Review undertaken in respect of the death of

Christy

A young person known to the then HSE

Child Protection System

October 2014

1. Introduction

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

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

2. National Review Panel

A national review panel was established by the HSE and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a

death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the National Review Panel. The National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which 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 with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

- **Recommendation for 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 Social 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 Young Person.

This review relates to the death of a young person here called Christy, whose family were known to the HSE SWD over a period of nearly five years before he died at 17 years old. He was one of a number of siblings. Christy and his family were members of the travelling community but residing in traditional 'settled' accommodation. He was attending Youthreach at the time of his death, and was reported to be doing very well. He died in an accident which was associated with risk taking behaviour. The most vivid account of Christy's

personality was provided after his death by a Youthreach manager who described him as popular, well motivated and very proud of an award he had recently received. He was planning to do his Leaving Certificate.

5. Level and Process of Review.

This was conducted as a desktop review, as the involvement of the SWD specifically with Christy had been very brief. The review was carried out by Deirdre Mc Teague panel member and Dr. Helen Buckley, chairperson of the NRP. A very helpful local review report had been provided to the review team; this had been conducted by two managers who had not been involved in the case.

The review focuses on the almost five year period that the family were known to the HSE Social Work Department (SWD) and the methodology used was a review of available records (consisting of two social work files) as well as the local review report.

6. Terms of Reference

The review adopted the following Terms of Reference:

- To examine the services provided to Christy and his family by the HSE and HSE funded services prior to his death.
- To indentify opportunities for learning from the findings of the review.
- To provide a report to the Child and Family Agency with conclusions and recommendations

7. Background and reason for contact with the HSE SWD.

Christy was one of a number of siblings and part of a settled traveller family. It appears from the file that the entire family had only moved back to Ireland and into this particular area a short time before their first referral to the SWD, but no detail is provided about their past history or possible involvement with services elsewhere. Christy's parents were divorced and his father, here called Martin was the sole carer of the children for much of the time. Martin had alcohol and mental health problems and found it difficult to manage the four children on his own. Christy's mother lived in another jurisdiction but occasionally came back to the family home to assist with parenting. Fights associated with alcohol consumption sometimes occurred when she was present, which were witnessed by the children. On initial referral to

the SWD, the children were reported to be poorly dressed and unkempt looking; the house was also reported to be dirty, untidy and bare. There were continuous reports of poor school attendance by the children. Over the period under review, numerous reports were made by Gardai, health and educational staff to the SWD.

8. Services involved with Christy's family.

The following services were involved with Christy and his family:

- HSE social work department (SWD). The case was initially open for a period of nearly three years. It appears from the records that it was first dealt with on duty and allocated a year later to one social worker for approximately eighteen months, closed for a year and then allocated again thirteen months before Christy died. Different workers were also involved as incidents arose. During the period in which it was closed, incidents were responded to by members of the duty team.
- Primary care social worker
- General hospital
- School teachers and principal.
- Visiting teacher for travellers
- Educational Welfare Officer.
- Gardai
- Housing Department.
- Addiction services
- Youthreach.

There is no specific mention of the above services working directly with Christy apart from Youthreach and his school.

9. Summary of family's needs

The initial referral, made by a hospital attended by the children's father, described the children as unkempt, poorly dressed and dirty; they had poor school attendance and over a four year period, no sustained improvement was noted in respect of any of these issues. The children's needs were never comprehensively or individually assed. The records indicate that their basic physical needs were not being met in the home environment. They also had educational needs due to erratic attendance. They had emotional needs as a result of living with parental domestic violence, problem alcohol use and mental illness. It was clear that

the children required a broad range of interventions in order to meet their needs and that their father, who was their primary carer, required both support and direct intervention.

