Review undertaken in respect of the death of a child in the care of the HSE: Sean

April 2012

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 t 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 and recommendations. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per

annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

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

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

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

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

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

4. Death of a child, here called Sean

This review is concerned with the death of a fourteen month old boy, here called Sean. The HSE Children and Family Services worked with his mother, here called Susan, for some months prior to his birth. He died in the summer of 2010. At the time of his death he was in

the care of the HSE and had been with the foster carers on a fulltime basis since the beginning of January 2010.

A post mortem examination carried out by the State Pathologist concluded that his death was from Sudden Unexpected Death in Infancy (cause undetermined), with an associated factor of hyperthermia.

5. Level and Process of Review

This was conducted as a desktop review.

The methodology adopted was a review of HSE records only. This review was conducted by Leonie Lunny, member of the National Review Panel. The records provided included three files on Sean and his family with over 1,100 pages and three files on the foster family with nearly 700 pages. These files included records post Sean's death.

6. Terms of Reference

- to examine events leading up to Sean's death and determine whether action or inaction on the part of HSE Children and Family Social Services had been a contributory factor
- to examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice
- to provide an objective report to the HSE

7. Details of Sean's family composition

Sean was in a HSE foster placement under an interim care order at the time of his death. Sean's mother Susan who was in her early thirties had older children. Because of problems with her capacity to care for them, her older children were not living with her at the time of Sean's birth. Sean lived with his mother for the first seven months of his life. During this period a range of formal and informal supports were provided, including respite care with his maternal grandmother. The records indicate that the identity of Sean's birth father was not known with certainty, but the person who was regarded as his putative father had problems with alcohol and drug use and was only permitted supervised access with Sean. It was the intention of the HSE to ultimately reunite Sean with his mother, and he had frequent access with her, and with his half siblings in the home of his maternal grandmother.

8. List of services involved:

The services involved with the family were:

- The HSE Children and Family Services which began their assessment three months prior to Sean's birth and continued to work with the family. The foster care team was involved from the time Sean was placed in respite foster care at week ends
- The public health nursing service which saw Sean for his prescribed visits and on other occasions, for example while visiting the nursery that he attended
- A family support service which had worked with the family in earlier years and worked with Susan and Sean from mid 2009 until the spring of 2010
- A crèche which was run by a voluntary organisation. Sean attended this crèche five days a week for three months until his admission to fulltime foster care
- A paediatrician to whom he was referred and who did not find any abnormality in his development
- A dietician to whom he was referred because of not gaining weight who did not find any abnormality in his development
- A psychiatric day hospital which Sean's mother attended for some years
- A counselling service attended by Sean's mother for drug users and another service for victims of physical abuse
- The Gardai who, on request, provided reports to the HSE prior to Sean's admission to care
- A number of other services were involved with Sean's half siblings but are not included in this review

9. Background and the reason why Sean was referred to child protection service

Sean was the subject of child protection concerns prior to his birth because of his mother's problems with depression, alcohol use and history of violent relationships. A pre-birth assessment was conducted by the HSE Children and Family Services and a child protection plan was implemented from the date of his birth. This plan included continued involvement by the social workers in the HSE, the public health nursing service, a family support service, and the adult mental health service.

10. Brief summary of child's needs throughout case career.

In order to provide a secure environment for Sean the pre birth case conference set out a plan to provide for his needs. Sean had the normal needs of a newborn infant; he needed a secure safe and caring parent or parent substitute to care for him. He was a baby who cried a lot and at times was difficult to comfort. There were questions about his low weight and crying, particularly as two of his half siblings had health problems. His mother's problems with depression, alcohol and violent relationships had contributed to an unsettled lifestyle, and in this context, she had not been able to prioritise her older children's safety or meet their needs.

Within two weeks of Sean's birth concerns arose over his exposure to domestic violence while in his mother's care. A supervision order was obtained by the HSE at this point. The situation was closely monitored and every effort was made to ensure his safety in his mother's care. Further incidents caused concern and when he was seven months he was taken into foster care on a fulltime basis.

