed was given the opportunity to provide their thoughts and reflections either in writing or personally, to help the team understand the facts, issues and context.

6. Terms of Reference

a. To examine events leading up to Os death and determine whether action or inaction on the part of the HSE and HSE funded agencies had been a contributory factor.

b. To examine the quality of service provided in terms of compliance with:
   i. Legislation
   ii. Policy direction
   iii. Key professional standards of practice

c. To examine the quality of inter-agency and inter-professional communication and action in terms of keeping L safe

d. To prepare a report for the HSE which
   i. Identifies opportunities for learning from this review
   ii. Makes recommendations

7. O

O had just turned 15 when he died in an accident. He was a middle child in a large family. He was of limited intelligence and was thought to be easily distractible and to require a lot of individual attention. He was, however, a popular boy who got on well with his peers. In the months leading up to the accident, he was involved with a group of boys, many of whom were misusing drugs and alcohol. At this time he was also increasingly missing school and it was feared that he was going to drop out entirely. He had come into conflict with the law and been arrested on different charges for which he had been placed on probation.

8. Background – Reason for Referral to HSE Children and Family Services

This family was first referred to Children and Family Services in 1991 when an older child was hospitalised for failure to thrive. Over the years the case was opened and closed on a number of occasions. The family had additional needs and there had been regular concerns about the parents' ability to care appropriately for their family however, all the professionals who worked with them believed that the appropriate course of action was to provide the family with support.

O always lived with his parents. When he was young his maternal grandmother also lived with the family. He appeared to be particularly close to two of his older brothers.

In March 2000 a child care worker was employed to work directly with O and the older siblings, one afternoon per week. Initially this was to help with homework as the children were to varying degrees falling behind with their schoolwork. As an offshoot of this work, the children also developed skills in sharing, empathy and mutual respect which helped their social development. As O grew older, his needs changed and discipline problems began to emerge both for O and his siblings. Increasingly the focus of attention became their poor school attendance, drug misuse and at times criminal behaviour. On several occasions O was arrested and, according to the file, was made the subject of a probation order when eleven. By the age of fourteen, if not younger, he was beginning to "dabble" in the use of "legal highs" and was also taking alcohol. There was a concern that older boys were using him to push drugs.

Following a series of incidents the HSE sought and were granted supervision orders on all of the children under the age of eighteen which included O. The records of the HSE Children and Families Service do not demonstrate that O was the focus of any sustained individual work during his adolescence. No individual assessment was undertaken of his needs, nor was any personal intervention plan put in place. There were grounds for concern, not just for O but the family as a whole, during the period 2006 to 2010.

9. Services Involved with O and his family

- The HSE Children and Family Services
- Public health nursing service
- An Garda Siochána
- Primary and secondary schools. O's attendance at secondary school was decreasing. On at least one occasion he was suspended from school.
- Community welfare services offered practical and material support to the family.
- Child care worker worked with him and his siblings for thirty months
- Voluntary organisation provided services for young children
- Drugs counsellor worked with an older sibling
- CAMHS to whom a referral had been made and an appointment offered. However, he did not attend the service prior to his death
- Juvenile Liaison Service

- Probation & Welfare Service

10. Summary of O's needs

O was a young man of limited intelligence. As a child he was described as hyperactive and easily distractible and requiring a lot of individual attention and supervision. He was a likeable, lively boy. As he became older he came under the influence of older boys, some of whom were using or pushing drugs. His behaviour became increasingly difficult for his parents to control and he began from an early age to dabble with alcohol and drugs.

O had been involved in minor criminal activity from a young age and was on probation. In the months prior to his death he had been arrested on two occasions. His father told the review team that he feared that his son was passing drugs and tried to monitor this. His father reported to the Garda and the Children and Family Services that O was using drugs. However he appeared helpless to do anything about this. By this stage, the family home was being regularly frequented by friends of the eldest child with the parents seemingly unable to exercise control. As a consequence, it is probable that O was exposed to negative influences from an early age.

Whilst in primary school, O was always regarded as a likeable child whom teaching staff could manage. However, once he started to attend secondary school, discipline problems began to emerge. He was suspended from school at one point and prior the accident his attendance record was deteriorating. There was concern that he was going to drop out of education, as had been the case with older siblings.

O had been referred by the social worker to the Child and Adolescent Mental Health Service (CAMHS). Initially he was put on a waiting list but was eventually offered an appointment which he did not attend. As his behaviour became more worrying, his parents requested that he be re-referred to CAMHS. Unfortunately the fatal accident occurred prior to an appointment being offered.

11. Chronology

Period prior to the time line which was the focus of review 1991 - 2005

1991

This family were first referred to Children and Family Services in May 1991. At that time there were serious concerns for the survival of the second child who was failing to thrive. At seven months old the child weighed 10lbs. There was concern about the parents' capacity to physically care for the child. Neither seemed to grasp how ill the child was, and there were concerns about the lack of attachment to this child, who was visited infrequently whilst in

hospital. Prior to admission to hospital, on a visit to the house by the G.P, the door to the baby's bedroom had to be broken so that access to the child could be obtained.

Two case conferences were convened, at which a range of options were considered, including reception of the infant into care. During this process it was discovered that there was a medical problem, which explained the failure to thrive. The focus thereafter moved to providing the parents with the supports necessary to care for a young baby with additional needs. The offer of a home help was made, but refused. After a period of seven months hospitalisation, the child returned to the care of his parents, with daily monitoring by the nursing services. At that stage Children and Family Services closed the case.

1993

In August, the Gardai re-referred the family after neighbours reported getting threatening letters from the mother. Another baby had been born and reports of this child's progress were fine. A social worker visited once. O's mother told her that she had written the letters in response to teenagers climbing over their garden wall, throwing stones at the home and abusing the parents. The case was closed.

1998 – 2000

The family were referred again in October 1998, by hospital staff concerned about bruising to O's face and body, and an old scar to his face. Before Children and Family Services could investigate these concerns, the hospital consultant discharged the child following a conversation with the father. This issue was formally notified to the Gardai and a joint visit made to the home. The father explained that these injuries were as a result of a fall and the explanation was accepted.

In November 1998, another child was born, and like an older sibling there was considerable concern about this child's failure to thrive and after medical tests, it was found that both had the same medical condition. Concern was expressed by a professional about the cold bleak conditions in which the family were living. It was noted that the father was the major care-giver, as the mother seemed incapable of caring for the children. The new born baby was hospitalised for four months.

In December 1998 the public health nurse expressed concerns about the children's welfare believing they were being slapped and shaken. A joint visit to the home was made and the offer of help around the home was again refused.

In the same week, the Matron of the local hospital referred the maternal grandmother who lived with the family, to the HSE, suspecting that she was the victim of abuse. The same month with the grandmother discharged home, a voluntary organisation phoned to report that the grandmother was alleging that she was being locked in her room at night. Concerns were reported about a lack of supervision of the children who were going "over and back on the bypass on their own". These issues of elder abuse and parental neglect were not

investigated although the issue of physical punishment of the children was raised with the mother.

In early 1999, prior to the new born baby's discharge, a ward sister raised with the public health nursing service the question as to whether the child's additional needs were such that consideration should be given to receiving the child into care. On discharge the public health nursing service visited daily. No fresh concerns were raised or identified other than the concerns about the possible abuse of the grandmother. As a consequence, Children and Family Services closed the case in the late spring of 1999.

In June, the G.P. referred the family again, saying that an older sibling, then aged 8 ¾, was seen alone in the town at night. This issue was discussed with the father who said he would speak to the child about this.