10. Chronology of service involvement

Christy aged 12

When Christy was 12, his father, here called Martin, was admitted to the local hospital following an injury sustained while drunk; some of the children were also admitted there for social reasons as he was their sole carer. Their neglected (dirty, poorly dressed) state was observed by the nursing staff and notified to the HSE SWD. An initial assessment form was completed by the duty worker on the basis of network checks; it transpired that Martin was known to the Gardaí because of his drinking; they reported that the eldest child did most of the parenting. No health concerns were reported in respect of the children but the school commented on their poor attendance. Although the neglected appearance of the children was the primary reason for referral, they were not met by the duty social worker as part of this assessment. Family support was recommended and a referral made to the social worker attached to the primary care team. The specific purpose of the referral was not clear, other than provision of family support and no follow up to this referral was recorded. The Educational Welfare Officer (EWO) was to be contacted and the case subsequently closed to the SWD. According to the records, a community development worker was involved with Martin, though this person's role is not clarified.

Christy aged 13

A further referral was made a year later, this time by the Educational Welfare Officer (EWO) who approached the SWD reporting concern not only with the children's poor school attendance but the fact that Martin, who was drinking heavily, was struggling to care for them. The SWD carried out an assessment which involved home visits and consultation with other professionals involved with the family, and identified concerns about welfare, neglect and emotional abuse. The case was allocated to a social worker (here called Social Worker 1) In the meantime, Christy's mother had returned to the family for a period and Social Worker 1 visited the family with the Visiting Teacher for Travellers; a full discussion of concerns was held and it was agreed that the visiting teacher would continue to work with them.

Social Worker 1 remained in contact with the family and with the network of professionals involved and it was agreed to hold a strategy meeting (a date was set for the meeting and invitations issued but due to illness of a key participant it was cancelled and not convened

for five further months). The SWD sought financial assistance to enable the children's mother to remain and help with caring for the children. A few months later, further concerns were reported to the SWD by the Gardaí about both parents drinking and some family violence. At this point, Social Worker 1 warned the family that any repetition of this behaviour would result in the children being removed into care.

The main focus of the strategy meeting, held several months later that year, was on the school attendance of the children which apparently improved for a while subsequently but then regressed. The case remained open and further concerns were soon reported about Martin's mental health, domestic violence (while Christy's mother was staying there) and housing conditions. Despite earlier warnings, issues about recurrence of parental violence, no specific action was taken on this by the SWD and the impact of these adversities on the children were not individually assessed or addressed. A few weeks after this, Social Worker 1 met with all of the children and discussed the implications of their erratic school attendance with them. This problem endured however and remained the main focus of attention. There appeared to be a good level of inter-agency communication about the different concerns with a number of professionals from different services seeing the family, but no sustained improvements were achieved. Further fights were reported.

Christy aged 14

Martin was hospitalised for injuries sustained in an interfamilial fight just after Christy's 14th birthday, and the children were cared for by family friends for a few weeks; the prospect of foster care was again raised as a warning if further family violence ensued. Concerns remained about the eldest child's wellbeing, as she was allegedly carrying a lot of responsibility for the younger children. Social Worker 1 had frequent direct contact with the family around this time; she met with the eldest girl to give her some guidance about doing courses and cautioned the parents against leaving the children alone when they went shopping. A plan to bring in a home help was proposed, as the children's mother planned to leave again but there is no evidence that this actually occurred. A report of physical abuse (hitting with a belt) by Martin against one of the other children was made during this year, it was denied by Martin when confronted by the Visiting Teacher and the file does not show evidence of further follow up of that particular incident. Christy is reported at this time to have been suspended from school for throwing an object at another student. He was suspended again the following school term for fighting and beating up another student and

concern was expressed in the school that the children were developing a reputation for fighting. There is evidence from Social Worker 1's case notes that she and the Visiting Teacher for Travellers were vigilant about the children's school attendance which improved somewhat over the year. The children's mother spent another period with the family and Gardaí were called to the house in response to a fight. Just prior to Christy's 15th birthday, the SWD decided to close the case on the basis that the children's needs were being met in the context of 'low level neglect'. While closing the case, the social worker conveyed to the family GP her concerns that Martin's drinking and mental health problems may have been deteriorating.