Sean's need for a secure, safe and caring environment continued. His crying behaviour remained a concern, as did his slow weight gain.

11. Chronology of the involvement of Children and Family Services with Sean and his family

The family was first referred to the then health board in 2004 in respect of the care of Sean's older sibling and was referred on to a voluntary agency for family support. The HSE Children and Family Services became involved again in 2009 when Susan's pregnancy was referred as a cause of concern. The Social Work Department (SWD) contacted a range of agencies and professionals who had had contact with Susan. Four pre-birth assessment interviews were carried out with Susan by two HSE social workers, one of whom is referred to here as Social Worker A. This worker continued to work with the family throughout the period under review. The assessment had concluded that the baby would require a child protection plan. At the core of this plan was a requirement that Susan would engage positively with services and ensure the safety of her baby.

<u>First three month period of Sean's life</u>

Approximately two weeks after Sean's birth a supervision order was sought and granted following an incident of domestic violence between Susan and her then partner. Initially two HSE social workers were working with the family, which included Sean's half siblings and his maternal grandmother. In addition the public health nurse was in frequent contact with the baby and a family support service was also working with Sean's mother. Susan was a patient of the psychiatric day service.

A constant series of concerns centred around Susan's habit of having people in her home who were drinking and possibly using drugs. There was also the question of her own drinking and a number of violent incidents involving herself and her then partner. An ongoing cause for concern was that Susan was not honest with social workers about whom she was seeing, or who stayed in her home.

Six weeks after Sean's birth, a review child protection conference was held. This review was conducted earlier than the scheduled date because of concerns about a violent incident that took place when Sean was present. Despite the violent incident, to which the Gardai were summoned, it was considered that Sean was doing well and Susan was engaging with all the services. Reports were sought and provided by the Gardai though they sent apologies to the review child protection conference. One of the decisions of the conference was that the case should be listed on Child Protection Notification System. The case was reviewed by the team leader, here known as Social Work Team Leader B and one of the decisions was that Social Worker A would be appointed key worker for the case. Social Worker A continued to make frequent contact and also tried to ensure a routine between workers and agencies so that Sean would be seen every day. On many occasions when Social Worker A would call by arrangement Susan would not be in or would be on her way out to some other engagement. Social Worker A consistently followed up and met Susan when she was available. Sean's maternal grandmother was concerned for his protection and safety. On a number of occasions she contacted Social Worker A with information and these incidents were subsequently followed up and discussed with Susan.

Period when Sean was three to six months old

In the autumn of 2009, an incident of domestic violence took place in the home, in Sean's presence. A further violent incident occurred at the end of the month which, in the view of Social Worker A, put Sean at risk. There had also been concerns about Susan allowing her older children to stay overnight when it was known they were smoking marijuana. A notification concerning these matters was sent to the Child Protection Notification System. it was signed by Social Worker A and Social Work Team Leader B. It was listed about a week later as 'confirmed neglect' due to serious domestic violence incident some months earlier.

At a scheduled review case conference which took place shortly after the second violent incident, concerns were expressed about Susan's ability to keep Sean safe. The meeting concluded that a child protection plan was still required and that Sean should continue to be listed by the Child Protection Notification System as at ongoing risk of neglect. Susan was receiving support from a family support agency that had also facilitated access for Sean's putative father. The conference recommended weekend respite care for Sean, ideally with a relative. It also recommended nursery care from Monday to Friday, with fortnightly weight checks by the public health nurse. A date was set for a month's time for the next review child protection conference.

The next conference again recommended weekend respite preferably with Sean's maternal grandmother, or, if she was unable to provide it, with mainstream foster carers. It also recommended that Sean be reviewed by a paediatrician and a dietician to rule out physical

or dietary reasons for his crying. It strongly recommended that the man who, at that time, was considered to be his father was not to have unsupervised access with Sean. Susan's mother was unable to continue to offer respite and a foster placement was identified which would provide this respite care at week/ends

Period when Sean was six to nine months

There was a further incident some weeks later. The supervision order was subsequently amended. By this stage, a DNA test had ruled out the first putative father, and a second person was assumed to be Sean's father though this was never confirmed. Susan and Sean's new putative father gave an undertaking to adhere to the conditions outlined in the order. Access with father was to be supervised. However, around this time, Susan began to disengage with services and allowed inappropriate people into her home. Her mental health also began to deteriorate. Weekend respite foster care was being provided to Sean, but concerns regarding his safety during the week continued.