In autumn of that year, a professional colleague wrote to the team leader in Children and Family Services saying that she had been visiting three times per week. She said she has evidence of the children being left alone, remains concerned about abuse of the granny and that "the house is cold, damp with broken windows, including one in the sitting room". She said that the new baby was being left unstimulated and alone for long periods and she believed that this was causing the child to miss developmental milestones. As a consequence she asked that the case be reopened and that a child care worker be employed to provide stimulation. The case was reopened in autumn 1999 with the incoming social worker indicating that a strategy discussion would be convened.

At that time, the first of three strategy discussions was convened, the others being held in late 1999 and spring 2000. The first strategy discussion which was attended by a wide range of professionals and agencies highlighted the concerns identified in the previous twelve months. To this was added information that both father and mother drank several nights per week. There was agreement that a family support strategy should be adopted with the family G.P. saying that the children were "most definitely better at home".

A plan of family support was agreed with a number of actions identified including the offering of material help and support for an extension to the home. Following this, the principal of the local school was contacted and she described the children as "happy, pleasant and lively", adding that their attendance was good. As with others, she felt the parents were appreciative and cooperative, and apart from the need for remedial educational support, identified no cause for concern.

With some practical improvements made to the home, the second strategy discussion, which was attended by the mother, concentrated on the need for additional stimulation for the children; the offer of a child care worker having recently been rejected by the father.

After the strategy discussion, father wrote to Children and Family Services asking for the social worker to be changed as"she is too fussy". He says that "he wants no more meetings". However, a professional who attended the strategy discussion wrote to Children and Family Services to express concern about how the discussion had been handled, saying that she felt

"the team leader didn't realise at what a low level the family were functioning". She concluded that "the children are being neglected and that work needs to be done now".

By spring 2000, a child care worker had been identified and parental permission obtained for her to work with the children, at the local resource centre. After a few sessions, the child care worker described the children as "well behaved, lively, good and overall happy". At the spring 2000 strategy discussion no new cause for concern was identified. The rest of the year was uneventful with the child care worker seeing the children weekly and forging a relationship with them. She noted some concerns about O, whom she describes as "difficult to manage, hyperactive, easily distracted and needing a great deal of personal attention".

In late 2000, the child care worker noted that one of the older children had a badly swollen lip. The children told the child care worker that their father had hit the child and in fact the father acknowledged that himself, saying that he had slapped the child for staying out late – 10pm. However, when the social worker called at the home the next day to investigate the incident, the father persistently stated that the child had fallen off a bike and got the child to confirm that this was the case, threatening to stop the child care worker's sessions and even move the children from their current school. No further action was taken.

2001-2003

With the child care worker in place for most of this period, these years were relatively uneventful from a child care perspective. In the early months of 2001, there were several incidents of damage being done to the house, with windows broken as local youths threw stones and iron bars. Numerous small bruises were found on O's chest and back which were attributed to rough play between himself and an older sibling.

In July 2001, one of the older children, aged seven at the time, was found in the house alone, having refused to go shopping with the family. This gave rise to a discussion about the parents' ability to control their children and set realistic boundaries. It was recognised that as the children grew older, this could become a significant issue. The child care worker noted that given the parents' limitations, they could easily be "outsmarted and manipulated by their children". It was agreed that the child care worker would introduce a Safe Care Safe Play Programme.

At the beginning of 2002, the major issue was the continuing anxiety surrounding potential physical abuse of the grandmother. After a series of strategy discussions it was agreed that the granny would leave the house and go to a sheltered housing scheme.

Around the same time, educational assessments were carried out on O and an older sibling. Both were found to have learning disabilities and both had higher verbal than performance IQs.

By late autumn 2002 the extension recommended at the strategy discussion in autumn 1999 had been complete for some time. Unfortunately it had not been used as a bedroom, but as storage space. It was described as sparse, bare, cold with a lot of items needing to be fixed.

More help in the shape of beds, bedding and flooring was provided by the community welfare service. The community welfare officer again wanted a home help to be placed as she felt all the furnishings were being poorly maintained.

In spring 2003, the school principal reported that the children were progressing well but that their hygiene and supervision were problematic. The children were also reported as being out late alone.

In summer of 2003, following supervision between the team leader and the social worker, the decision was made to review the case in six months with a view to possible closure. By the end of the year, the child care worker had withdrawn from the case after approximately three and a half years of involvement. The strategy over this period was to engage the children in as many community activities as possible.

2004-2005

In the summer of 2004, a visitor who had been staying with family members in the area, wrote a letter to the Regional Director of Child Care Services, and described O's home as a magnet for children, saying "for years children had come and gone at all hours of the night, one day throwing stones at the windows, the next being inside the house". The letter writer feared for the safety of these children, as they used the family's home to climb up onto the roof and feared what might happen if the children had been using drugs. The letter concluded that "if the parents are incapable or choose to abdicate their parental responsibilities, the burden of protection lies with the Children and Family Services". Shortly thereafter, a member of the public phoned to complain about a number of issues which included one of the children "tail gating" the father's car.

These issues were raised with the parents some weeks later, with O's father accepting that boys did climb from his house onto the roof and that his child did hang onto the back of his car when he was driving. No further action was considered and the issues were allowed to rest.

In early 2005, O's father approached the child care worker to say that he was upset as big lads who were friends of the eldest child were in his house to the early hours of the morning. He described these lads as being cheeky to him. He said that he got no support from his wife on this issue and believed that she was negatively influenced by his sister-in-law. In a follow up visit, the social worker spoke to the mother, who said she did not mind the boys being in the house, but would tell them to leave in future. The social worker agreed to speak to this child about the setting of some acceptable house rules.

As a consequence of the earlier report of one of the younger children "tail gating" the father's car, an assessment of the child's needs was completed. The social worker concluded there was a child protection issue arising from neglect and determined that a family support plan should be put in place. The then team leader noted that there was an inconclusive outcome to the question of child protection. Within four weeks, the supervision record stated "No evidence of young people calling to the house and staying", a judgement which appears to have been totally based on the parents' comments

In the summer of 2005, consideration was again given to closure but when the school principal was contacted, she felt that she would have concerns if social work involvement terminated. The year ended with no visit to the house apparently having been made for ten months.

Period which was the principal focus of review 2006 – 2010

2006-2007

The year began with the father coming to the Children and Family Services office to again ask for help. He was again concerned about his eldest child, who he said was taking drugs. He said this young person who was soon to appear in court was associating with an older cousin who was a bad influence. The duty social worker suggested that an initial assessment should be completed but there is no record of this having been undertaken.

Six weeks later, the social worker visited but did not see the eldest child, who was suffering from a cold. There was clearly some ambivalence from the parents, because when the social worker offered to find the young person training, the family replied that she should leave it. The social worker observed that the house was again a mess and the parents said they had significant debts. O was now the subject of a probation order having been involved in a theft.

In the middle of the year, following a supervision session, the social worker recorded that "the plan agreed is to conduct an initial assessment of the family, discuss with other professionals and if there are no major concerns, in spite of the ongoing general neglect of the house, to consider closure". There is no documentation to suggest a family assessment took place.

In the autumn, O's father again asked for help with management of the eldest child, who he again said was taking drugs, was threatening the mother for money, and was facing a serious criminal charge of theft and assault. He asked for a social worker and a garda to speak sternly to this child as he was sure they were going to get into further trouble. He reported that another sibling had been suspended from school and he was concerned that he would follow in the eldest's footsteps.

2007 began with O's father seeking assistance for the fourth time with management of the eldest child's behaviour. He again reported drug misuse and repeated his concern about an elder cousin, who is one of a group of lads who come to his house and take it over. The eldest child was to be charged with twenty two offences. He repeated that an older sibling was also causing problems, saying "that if the eldest can do things, so can they". He mentioned that he found one of his children in a field in a state of undress.