Christy aged 15

In the months after Christy turned 15, further concerns were again expressed to the social work duty service about the family. Later in the year, the local authority (housing) social worker reported serious concern about the state of the house and the care of the children. The records indicate that this was followed up by the HSE duty social work service. Network checks revealed a number of concerns on the part of the professionals involved and it was agreed to wait list the case for allocation to a social worker. There is a note on file from the social work team leader outlining a case plan for the new worker.

Christy aged 16

Around Christy's 16th birthday, the family was allocated a social worker, here known as Social Worker 2, who remained working with them for the period under review. At this time, a clear plan of intervention was made, all the concerns received were directly addressed with the family, network checks were conducted and there was ongoing professional liaison on the case. Social Worker 2 took an active and consistent role in respect of this case, driving the issue of school attendance with the children while also dealing with parenting issues and actively linking Martin with addiction services.

There were still concerns about the younger children's school attendance, and a worry that the family might move away which might jeopardise their education. At this point, Christy had taken up a place at Youthreach. According to the records, the situation at home improved over the following months; the eldest child moved out and one of the younger ones went to live with their mother. Martin was availing of addiction services.

Christy Aged 17

Tragically, one month after his 17th birthday, Christy died in an accident which was associated with risk taking behaviour.

11. Analysis of involvement with the HSE Child and Family Services.

This analysis has been greatly assisted by the review completed locally by managers in the Child and Family Agency.

11.1 Compliance with regulations.

While Children First was largely followed in respect of responding to reports, the quality of practice was weak in certain respects. These issues will be addressed in the following sections.

11.2 Initial response to concerns

It appears from the records that when referrals were made to the SWD, they generally received a response and network checks and home visits were carried out. However, until the case was allocated, the responses tended to be one dimensional and often only focused on issues such as Martin's drinking problem and behaviour, individual instances of parental violence and the attendance of the children at school. The family was relatively new to the area when the first referral was received. It may have been difficult to access any previous records of their contact with services in the jurisdiction they lived in previously, but there was no information on the records about their lives prior to that time and this could have been obtained from the family themselves. It may have given important clues about their family functioning and assisted in making intervention plans.

11.3 Assessment of Christy's needs during the contact with the HSE children and Family Service.

The SWD responded to incidents of concern as they arose, but there is no evidence that a comprehensive assessment was undertaken of the individual needs of the children in this family despite the information available in respect of physical neglect, behaviour problems including poor school attendance, exposure to domestic violence and the fact they were being mainly cared for by a parent who had significant alcohol and mental health difficulties As a result, interventions were not tailored to meet the specific physical, emotional or psychological needs of individual family members, and certain issues dominated at different

times, mainly school attendance. Christy did not feature significantly in any negative reports and this meant that he didn't receive much individual attention. The nature of the relationship between the children and their parents was not assessed.

The family were members of the travelling community, albeit living in settled accommodation. In this regard, an assessment should have examined any factors relevant to their ethnicity, such as the impact of their recent move into a new community and the number of family or other supports available, any barriers to their use of services, cultural norms around child rearing, supervision and safety.

There is evidence that members of the community provided support to the family but the support and promotion of such protective factors was not assessed. As a result, potential opportunities to promote the welfare of the children were missed.