A few weeks after Sean started in week end respite foster care, the link social worker for the family did a home visit. The foster carers reported that they had found the first two weekends difficult, but that he had he been less fretful on the third week-end. A week later the link foster care worker, who was going on maternity leave, completed a transfer summary and it was signed by the foster care team leader. The summary report noted that the foster mother owned and ran a crèche; for this reason, her availability to take placements was determined by the ability of the children to fit in at the crèche.

Another review child protection conference was held, as scheduled, early in 2010 and concluded that Sean continued to need a child protection plan. The conference recommendations supported the Social Work Department's plan to apply for an interim care order in respect of Sean. Susan agreed to Sean's placement in voluntary care on a full time basis, with the same foster carers. Shortly afterwards the HSE applied for and was granted an interim care order with Susan's consent.

Period when Sean was nine to fourteen months

About six weeks later a further interim care order for a period of three months was granted in respect of Sean. The hearing had been postponed for a fortnight to facilitate Susan getting legal representation. Although Social Worker A ensured Susan had legal representation she did not attend the hearing. Access between Sean and his mother was provided in his grandmother's home, midweek with an overnight at the weekends. Social Worker A usually brought Sean midweek for access but Susan would not always be there when she arrived. Weekend access was arranged by the foster carers and Susan's family to coincide with their individual arrangements. There was a good relationship between the two families. The new fostering link worker visited the foster carers, it had been about three months since the previous worker had visited and the family were now fostering another child who had

previously been placed with them. The worker noted that the placement appeared to be meeting both children's needs.

Social Worker A continued to provide support to Susan, visiting and telephoning her on a regular basis. She also had contact with the wider family..The plan for reunification of Sean with Susan remained in place. Following the review child protection conference recommendations, Sean was referred to a dietician regarding low weight. Social Worker A also arranged a consultation with a paediatrician as there were concerns about his crying and development. Both these medical examinations concluded that he was functioning within the normal range. Access visits were arranged in Sean's grandmother's house. Susan would miss these from time to time, but reported how she missed Sean and appeared to be more engaged with services. The file records frequent home visits to Susan by Social Worker A when she was not home these visits were both planned and unplanned.

Following a decision of the scheduled review child protection conference in early summer, a six month extension of the interim care order was sought and granted. A short time later the fostering link social worker visited the foster carers by arrangement. She discussed the progress of both children. The foster mother described Sean as quite a difficult child, cranky and irritable who did not sleep well. The social worker addressed Sean's sleeping arrangements; he had a cot in their room and they took him into their bed some nights. She advised against this and they agreed to stop. They asked for respite care for him during their holidays but agreed that if it was not possible they would either not go or take him with them. Three weeks later the fostering link worker visited again in connection with the other child, she asked about Sean, who was reported to be doing very well while still considered to be cranky. He was beginning to walk.

In summary, from the time of his birth until his admission to fulltime foster care a range of supports were provided to Sean, including care in a crèche Monday to Friday; he was seen by the public health nurse for his core health checks, and also seen opportunistically at his nursery by a public health nurse. He had constant and frequent social work support and week end respite foster care. A number of voluntary agencies were offering support. There was good communication between the different services and disciplines. The social work input was reviewed in supervision on a regular basis. In the period from the first referral it was reviewed at least ten times. Social Worker A and the social work team leader both worked with the family throughout this period. The minutes of all child protection conferences were comprehensive with decisions and recommendations noted.

A Child in Care Review had been planned originally for a date two months before Sean died but was postponed twice and was scheduled for early autumn 2010. One of the matters to be discussed was a safety issue in respect of the foster mother taking Sean into the bed at night to comfort him. Sean was in the care of the HSE at the time of his death. He had been placed with the foster family originally for week end respite care and some months later on a fulltime short-term basis. There was constant and frequent access arrangements in place throughout this period including an access visit the day before his death. The records

indicated good contact between the link social workers and the foster family and between Social Worker A and the link workers.