Shortly afterwards, the social worker visited the home and discussed the matter of friends of the eldest child being allowed in the house as well as the general neglect of the house. The mother was then expecting another baby, but there was no discussion of the eldest child's behaviour. When the social worker later met the father, she recorded how he shouted at her that "the eldest child needed to be spoken to by someone who could make them see sense".

By the spring of 2007, an initial assessment on the eldest child had been completed. The young person had not been spoken to as part of the assessment and only the Juvenile Liaison Officer had been involved in this process.. The social worker concluded that this child had emotional /behavioural problems and a child-parent relationship issue. The assessment failed to fully consider the impact of this child's behaviour on the family as a whole, and therefore the nature of any support to be offered. The social worker indicated that the young person was not prepared to engage with her. The conclusion reached was that the young person could remain at home and that no urgent intervention was necessary. However, P's father reiterated that as this young person was about to reach 18, leaving home was the preferred option.

The new baby was born in May 2007. As before, the focus of attention prior the birth was on improving the home conditions which were again described as 'appalling'.

In supervision with the social worker in July 2007, the team leader agreed that they should move to closure and letters to this effect were issued to the family and other professionals. As part of this closure process, a letter was written to the HSE Supported Accommodation Service seeking accommodation for the eldest child, given the impact his behaviour was having on family life.

2008

In early 2008, one of the older siblings self referred, seeking help to find accommodation. This sibling said that the eldest child and their friends were threatening, bullying and physically assaulting them. This child alleged that they were being forced to hand over money and made to get up in the middle of the night and do messages for the friends of the eldest child. At the same time, the coordinator of a voluntary organisation contacted Children and Family Services to say that that he was concerned about this younger sibling being forced out of the house. Discussions ensued and the question of Children and Family Services taking a barring order on the oldest child was raised.

This incident was to receive considerable attention in the following three months with the child who had self referred repeating the request for temporary accommodation on several occasions and bringing evidence of the verbal threats and physical assaults to which they were subjected. As a consequence, this child was initially offered temporary accommodation in a hostel before being offered a place in supported lodgings. However it soon became clear that this child was very attached to his family and home and after a night in the new lodgings they wanted to go home.

A discussion took place within Children and Family Services about the use of legal powers (barring order), to keep the eldest child out of the home. This issue was discussed with the parents, who were given an ultimatum that if this child's friends were not kept out of the home, Children and Family Services would have no alternative but to intervene. The mother confirmed that she had told the eldest child that no friends were allowed in the home, and if

they were, she would agree to the barring order. However, the very night this assurance was given, it was reported that the eldest child and friends were in the house.

A few weeks later, it was reported that there was a drugs party in the house and that someone had broken into the house, armed with a hammer, looking for the eldest child. At this stage, concern was expressed for the wellbeing of all the children. As the child who had self referred refused the offer of supported lodgings, an initial assessment was conducted. The conclusion reached was that this was not a case of child protection, but a child welfare concern involving parent/child relationships. As a consequence closure was recommended and at a discussion with the principal and team leader, it was agreed "there will be no further contact in the next few weeks with a view to moving to case closure".

A few weeks later the same child arrived at the voluntary organisation with bruising on his face. Whilst events continued to unfold, a colleague professional wrote to the principal social worker saying "the current situation is not safe for any of the children". He acknowledged the help this child had received but felt that they needed a more local housing option.

In the early summer, the public health nurse who had known the family for a long time reported her concern about the care and stimulation the new baby was receiving. She commented that "over all the years, nothing has changed." In the PHN file she noted that she had devoted a lot of time to this family over the years but got little support from Children and Family Services. This prompted Children and Family Services to contact the schools. The principal of the Secondary School described O as "tough, cunning and wily". He had missed sixty eight days, was not achieving, and had recently been suspended.

During the summer, a strategy discussion was convened. The meeting was not well attended and concluded that it should be reconvened with the parents present. After this, a professional from a non HSE service wrote to Children and Family Services setting out his strong concerns about the environment in which the children were residing. The team leader replied stating that "you will appreciate that at any one time, every social worker is dealing with several cases of high or potentially high level risk, as well as many other of moderate risk. I can assure you this family remains a priority".

The focus for the rest of the year reverted to the home conditions with the family again requiring practical help from the community welfare service. In the late autumn the team leader and social worker visited and discussed the possibility of the social work department taking legal advice, if the home conditions had not improved. A list of required improvements was drawn up. These included measures to dispose of rubbish and deal with the problem of sewage in the garden.

2009

The year began with the home conditions dominating the agenda as Children and Family services, nursing and the community welfare services sought to bring things back to an acceptable standard. This prompted a response from the family who wrote to say they did not want the social worker or nurse to call but they were told that staff should be allowed entry or legal action would be considered.

In late spring a meeting between the social work department and the parents was arranged. By then an older sibling was regularly truanting and the father reported that they were also using drugs. O had been suspended from secondary school and the parents reported that they were losing control over one of the younger children, saying, "if grounded they climb out the window and would swear at them". By the mid year, considerable help with beds, bedding, floor covering and furnishings had again been given. The eldest boy was jailed for three weeks for possession of a knife and another child was arrested for assault.

In the late autumn, a strategy discussion was convened. This meeting was very poorly attended. It was noted that O had been involved in a robbery and there was concern about two other children. An older sibling was described as "heading down the wrong track", whilst a younger child had missed sixty two days of school. At the end of this meeting, which was generally inconclusive, a professional from a non HSE service recorded that the "social work department had again decided to hold off on a care order". She indicated that she had considerable concern for the two younger children given their ages. One consequence of the strategy discussion was the introduction of another child care worker to work directly with one of the children to try and improve their appearance and self image. This child had been caught stealing alcopops from a local shop.

2010

In the spring of 2010 the parents and a younger child met with the social worker, a garda and the nurse to discuss a younger sibling's behaviour as they were staying out late and being cheeky to the parents. At this meeting, which set a time for the child to be home each night, it was reported that O had been seen 'out of his head' in town. Later in the same month there was a further meeting of the mother, O and a younger sibling, with the social worker. At this meeting O said he had been in the "head shop" and was reported as looking dazed. During this time the parents were told that legal action would be considered if they did not ensure their children's safety

A meeting of professionals held a few weeks later, including the school principal and education welfare officer, reported that O had missed seventy five days at school, and was becoming more difficult to manage. The principal expressed concern that he was using "legal highs" and were at risk of dropping out of education entirely. The parents who were in attendance, claimed that they did try to get him to school. They asked that he be referred to CAMHS.

Around the same time, a notification was made by An Garda Síochána in respect of a younger sibling who was seen around town at 4am. There appears to be no note of any discussion of this with the child whose behaviour was being reported, the parents, or the garda officer who made the referral.

In late spring, a joint visit to the home was made by the social worker and garda. The garda was so shocked by the conditions in the house, and by the youngest child's physical condition that he indicated an intention to use his power to remove the younger children from the

home. In the event it was decided to have the child medically examined. This did not reveal any medical concerns. The garda noted the living conditions as "dirty, the bathroom was disgusting, the outside shed had fifty black bags of rubbish in it and there was sewage everywhere from an overflowing toilet pipe, which wasn't connected to a mains sewage pipe". The garda recommended that the youngest child be removed from the home for their own safety and wellbeing.

This recommendation was discussed by the principal social worker, the team leader and social worker. A decision was made not to seek care orders but instead to seek supervision orders on all of the children under the age of eighteen. These orders were eventually granted by the court in the early summer of 2010. A number of clauses were inserted into the supervision orders, which was to last six months, with which the parents were required to comply. The parents did not oppose the granting of these orders. The day before the supervision orders were granted, a friend of one of the younger children was taken from the home having taken an "overdose". It was alleged that the younger child had gone into an older sibling's bedroom and had taken a bag of tablets, giving some to their friend.