11.4 Interaction with child and family

Although the case was open for a number of years, the level of contact between the SWD and the family was not always consistent. There is evidence of Social Worker 1's active involvement in contacting the various professionals involved and advocating on the part of the family. She also had a lot of face to face contact with the family at certain points and her case notes indicate that she tried hard on a number of levels to improve the family's situation. On two occasions, the parents were cautioned that the children could be removed to care if further family violence occurred which suggests a level of concern that is not reflected in any follow through even though further incidents did take place. While there was a lot of communication about the case between the various professionals involved, there is no evidence of any review to evaluate whether recommendations or referrals to some services had been effective or had actually occurred. Ultimately the decision to close the case, made jointly between the social work team leader and the social worker, when Christy was 15 on the basis that the children's needs were being met in a context of 'low level neglect' seems contradictory particularly as it coincided with the social worker's perception that Martin's drinking and mental health were getting worse. This review acknowledges that the issue of school attendance seems to have been particularly difficult to address in this case, and that Christy and his siblings did ultimately benefit from the many attempts at intervention that were made jointly and individually by the social work and education services, particularly when the children became involved in educational projects.

However, the identified concerns were broader and while this was recognised from time to time, the response was not consistently holistic.

11.5 Child and Family Focus.

It is difficult to get any sense of Christy from the records, which tend to focus on the family as a whole. Concerns about the family were largely framed in terms of parental behaviours and the attendance of the children at school. While there was some direct focus on the eldest sibling, there was little sense that workers really understood the experience or actual impact on the other children of their non-attendance at school how they felt about their mother's intermittent presence, their father's drinking and depression or even their own identity as settled members of the travelling community recently arrived in the area. While social workers did seek out and speak to the children on a number of different occasions, the service was not always child centred for the reasons outlined. The work appears to have been based on the assumption that if Martin controlled his drinking and the children went to school regularly; their welfare would have automatically been enhanced. This was not at all certain.

11.6 Quality of recording.

Social Worker 1 and Social Worker 2 kept contemporaneous case notes of their involvement. Social Worker 1's notes were handwritten and not always easy to read but were copious and recorded a lot of contact with other professionals as well as home visits. Social Worker 2's notes were also comprehensive and as some were typed, were easier to read. The social work record as presented to the National Review Panel was not easy to navigate and was not well organised.

11.7 Management.

There appears to have been a lack of management oversight in the work with this family or of linking the referrals to get a cohesive view of the family's circumstances until the year before Christy's death. Over the years of involvement, there was scant evidence of any sustained improvement in the family's situation; the level of reported concerns remained the same with recurring instances of domestic violence and diminished parental capacity particularly when Martin was parenting by himself, but there is no evidence that the lack of progress was acknowledged. The decision to close the case was not based on evidence that

positive change for the children had occurred apart from a slight improvement in school attendance.

The local review of this case, completed by two managers in the region, pointed out a serious shortfall in social work staff due to the recruitment embargo. It inferred that the pressure on the service exceeded its capacity to respond with the result that cases were prioritised on the basis of risk. The implication in the local review was that this case did not reach the threshold required for a comprehensive response. This is acknowledged in the current review, but it must also be pointed out that the practice which did occur when the case was open was weak in parts particularly in terms of assessing and evaluating the welfare of the children.

11.8 Interagency cooperation.

As earlier sections have shown, there were a number of services in contact with the family, and at different times, there was a lot of communication between the SWD and other professionals. There is less evidence of joint planning or follow through on any of the matters discussed. Positive inter-agency relationships are useful but must be based on active and coordinated intervention.

11.9 Interagency meetings

A strategy meeting took place six months after it had been first proposed. This meeting addressed school attendance and the behaviour of one of the siblings. Other identified concerns were not given the attention that was warranted.

11.10 Supervision,

Evidence of supervision by a social work team leader was lacking until just before it was allocated to Social Worker 2, at which point supervision notes appear for the first time. The local review concluded that the policy on supervision operating in the area was not consistently followed in this case. It is noted that a national policy on supervision has been issued in the meantime.