12. Analysis of the involvement of HSE Children and Family Services

12.1. Assessment

The assessment of Sean's needs began prior to his birth with a series of four interviews conducted with his mother by two HSE social workers. There was also extensive information gathering from agencies and individual professionals who had known his mother. The evidence was gathered and then analysed in respect of mother's behaviour and the risks this could pose for her baby. A pre-birth child protection conference was held and a plan set out to ensure Sean's care and protection. There is evidence that this approach continued throughout the period of Sean's life. The social work reports prepared for court hearings and for case conference reviews include a review of Sean's needs and an analysis of risk to him. They also include an assessment of parenting capacity and a plan of action to ensure Sean's safety. Throughout the period it was recorded that Susan cared for Sean in a loving and caring manner but the risks related to her inability to protect him by allowing others into her home who posed a risk to him. Needs which were identified were followed up, for example the question of Sean's irritability, his developmental milestones and his weight were referred to a paediatrician, medical officer and a dietician. There was an ongoing review of the mother's behaviour and the potential for change. There were seven child protection case conferences held on Sean. The records provided indicate that they were comprehensive and relevant.

The decision to place Sean with the foster carers originally on a weekend respite basis and subsequently on a short term basis was in line with the stated approval status of the foster carers. Some months after his placement, another child who had previously been in their care was also placed with them. There is no record that Sean's needs were reviewed at that time. A Child in Care review which was planned had to be cancelled twice and was scheduled for approximately one month after his death. This review could have provided an opportunity to assess the situation having regard to Sean's needs, his sleep pattern and what is described as cranky behaviour and the burden this placed on the foster carers.

12.2. Compliance with regulations

Prior to Sean's birth and until his untimely death there was full compliance with regulations. He was identified as being at risk prior to his birth and there was a plan made to offer him protection. When issues arose which could pose a risk they were followed up in a timely manner and addressed. On several occasions Susan, Sean's mother, was confronted about behaviour that could have presented a risk to him. Plans were revised and appropriate action taken when the need arose. Evidence of this includes the supervision order, the amended supervision order and care orders. There was evidence of sharing of information between the relevant people. While Sean was in foster care he was seen regularly by Social

Worker A as she facilitated access with his family on a weekly basis. The files indicate frequent contact with various agencies as the need arose.

There were regular child protection review conferences and a planned Child in Care Review. There was a Child Protection Notification (CPNS) on file, and a Child Protection Notification Management Team (CPNMT) acknowledgement and decision to list the case as confirmed neglect due to a number of domestic violence incidents. The plan for Sean at the time of his death was reunification with his mother and this was reviewed at the last child protection review conference, two months before he died.

12.3. Quality of practice

Frontline practice

The quality of practice as indicated by the records shows that factual information was gathered and assessed. The supervision notes show that this case was reviewed ten times during Sean's lifetime.There was consistency of workers in that both Social Worker A and Social Work Team Leader B worked with this family throughout this period. There were seven child protection conferences and plans were adhered to and revised as required. On a number of occasions joint visits were undertaken by Social Worker A and the Social Work Team Leader when a significant issue had to be addressed such as why they were pursuing a court order. There was a constant alertness to incidents that could affect Sean while he was in his mother's care and these were followed up in a timely manner by Social Worker A who frequently addressed the issue of Susan's lack of honesty with her and was always clear in her communications with her and Sean's putative fathers who posed a risk.

The placement of Sean with the particular foster carers was initially for weekend respite care and he was the only child currently in their care. At the time of this placement the foster family stated their wish to be available for another placement. There is no evidence that the issue of a second placement with this family was considered in the context of a decision recorded in the foster family's file about fifteen months earlier. Sean's respite care changed to short term fulltime care approximately two months after the initial placement. Subsequently a child who had been fostered by them returned to care and this child was also placed with the family. These actions appear to contradict an earlier view formed about the capacity of the foster family.