In early summer, O was arrested for being drunk and disorderly, and again a few weeks later for assault. The CAMHS service having issued an appointment for O, which he had not attended, sought the advice of the social worker. In another incident a community worker called at the house, in the afternoon and found a group of young people, "all high on drugs, with a big bag of stuff on the table".

During the summer, the father contacted Children and Family Services to say that he was doing his best to get an older sibling back to the Youthreach scheme and O back to school, but added that the latter was "on drugs". The father revealed where O was getting the drugs and the social worker shared this information with the Gardai.

Tragically, O was involved in a fatal accident a few days later.

12. Analysis of Involvement of HSE Children and Family Services with this Case

12.1 Initial Response of the HSE Children and Family Children and Family Services to reported concerns

This family were known to HSE Children and Family services for almost two decades. The family had a range of significant needs. The parents appeared to have frequent financial problems, intermittent problems with neighbours, and regular difficulties looking after their home and their children, especially as the children grew older. However, most who knew them felt that the family was stable, the parents were not abusive and nor were they wilfully neglectful of their children. It was the opinion of those who worked with the family that the father in particular cared for them to the best of his ability. As a consequence of this widely held perception, Children and Family Services and other professionals decided to adopt a

'family support approach', that is, to treat the issues as 'welfare' rather than 'child protection' concerns.

However, as the children grew older they became increasingly involved in anti-social or criminal behaviour. At the same time, staff became increasingly concerned about what they believed to be very poor physical conditions in which the family lived. It is significant to note that when O's parents met the review team they disagreed that the conditions at home were poor or neglectful. They expressed their own perception that the children had good clothes and were well fed with 'meat on the table' every day. They also claimed that in their view, the house was warm and that it was well kept and maintained.

Staff believed that the parents loved their children and did their best for them, given their limitations. This perception appeared to affect their judgement; they appeared to believe that since the neglect was not intentional, the impact upon the children was somehow less serious than it might have been had the neglect been wilful. It seems that the material problems in the home became the focus of attention for professional staff whilst the developing problems of the adolescent children did not elicit a multi agency intervention plan.

Over the period 2006-2010 a number of incidents occurred which, in the view of the review team, should have given rise to concerns about the children's welfare and protection. These include:-

- A child being found by the father, in a field, in a state of undress
- A friend of one of the children being involved in an accidental overdose at the home, when tablets were given to this young person
- A 'drug party' occurring in the house involving this child's older sibling and their friends.
- O being seen on several occasions having taken alcohol or legal highs and the father's statement that they were taking drugs
- Someone breaking into the house armed with a hammer looking for one of the older children
- The eldest child having reportedly given his mother a black eye

None of these incidents, individually or collectively appeared to provoke a questioning of the strategy of ongoing family support. Neither did they lead to a child protection case conference being called.

In her interview with the review team, the team leader indicated that Children and Family Services had not ruled out any course of action, including the reception of the younger children into care. Indeed she told us that possible legal action had been discussed with the parents in 2008 and 2010. However, reading the files it appears that the course of action taken by the social work department was often prompted by the reaction of other

professionals to the home conditions. For example, the application for a supervision order was undoubtedly provoked by the garda's reaction to the conditions which he found when he visited the home in May 2010, and his apparent willingness to use garda powers to bring the younger children into care.

On four occasions between the beginning of 2006 and early 2008, the children's father had approached the social work department seeking help. He could see that as his eldest child grew older, he was losing not only control of this child, but also of the house, as from time to time teenagers had almost free rein to come and go at all hours of the day and night. The father recognised that this was setting a very bad example for the younger children. On several occasions he reported that his eldest child was using drugs, and he feared what effect this would have on the other children. In January 2008 he reported that this child had given his mother a black eye and wanted the child out of the house as they had lost control over him.

Whilst the father's proposal that the eldest child would "see sense if sternly spoken to by social workers and Gardai" was unlikely to be successful, it showed that he had sufficient insight to recognise that his child and home were drifting out of control and that something needed to be done. These requests for help were very much out of character, as his earlier dealings with Children and Family Services, had been characterised by a desire to keep staff at arms' length and out of his home. Despite this, the consequences of this developing situation appeared to be given insufficient attention by Children and Family Services and others.

On a number of occasions between 2007 and 2010 strategy discussions were convened and the decision to continue to offer family support was endorsed.

12.2 Assessment

From the first contact with this family, which led to a child protection conference in 1991, serious doubts were expressed about the capacity of the parents to care for their children. With the birth of each child, similar issues about attachment, stimulation and physical care were raised by health professionals. As the children grew older a different range of parenting issues were identified, in terms of controlling the children's behaviour and setting boundaries for them.

Throughout the period of social work contact, no assessment was made of the adults' parenting skills and capacity. Why was this? Staff told us that they were constantly trying to address the presenting problems, in the belief that if they could be resolved, improvements might generalise to other areas of the family's functioning. This focus on the presenting problems meant that staff failed to address the central question of whether the parents had the capacity, with assistance, to successfully parent their children, or whether their parenting shortcomings so significant that family support was unlikely to be successful.

If today, a family with this range of complex needs was referred to the Children and Family Services, best practice would require a multi-disciplinary assessment of the parents' capacity to care for and manage their children to be undertaken by child care staff and others. Such an assessment would determine their capacity, their willingness to accept help and guidance,

the degree of extended family support available and the manner in which support services could best be organised to provide them and their children with the help that they required.

All the children were very different. They had a wide range of abilities and needs. Best practice, would highlight the importance of looking individually at the children in terms of their needs, abilities and temperament. Assessments of the children's individual needs were generally not undertaken.

The process used by the local area for carrying out complex family assessments consisted of observation of the family by individual social workers and nurses during home visits. Where necessary, this would be augmented by psychological assessment of parental capacity. From what we gathered during our discussions with staff, there were no local services to which the family could have been referred, for a non-residential family assessment based upon direct observation of their parenting skills and family interaction. To the review team, this seems a serious gap in provision in a case as complex as this.

Individual child assessments were undertaken, by social work staff, on the two older children in 2007 and 2008 respectively. These assessments were in response to a number of incidents. In the case of the eldest child, the assessment had been prompted by drug misuse, physical abuse of the mother, and friends coming and going from the family home at all hours. For the other sibling, the assessment followed a period when they were bullied by the eldest child and his friends, and had been physically assaulted and threatened, to the point where they felt they could not remain at home.

In both cases, the assessments were undertaken when the young people were seventeen years of age and the Children and Family Services would shortly have no further legal duty to them. The assessment on the eldest child was tokenistic. The social worker conducted this without speaking to the young person. Indeed the social worker's only source of external information, as recorded on the file, was the juvenile liaison officer. The assessment of the other sibling was, by virtue of the intense period of contact with that child, in 2008, a much more rounded piece of work.

Both assessments concluded that child protection was not a major concern in this family, but that there were issues of child/parent interaction and child welfare concerns. These behaviours clearly had the potential to become child protection concerns as demonstrated by the younger sibling's unhappiness at home in 2008 and they also exposed the younger children to negative influences.

The review team were told by the social worker that it was recognised that there were tensions at home. Social workers who were interviewed by the review team commented that they did not consider themselves in a position to force the removal of this child and thought at the time that the most beneficial option for everyone would be for the eldest child to move out of the family home.

In this Local Health Office (LHO), local assessment guidance emphasised the three domains of:-

- parenting Capacity
- child's developmental needs
- family and environment

A thorough examination of the factors associated with each of these domains would have highlighted concerns, doubts and shortcomings in each. For example, there is no reference in the file to the family receiving help from extended family, other than their maternal grandmother, who lived with them for a period. On the contrary, reference to other family members were generally negative, with some relatives being perceived to have significant personal problems, including drug misuse. The family received limited support from their neighbours. In fact they were so alienated from some, that on occasions, the house was attacked with "stones and iron bars".