12. Conclusions

Christy died in a tragic accident which occurred in a context of risk taking behaviour. The review has concluded that there was no direct link between this accident and the quality of

services provided to the family. It notes the efforts made by the two allocated social workers to effect improvements. Nonetheless, it has identified a number of weaknesses in practice as follows:

- A failure to comprehensively assess the individual needs of the children despite evidence that they were being neglected. While there is evidence of the active involvement of the two allocated social workers and serious efforts on their part to effect change in the parents' behaviour, the absence of a comprehensive assessment meant that the children's individual needs were not consistently understood or met.
- A weakness in coordinating and following through on interventions to address the different issues or systematically review progress
- Supervision was not provided to the required standard at the earlier stages of this case. It is noted that a national supervision policy has been introduced and this review assumes that it has now been implemented in the area.
- The case reflects a failure at the point of first closure to take seriously the cumulative impact of neglect on children's safety and welfare

13. Key learning points.

- A number of key reforms have taken place since the time of Christy's death, including the establishment of the Child and Family Agency and the development of a new model of service delivery which is in the process of implementation. Under the new model, a case such as this, where children were considered vulnerable but not at risk of significant harm should receive services in the community via the local area partnerships. There was no indication in this case that the family were unwilling to engage or accept services, therefore they may have responded well if such a coordinated approach were available to them at the time. However, weaknesses such as those identified here (inadequate assessment, lack of coordination, failure to evaluate or review) could persist even in the context of recent reforms so it is important to recognises that unless vigilance in respect of practice standards is consistently applied, the effectiveness of area based partnerships will be undermined.

- This case was closed at one point in the knowledge that the children were experiencing 'low level neglect'. This action reflects a trend, reflected in research

whereby 'low-level care' may be tolerated when there is no evidence of sustained improvement in standards of care over the long term. However, it should be noted that Miller (2007)[1]and Bromfield & Miller (2012)[2] have looked at the negative impact of cumulative harm i.e. patterns of circumstances and events in a child's life which diminish a child's sense of safety, stability and well-being and ultimately undermine their capacity to develop necessary coping skills. They caution practitioners not to underestimate the long term damage to a child and point out that a focus on cumulative harm requires each notification to be assessed as bringing new information which needs to be integrated into the history of previous assessments. In order to pre-empt further deterioration, goals and clearly articulated responsibilities need to be set and to be monitored. The review team considered whether the fact that this family were members of the travelling community meant that lower standards, indeed 'low level neglect' was tolerated. Without comparison of this SWD's practice in other cases it is not possible to make such a judgement. However, it is a point worth considering in light of research which shows that differential assessments and cultural relativism may be applied to minority groups. In that regard, SWDs must take great care to ensure that they are alive to this concept and its potential to permit the continuance of unacceptable risks and substandard practice.

- As well as living with a parent whose mental health and addiction problems impeded his parenting capacity, Christy and his siblings were regularly exposed periodically to domestic violence. Research shows the detrimental impact of each of these social factors on child development, but importantly, it also demonstrates that more than one adversity in a child's life has a 'multiplicative' effect. Practitioners and managers should be aware of, and apply, formal knowledge (e.g. empirical research) that is relevant to the families who come into contact with the service. The best way to achieve this is to firstly, commit to evidence informed practice and utilise available resources such as the North South Child Protection Hub (NSPCH.com) or the NSPCC inform website (NSPCC.com) and, secondly, use an approved assessment framework to ensure a comprehensive approach.

[1] Miller, R. (2007) *cumulative harm: a conceptual overview*. Victorian Government http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf

[2] Bromfield, L. And Miller, R. (2012) *Cumulative Harm: Best Interests case practice model specialist practice resource.* Victorian Government. http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/665902/cumulative-harm-specialist-practice-resource-2012.pdf

14. Recommendations

The local review made specific recommendations for implementation in the area, and the Child and Family Agency is in the process of implementing a service delivery model which incorporates many of the issues highlighted in this report in respect of the assessment of welfare cases and a partnership response. This review endorses that model and recommends dissemination of the above key learning points to staff in the Child & Family Agency and funded agencies.

Dr. Helen Buckley

Chairperson, National Review Panel