In reviewing the three files provided to the National Review Panel on the foster family it is clear that this family had been challenged in the past by the care required for a boy who had difficulties. This placement had broken down quite dramatically. Decisions made at that time were recorded on the files. Questions arise as to whether these decisions were considered when Sean was placed with this family. There are also records of some issues in respect of the accommodation provided to another child to be considered and the possible long term care of this child. These matters are outside the remit of this review but need to be addressed by the HSE.

12. 4 Child and family focus

The focus of the HSE Children and Family Services social workers was primarily on identifying and meeting Sean's needs. A place was secured for him five days a week in a nursery when concerns increased about his care. In the autumn when there were increased concerns about his protection Social Worker A attempted to coordinate visits so that Sean would be seen every day. Attention was paid to his development and questions about his health were referred to a paediatrician. A range of supports were sought for his mother to improve her parenting skills..

12.5. Quality of management

The case was reviewed by the social work team leader ten times. The records show that there were seven case conferences over a period of fourteen months. Clear decisions and recommendations were made at these meetings, and actions were taken in line with them. The attendance at review case conferences represented a broad range of professionals and agencies and the minutes were comprehensive. The format of social work reports was good and covered all relevant issues for child protection and development.

12.5.1 Quality of record keeping

The majority of the recording of visits and contact with Susan and Sean in this case is handwritten circa 100 pages. This is a significant issue as the records begin in 2009. While the handwriting was reasonably clear, it is very difficult to decipher certain words and makes the file difficult to read. The order of the files is difficult to understand as the chronology goes backwards and forwards. In the midst of one section there are records relating to something else. In one file of over six hundred pages, there are nearly 100 pages of forms recording the change in circumstances, relating to foster care. The records on the files continue after Sean's death which indicates that the file was not shut down as is required on that date.

12.5.2 Quality of inter-agency work

The records indicate that a number of agencies were involved in the assessment and support of this family. Evidence from the records indicate that there was good communication between the agencies working with this family particularly the crèche, the family support service and the HSE Children and Family Service. The records indicate that Social Worker A was in regular communication with those agencies and professionals who were offering services to Sean and his family. There was good attendance and participation at case conferences.

13. Conclusions

- The review concludes that action or inaction on the part of HSE Children and Family Services was not a contributory factor to Sean's very sad death.

- This review examined the services provided to Sean and his family. In this respect the files indicate that the assessment, compliance with regulations, quality of practice and quality of interagency work were of a high standard. The work with Sean and his family was focussed on his welfare and protection. A number of supports were provided to assist Susan in her task of caring for her young baby. When issues arose concerning his protection action was taken.

- The quality of management was also of a high standard except for issues relating to the the presentation of the file on Sean and handwritten records in 2009 and 2010

- Sean died while he was placed on a short basis with a foster family. There is no suggestion that action or inaction on the part of the foster family was a contributary factor to Sean's death. In reviewing the three files provided to the review Panel on the foster family the review notes that some earlier incidents and decisions made in respect of these foster carers were not considered when Sean was placed, and particularly when a second child was placed with him. It is outside the remit of this review to investigate this matter further but it needs further consideration in the local area.

14. Key Learning Points

The key learning from this review is overshadowed by the very sad death of baby Sean, but it has found very positive examples of practice in this case with respect to the protective actions taken in respect of Sean prior to and following his birth, culminating in his placement in foster care.

It has also highlighted the necessity for sensitivity to the capacity of foster carers and the importance of considering the implications of decisions made and recorded on file.

15. Recommendation

- The HSE should undertake a full local review into the assessment and support provided to the foster family over the years. This should include the HSE's decision making process in respect of the family's capacity to care for particular children who may prove challenging and decisions to place two children in the family.

- All records should be organised in an identfiable, logical sequence and typed. Files should be closed and secured immediately after the death or serious incident of a child.

Signed : Leonie Lunny Date: 18.04.2012

Review Chair

Signed: Helen Buckley Date: 18-4-12

Chair of National Review Panel