Had the local assessment guidance been followed this would have highlighted the need for a fuller, multi-disciplinary assessment and at the very least, the need for a coordinated, child focused, family support plan.

12.3 Compliance with Regulations

There were many examples of compliance with regulations by staff in this area during the twenty years of involvement with this family.. However there were certain occasions when staff failed to comply with policy directives or demonstrate that they gave due consideration to alternatives. Examples of this were,

- There was evidence to suggest that between 2006 and 2010 some of the children were beyond the control of their parents. There was also evidence that the children were putting themselves at risk of significant harm. . Part IV, Section 16 of the Child Care Act 1991 states "where it appears to the Health Board, with respect to a child who resides in its area, that he requires care or protection which he is unlikely to receive unless a court makes a care order or a supervision order in respect of him it shall be the duty of the Board to make application for a care order or supervision order as it sees fit." In this instance the professionals must not have believed that this threshold had been reached until the supervision order was sought in the summer of 2010, although there were several examples in the previous two to three years where, arguably, this threshold had in fact been reached.

- As this report demonstrates, a number of events warranted child protection or child welfare investigation which did not happen.

- The range and complexity of incidents which occurred over this period should have resulted in a child protection case conference being called. .

- Contrary to section 8.18 of Children First, there was no assessment of this family carried out, either of the adults' capacity to parent or the children's individual needs. of the two assessments that were completed on the older children during this period, one was at best tokenistic.

- Contrary to sections 7.6 and 7.7 of Children First, there was no family support plan developed, to assist the family in a coordinated fashion or to test the parents' commitment and support, for actions which they needed to take, to keep their children safe.

12.4 Quality of Practice

12.4.1 Interaction with the Child and Family

A great deal of help was offered over the years to the family by HSE staff and HSE funded organisations. Much of the intervention was targeted upon the poor physical conditions of the home. Efforts were made at regular intervals to repair damage, replace furnishings and bedding, and generally make the home more habitable. All of this was badly needed.

It is important to note that in February 2009 as both the social worker and public health nurse sought to achieve physical improvements to the house, the father indicated that he would refuse them entry to his home. This was the second time this had happened. In this instance he described both as being "too fussy". By then the concerns were so serious that he was told that there could be legal consequences if he persisted and eventually his position softened.

Despite the view expressed by O's mother and father that they were coping well and the children were not neglected, all of the professionals who were involved recognised this family as having complex needs which meant that they required extra support to effectively meet their children's needs.

Two of the children suffered from a rare medical condition, both had been ill as babies and had been hospitalised for months, making the attachment process more vulnerable. Both were enuretic. Three of the children had learning disabilities. The capacity of the parents, to care for children with additional needs was queried as far back as the first case conference, held in 1991.

The review team believes the public health nursing service should be commended for their commitment to this family. At times, public health nurses were visiting three times a week, trying to ensure good care. However, little of this appeared to transfer, with the result that after the birth of each new baby a similar level of intervention was required to guarantee safe care. The commitment and willingness of the current public health nurse to constructively challenge the family was noteworthy.

However, there was almost no discussion of the huge problem that the nightly enuresis of two children must have caused. Any parent would be daunted by this but these were parents with additional needs. The impact upon the family's morale and the home environment of failing to keep on top of this problem is self evident. It is also a partial explanation of the concern expressed by the community welfare service that new furnishings never lasted long in this home. The records show only limited evidence that this significant issue was given any consideration by health services.

12.4.2 Child and Family Focus

The Social Work Department (SWD) recognised that the family had additional needs. In 2000, they employed a child care worker to work directly with the four older children. Ostensibly this was to help them with homework, but it also helped develop their social skills, and learn skills of cooperation, respect and empathy. The child care worker worked with the children for around three years. There is no doubt that she contributed to their social development and this was recognised by others, including the local schools. The child care worker, the social worker at that time, and the senior staff who put this service in place are commended.

However, there did not appear to be a family support plan in place which linked this initiative of working with the children to a wider plan to work with the parents to create change. Therefore this work appeared to be largely tangential to what was happening at home and as such, was unlikely to transfer to the family setting.

The inability to engage the parents in a family support plan had been a long standing issue. As far back as 1991, when one of the older children was born, HSE staff believed that the placement of a home help was needed to guide and instruct the parents. The parents refused this offer of help then, and on many other occasions over the years, even though health professionals, the SWD, community welfare officers and voluntary organisations all believed that the home conditions were unacceptable and more had to be done. The father took the view that he didn't want strangers "running in and out of the house" and that he was perfectly capable of looking after his children. His refusal to accept support coming into his home was unyielding and final. The review team believe that this was a source of professional tension in terms of how directive Children and Family Services were prepared to be.

The professionals involved were dismayed and concerned by the home conditions. On several occasions over the years the home was described as appalling, filthy, cold, damp, with furnishings damaged and broken. In 2008 the Team Leader and Social Worker carried out a full tour of the house listing all the matters needing to be addressed with immediate effect if legal action was to be avoided Financial and material support came from many sources, personal, charitable and statutory, but all of this was short term, and within months the home conditions were as bad as before. The social worker described the house as neglected which it undoubtedly was, but the impact this was having on the children, including the older siblings was perhaps not fully recognised.

There was clearly concern for the younger children. However, professionals did not appear to recognise the impact years of physical and emotional neglect could have on the adolescents. Increasingly it was the children's behaviour given their differing temperaments, which became the focus of concern. This is in keeping with research by Hicks et al[1] which highlights the lack of understanding and attention professionals often pay to neglect in adolescence.

From an incident in July 2001, when one of the children, then seven years old, refused to go shopping with the parents, HSE staff recognised that the parents' ability to supervise or

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[1] Hicks, L. & Stein, M. (2010) *Neglect Matters: a multi- agency guide for professionals working together on behalf of teenagers, London:* DCSF

control their children's behaviour was going to be an issue as the children grew older. This was quite prophetic. Plans were put in place for the child care worker, to work on helping set boundaries. How this was to be achieved, when the child care worker worked almost exclusively with the children and not with the parents, was never discussed.

The work of the child care worker from 2000-2003 with the four eldest children was undoubtedly of benefit. After this however, with only a few exceptions, there appeared to be no individual focus on the children's needs, nor any plan to work with them. The file records the different problems being experienced by the children. Nevertheless, with the exception of the young person who self referred, there is no evidence that the children's own views on what was happening were solicited. It is, however, notable that on a couple of occasions before O's death, the social worker brought the parents, him and a younger sibling together to talk about their behaviour.

The focus of professional staff generally appeared to be on the parents and the house. Contact with the parents was influenced by the father's wishes. There is evidence especially in 2010 of efforts being made to engage the parents and some of the children and in so doing hear the children's views but by then it appeared to the review team as if events were spiralling out of control.

12.4.3 Recording

Over the years, the quality of recording was variable. For the period 2006-2010 the file record was maintained to an acceptable standard with discussions between professionals and with line management recorded. There were no case summaries. Seven different social workers had been at one point the primary worker for the family over the years, but only one produced a transfer summary. Recording was therefore descriptive rather than analytical or reflective

There was no record on the file, of 'Untoward Events' or issues of concern involving the children which could not immediately be explained, and how these had been dealt with or resolved. In circumstances such as these where Child and Family Services have been involved with a family for many years, a record of Untoward Events is essential for new staff to quickly grasp the family history and the various issues of concern that have arisen over the years.

12.5 Management

12.5.1 Allocation

During long period of involvement with this family by Children and Family Services, seven different social workers and five different team leaders had the responsibility for this case. Only one transfer summary was completed. On several occasions there was a gap of some months the old worker leaving and the new worker visiting. Rarely did the old and new worker visit together. Most new workers were immediately struck by the physical conditions in the home. Given the fact that previous colleagues had struggled unsuccessfully to effect

change in the home conditions, new workers found themselves confronting old unresolved issues.

The focus of the workers' attention was generally the parents. Very occasionally the file records the social workers being involved in activities or events which would have allowed them to spend time with the children. Once the child care worker was employed, she was left, almost alone, to get on with the task of working with the children and listening to their voices. When she left, no one picked up this mantle. This feature, namely social workers becoming brokers of service rather than direct workers with children, is not unique to this case and is increasingly recognised as an issue in child protection work. The emotional distance created by this type of practice makes it more difficult for staff to retain their focus on the key task of protecting the children and much easier for staff to become focused on adults.

12.5.2 Inter-Agency Meetings / Conferences

The relationships between the professionals and the sharing of information in this case were of a high standard. Formal strategy discussions were called, on a number of occasions between 2007 and 2010. These meetings were attended by professionals from within and outside the HSE, including schools and Gardai. None of these meetings led to a change to the ongoing orientation of intervention, which was family support rather than child protection.

It is clear that there were some tensions between the professionals as to what approach might be adopted in order to provoke change in the family dynamics. The frustration of some of the professionals involved was best illustrated in correspondence between a non HSE professional and the Children and Family Service, over the degree of risk faced not only by the young person who self referred, but by all of the children, as the house became increasingly a "hang-out" for older boys where drugs were regularly being used.

Notes from 2008 record discussion with the family about the possibility of legal action should home circumstances not improve. In 2010, the prospect of legal action being pursued if the parents could not ensure their children's safety was also raised. However, there was insufficient multi agency discussion of the risks to which, the older children were putting themselves, or whether they were beyond parental control and what contingency plans might be made for them.

12.5.3 Supervision

The team leader provided regular supervision to the social worker. This took place monthly. The social worker had a great deal of life experience but relatively little social work experience when she became responsible for this case in December 2006. In 2006, 2007 and 2008, the Team leader considered closure, despite the fact that there were constant unresolved issues. Indeed in 2007 the case was closed for a few months. Generally it appeared that the rationale for considering closure was more to do with the recognition that progress was not being made, rather than a belief that the children's and family's needs had been met.

In 2008, the team leader produced a report for the principal social worker's signature in response to an earlier letter from a professional, in which considerable concern had been raised about the safety and well being of this family. The report noted that this case remained a priority for Children and Family Services. It is difficult however to reconcile this with the fact that the social worker visited the home infrequently. The file records that in three and a half years the social worker gained entry to the home eight times. On a further two occasions, she visited but no one was home. In fact only twice in three and a half years did the social worker visit the house on her own.

Nevertheless, it is important to note that the social worker had ongoing consultation and discussion with the Juvenile Liaison Officer, the Public Health Nursing Service, a tutor at Youth Reach, Child and Adolescent Mental Health Services, a Project Worker on a Drugs Initiative, Garda from the Drug Squad, school Principals and an Educational Mentor amongst others. It was also the fact that the social worker and nurse worked closely and frequently discussed the results of their visits. The social worker also pointed out to the Review Panel that she had had other cases where there was a greater risk of physical or sexual abuse and that she had other contacts with the family, outside the family home. In fact she had met the family by appointment in the office on a further nine occasions over the same period.

It is the review team's opinion however, that given all the circumstances and the possibility that legal action might need to be taken, it would have been important for the social worker to see firsthand the conditions at home. This would also have provided her with the opportunity to meet and talk to the older children. There was no evidence that visits were made to the home outside normal working hours. The team leader was unaware of the pattern of visiting as it was not normal practice for her to read the case file, either randomly or as preparation for supervision sessions.

12.5.4 Policy

This Review raises the need for local HSE management to review a number of policy issues.

- Within this community there was a significant problem of drug misuse involving a group of young people. The group of boys and young men with whom O associated were all using drugs. His father had told HSE staff that P was also using drugs from an early age. We were told both by HSE staff and by the coordinator of a voluntary organisation that P was not alone in misusing drugs at an early age. We were also told that the within the LHO there was a drugs counsellor employed by a voluntary organisation but there appeared to be no service to refer younger adolescents to, for treatment or support.
    - We were also told that within the LHO there are fora where Health, Children and Family Services, Gardai, Education and local councillors can meet to discuss issues such as drug misuse. This is a good platform from which to build such an approach. As a result of this review, we would urge that the current level of response to drug issues in the LHO be re-assessed.

- From 2010 a Children's Services Committee has been established and has identified drug and alcohol abuse as one of its primary target areas. A sub group has been established and is reviewing the level of responses to drugs issues throughout the LHO. This is to be welcomed.

- There is a need for the local area to consider its current approach to the organisation of child protection case conferences. We were told that the current system of independent chairmanship, whilst valued by all who use it, often resulted in delays of three to four months. Social workers and the team leader had been advised, notwithstanding any delays in terms of convening case conferences that requests to hold them should always be submitted when they deemed it appropriate. Despite this, staff told us that in practice the potential for delay was a disincentive to such requests. This lack of responsiveness is unacceptable given that the essence of good child protection work is effective and timely multi-agency, communication, planning and intervention.

12.5.5 Inter-Professional and Inter-Agency Collaboration

Information was shared between the professionals involved with the family, and communication was clear and unimpeded. There appeared to be a high level of trust between staff members of different services. The Children and Family Services file records many contacts with local schools, nursing services and gardai, amongst others. This level of multi-agency communication is a positive reflection of the degree of inter-Agency and inter-professional cooperation in this case.

Whilst there will always be differences of opinion between professional staff, it is clear that on occasions, there were tensions between Children and Family services and their partners, as to the direction that should be taken. Some of the professionals were concerned that the management of this case was characterised by 'drift' and a non directive approach. They appeared to expect more decisive action to be taken. There appeared to be a general consensus against removal of the children, which was reinforced in strategy meetings but there was also a view that a much greater use of authority or challenge of the parents was required. Comments were made that the problems which the family currently faced were "no different from those of 10 years earlier", "that the family only respected the law and the threat of it", or "that Children and Family services had become complacent".

The review team believe that an opportunity to robustly debate some of these issues was missed when a professional colleague wrote in very strong terms about the safety and well being of these children a couple of years before the accident. The files show that a written response was provided but do not record subsequent face to face discussion of the concerns with this agency albeit that there was discussion with others.

12.5.6 Leadership

The review team believe that the team leader sought to provide regular support and supervision to the social work staff. We were told by staff that she was readily available to

them, for consultation, advice and assistance. She appeared to provide emotional support for the team. The review team was made aware of the significant pressures facing team leaders coping with the various crises which child protection work throws up for each team member.

It is nevertheless the opinion of the review team that in the absence of a comprehensive assessment, there was insufficient challenge to the wisdom of continuing the prevailing ethos of family support. In the absence of a more questioning and strategic perspective, workers were constantly reacting to the next incident, without appearing to have a coordinated plan. The review team are not in a position to conclude whether ongoing family support was or was not the right stratagem. However, from our interviews and file records, we found, insufficient record of this issue being robustly debated.

When interviewed, social work staff made the point that caseloads were increasing and they had cases of higher obvious risk or which demanded more urgent attention than this family. The review team can empathise with this with this fact and acknowledge that social workers were carrying cases of physical or sexual abuse, where risk was more obvious. However the social work literature has frequently drawn attention to the pervasive and damaging effects of neglect on child development. We do not believe that the staff fully recognised or appreciated this.

The review team sought to clarify whether the threshold had been reached for a child protection case conference to be called. Both the principal social worker and the team leader told us that with the benefit of hindsight, it could be argued that a conference should have been convened. This LHO has a system of independent case conference chairmanship which is generally believed to deliver reviews of high quality. However we were told that there is a waiting list for this service and it is not unusual for three to four months to elapse from the time of referral to the conference taking place. This lack of responsiveness is not acceptable in child protection work and acts as a disincentive to staff to actually request a conference. In cases that have been known to health and social care professionals for a long time it is often important to ensure that a "fresh pair of eyes" looks at situations such as this It is possible that had there been a case conference, independently chaired, that this would have encouraged professionals to reflect on the emerging risks and how, or if, continuing adherence to a family support, as opposed to child protection, approach could achieve better outcomes for these children.

Staff involved with this case have been affected by this tragedy. Those involved in child protection work are doing a demanding, judgement orientated task. For front line practitioners and managers, the emotional impact of the work can have a significant personal effect on the worker and his or her performance. We have no reason to believe that the local service is anything but caring and concerned for its staff, but this tragedy has impacted upon a number of members, whom we believe would benefit from personal support. We recommend the organisation looks afresh at the personal and emotional support it offers staff in these circumstances.

The area covered by this LHO lends itself to working on a neighbourhood/locality model. There are many advantages to such an approach, not least local awareness and the ability to build networks. However, this model also has a downside in terms of it being generalist in

nature and therefore more difficult for staff to acquire specialist knowledge or skills. Research into Serious Case Reviews, in the UK, shows that one quarter of such reviews are of teenagers, and 10% involve those over 16 year olds who have taken their own life or find themselves in situations of serious harm as a result of their risky or reckless behaviour.
In light of this evidence, it is the opinion of the review team that local management should audit the skills and services within the Children and Family Services to deal effectively with this group of young people. Some building blocks exist, not least local community supports, with whom closer partnership work is likely to prove helpful.

13. Findings

In 2010, O who had just turned 15 was involved in an accident, in which he died. His family had been known to HSE services for almost twenty years. The parents and some of the children had additional needs. As the older children grew up, some of them became increasingly difficult to manage. They were taking drugs, and becoming more involved in anti-social and criminal behaviour. The file record suggests that O was increasingly experimenting with drugs, getting into trouble at school and becoming involved in crime. In the months before his death, his behaviour had become very concerning. According to his father, O had also been given drugs to sell by older boys.

When this was happening, O's father sought help from Children and Family Services and the Gardai. He was concerned about both what was happening in his house and the fact that some of his children including O were using drugs. No specific help on these issues was made available to him.

In the year leading up to the accident, O's lifestyle put him at increasing risk. Children and Family Services made an application for a supervision Order in 2010. In the view of the Review Panel there were grounds for a similar application to be made in 2006/2007. Had an application been made then, it is possible that intervention may have reduced the negative influences to which O was exposed. However, there is absolutely no certainty that this would have changed the outcome for him.

The review found that the quality of service provided to O and his family in the period 2006 – 2010 was influenced by the following issues:

- No assessment of the needs of this family was undertaken. The parents had particular needs; yet no formal process to assess their capacity to successfully care for and rear their children, was ever put in place. All of the children were very different; intellectually they were of varying ability, they had different temperaments and some had medical conditions. The children, despite these differences, appeared to be considered as a group rather than individually.

- Individual assessments were carried out only on the two oldest children. The assessment completed on the eldest child was particularly weak and fell far short of what was set out in the assessment guidance provided for staff in the area. These

assessments failed to recognise the potential negative impact of the eldest child and his friends' behaviour and the risks to which the younger children were being exposed. Both assessments were undertaken when the young people were aged 17+ and the involvement of Children and Family Services with them was about to terminate.

- In the year leading up to O's death, there was little individual focus upon him. No assessment of his needs was undertaken nor any plan made to engage him by either HSE staff or other statutory bodies. There is no evidence of focused multi-disciplinary planning as to how he might have been helped.

- Most, if not all, of those who worked with them felt that the family was stable and caring. The parents were not abusive, nor were they considered to be wilfully neglectful. However, the file records suggest that the children experienced physical neglect over the years. The neglect to the home was a huge focus for professional staff from all the agencies involved, who were especially concerned about the impact that this would have on the younger children. There appeared to be less appreciation of the social and emotional effect of cumulative and long term neglect on the adolescent children, although this was increasingly "played out" through their anti-social and criminal behaviour. There appeared to be a "hierarchy" of risk employed by professional staff, with neglect being judged as less pressing or urgent than physical or sexual abuse. Staff did not appear to appreciate, and therefore give due weight to, the pervasive and damaging nature of neglect when experienced over years.

- Apart from a period where a child care worker was employed to work with the children, the concentration of professional staff was generally on the adults or the conditions within the home. During these years, the house frequently fell into an appalling state of disrepair which required a number of agencies to come together to make practical improvements. During this time, little sustained attention appears to have been paid to the experience of the children in these circumstances.

- Despite the problems, the clear view expressed by all professionals was that these children appeared to be better off with their parents than in care. As a consequence a strategy of 'family support', as opposed to 'child protection', was adopted. There were a number of strategy discussions held between 2007 and 2010 following which the professionals continued to hold this perspective even when there was mounting evidence that the children were getting into difficulties.

- Communication and information sharing between the agencies involved with the family was of a high standard. The Children and Family Services files record many contacts with local schools, nursing services and Gardai, amongst others. However, it is clear that, on occasions, there were tensions between Children and Family Services and their partners as to the direction that should be taken. Whilst no professional appears to have thought it appropriate that the children be received into care, some professionals would have preferred if a more directive approach was taken with the family. Several strategy discussions were held during this period which, in the opinion of the review team, were not used to create a strategic focus for staff working with

this family. Instead, they concentrated instead on current problems. The review team have formed the view that O's needs and those of his family were so complex that no one organisation alone would have been able to meet them. While there were efforts to improve the physical conditions at home, there was limited evidence of a coordinated, multi-disciplinary and multi-agency plan to improve the family's functioning.

- A number of incidents which raised questions about the protection and safety of the children occurred during this period and should have been investigated. They were given less attention than would normally be expected. The review team believe that, cumulatively, these incidents required the convening of a child protection case conference. For reasons that are unclear, this was never requested. The review team believe that some of the adolescents in this family were beyond parental control. There was limited evidence of discussion about the possible use of statutory powers in response to this.

- Experimentation with drugs by O was a developing issue as, we were told, it was for other young adolescents within the town. While a drugs counsellor was employed by a voluntary organisation in the area, there appeared to be no local HSE service where young people with developing drug issues could be referred. This is an issue which local HSE management need to consider.

- In this LHO, independent chairing of child protection conferences is the norm. This is generally regarded as good practice. However, there was often a delay of several months between a decision to hold a conference and the actual conduct of a conference. The prospect of such a delay acts as a disincentive for staff, and undermines the timeliness necessarily for effective multi-agency information sharing and planning. The review team found this delay to be unacceptable.

- The problem of young people putting themselves at risk by their reckless behaviour is a complex one. We believe that there is a need to review on a multi-disciplinary basis the current skills and services being provided by the HSE and its partner organisations to adolescents in this situation.

- In the aftermath of this tragedy, no organisational plan was devised by the HSE to offer support to the family, albeit that individual members of staff were supportive and showed their concern. There is a need for the HSE to review how it offers support or counselling to family members in circumstances such as this, particularly when there are other children involved.

- Staff involved with this case have also been affected by this tragedy. Those involved in child protection do an emotionally demanding, judgement orientated task and events such as this can have a significant personal effect on the worker and his or her performance. We believe staff would benefit from personal support in these circumstances.

14. Key Learning Points

This review has identified a number of key learning points from the case, as follows:

14.1 Assessment

In this case staff failed to follow their own LHO's assessment guidance. As a result, there was no analysis of the children's or young persons' needs, the adults' capacity to parent or the level of family or community support available. The lack of assessment meant that objectives were not formulated, no plan of intervention was developed, or indicators to measure success set.

O's parents had particular needs. Their ability to successfully rear their family was never systematically assessed. If today, a family with this range of complex needs was referred to the Children and Family Services, best practice would require that a multi-disciplinary assessment of the parents' capacity to care for and manage their children should be undertaken by child care staff and others. Such an assessment would, *inter alia*, determine their capacity to parent, their willingness to accept help and guidance, the degree of extended family support available and the most effective way to organise the help required by both parents and children.

14.2 Cultural Acceptance

Over the years, the living conditions within this home which were considered unsuitable by successive new social work staff, proved very difficult to change. The family support approach to this case established in 1997-98 was continually re-adopted in strategy discussions in 2007-10 despite the very different nature of problems and issues facing the family. The review team are of the view that there was insufficient challenge to this thinking at a senior level. Certainly this is not immediately apparent in the case records. Mechanisms to question or challenge fixed ideas in these circumstances are vital

14.3 Neglect

Staff appeared not to fully appreciate the very damaging effects on child development of long term neglect. Whilst unspoken, it appeared as if there was a "hierarchy" of risk with neglect being viewed as less pressing than physical or sexual abuse. Staff appeared to be less aware that neglect is also a significant and damaging issue for adolescents[2]. The focus was upon the conventional view that neglect is a major issue for young children, with less attention paid to the impact that years of neglect can have upon adolescents.

There was also a sense that the parents would not be wilfully neglectful. The file records would suggest, however well intentioned the parents' might have been, that their children experienced physical neglect over the years. The father was allowed to exercise a veto over who came in and out of the house, despite frequent suggestions being made that a home help should be placed. In terms of the conditions in the home this resulted in inadequate preventative measures being put in place.

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[2]Hicks, L. & Stein, M. (2010) *Neglect Matters: a multi- agency guide for professionals working together on behalf of teenagers, London:* DCSF.

14.4 Working with adolescents

The problem of young people putting themselves at risk by their reckless behaviour is a complex one. We believe that there is a need to review, on a multi-disciplinary basis, the current skills of HSE staff and the services being provided by the HSE and its partner organisations to adolescents in this situation.

14.5 Drugs

The use of drugs by young teenagers is unfortunately becoming more prevalent. Some of these young people will end up with significant problems[3]. There were limited services for families and young people in terms of treatment, support and advice. This is a problem which is by no means unique to this LHO. There is a need for the HSE to reflect on this issue and how services can be improved at a local level, conscious of the fact that there will be both financial and human limitations as to what might be done quickly.

In this instance there were fora in the locality where Health, Children and Family services, Gardai, Education and others could meet to discuss issues such as drug misuse. However it was the view of those we met that they were not working effectively in terms of producing a multi-agency approach to prevention, education, support and treatment. As no one agency will be capable of dealing with drug issues in isolation from its partners, it is critically important that a local plan be put in place which can regularly be reviewed. The review team note and welcome the establishment, since 2010, of a sub-group of the Children's Services Committee to address the problems of drug and alcohol abuse.

14.6 Governance

Staff within Children and Family Services told the review team that they were working under considerable pressure, resulting in a constant need to reprioritise work. They indicated that the size and case mix of their workload meant that they were unable to fulfil all their tasks, as they would have wished.

Organisations are accountable for continuously improving the quality of their services, ensuring safe and effective practice, and seeking to provide the highest possible standard of social care, within the resources available. This duty can only be discharged by working at different levels, the individual practitioner, the team leader, the child care manager and the organisation itself. Whilst there were good working relationships between practitioners and management, there appeared to be few processes or systems in place to systematically allow senior management and the organisation as a whole to identify areas of weakness and take the necessary corrective action. Similarly, there were no mechanisms by which the senior HSE management in this LHO were routinely made aware of performance and issues in the area of child protection and child care. Given the many pressures on the HSE, a routine focus on children's work is vital to ensure that the organisation understands its statutory obligations and gives these the priority they require.

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[3] Ambreen Taj, A., Keenan, E. and Casey, P. (2008). 'Childhood adversity and substance misuse', *Irish Journal of Psychological Medicine*, 25, 29-30; Mayock, P. (2005). ' "Scripting Risk":Young people and the construction of drug journeys', *Drugs: education, prevention and policy*, 12, 349-368

There was no clear governance trail from the practitioner to the organisation. Seeking to improve governance arrangements should not be about the imposition of further administrative burdens on staff but rather the desire to create a learning culture which places a duty on the professionals to reflect and audit practice, in order to ensure that practitioners and the organisation as a whole are discharging those duties for which they are accountable. A paper issued by the Social Care Institute for Excellence, entitled Social Care Governance – A Workbook would encourage discussion and debate[4].

15. Recommendations

The Review Panel has decided only to make recommendations which have significant operational or strategic impact. There are a number of areas where practice could have been improved, which have been highlighted earlier in the report. Our expectation is that the HSE will seek to improve performance in these areas.

I. The HSE should take steps to ensure that, where children are born to parents who themselves have complex needs, a multi-disciplinary assessment of their parenting capacity is undertaken. This assessment should be conducted jointly by child care staff and others as appropriate. Such an assessment must be based on the principle that the needs of the child are paramount.

II. The HSE should consider their current approach to conducting complex or intensive family assessments. The LHO should consider adopting a model which is capable on a non residential basis of providing detailed observation of parenting skills and family interaction.

III. The HSE should review the current level of services available to families where young people are misusing drugs and alcohol. Local management should also ensure that there is an appropriate forum to discuss local drug and alcohol issues on a multi-disciplinary basis, with other statutory and community partners.

IV. The HSE should ensure that all families known to Children and Family Services who have been affected by the death of their child should automatically be offered support and/or counselling. Similar provision should be made for staff members who have worked with these children and families.

V. The Child Care Manager should review the current arrangements for conducting child protection case conferences and ensure that whilst retaining the independence of chairmanship, the process is made much more responsive. A target should be set in respect of the waiting time for a child protection case conference to be organised.

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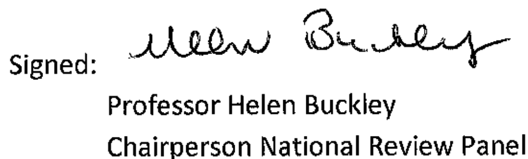
[4] SCIE (2011) Social care governance: a workbook based on practice in England http://www.scie.org.uk/publications/guides/guide38/index.asp

VI. The Child Care Manager should work to develop a system of governance within Children and Family Services to ensure that there is adequate quality assurance of the work being undertaken. Amongst other things this should include a requirement on team leaders to randomly review file records as part of the supervision process.

VII. The Child Care Manager should audit the range of adolescent services, knowledge and expertise of HSE staff working with this client group.

VIII. The Child Care Manager should initiate a training programme highlighting the damaging consequences of neglect on child development, in order to ensure that chronic neglect receives the professional attention it warrants. Staff should be helped to recognise that neglect is not restricted to younger children and also has very damaging consequences for adolescents.

IX. The Principal Social Worker should ensure that all files have a section at the beginning, in which are recorded, all incidents of a child protection nature which have been investigated, the outcome of that investigation, even if this is inconclusive, and any other incidents of concern which is regarded as being not immediately explainable.

Signed: 

Professor Helen Buckley
Chairperson National Review Panel

Date: 12-12-2011