National Review Panel

Review undertaken in respect of the death of a child known to child protection services: Lucy

Executive Summary

August 2014

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This was undertaken as a desktop review. The method used was a review of files from the HSE social work department (SWD), the public health nursing record and files provided by a voluntary agency which was contracted by the HSE to provide aftercare, social work and family support services. The review was conducted by Michele Clear, panel member and Helen Buckley, chair of the National Review Panel. Extracts of the report were sent to key relevant staff and their responses were considered in finalising the review.

Background

Lucy was 10 months old when she died, and the post mortem concluded that her death was consistent with Sudden Infant Death in Infancy. It was noted that she was a well-nourished child. Lucy was born to her young mother, Rachel, who had formerly spent periods in the care of the HSE and had one older child. Rachel had been diagnosed with a learning disability as a teenager. She had received support from a voluntary agency for a period after she left care. This support resumed when she was expecting her first baby and continued thereafter. The PHN service was also consistently involved in offering support and guidance to Rachel. Rachel also got support from her children's paternal grandmother.

Although Rachel managed to meet her first child's needs reasonably well with support, she began experiencing some parenting difficulties when Lucy was born; she then received additional support from a social worker and PHN and made positive progress. She experienced further stress when her boyfriend was charged with a serious offence, and deterioration in her home conditions was noted when Lucy was a few months old. She agreed to a support plan offered by the voluntary agency and her PHN. Shortly afterwards, the SWD received a report from a member of the public suggesting that Rachel's home management skills were poor, and a duty social worker visited her with the aftercare worker from the voluntary agency. The support plan was put into action. Sadly, Lucy died shortly afterwards. A recent examination had shown that she was meeting her developmental milestones.

Findings

The review has found that the children and their mother, Rachel, were offered a range of very appropriate services, from the SWD, the voluntary agency and the PHN service. It was noted that Rachel was suspicious of social workers, but the review has found that a respectful working relationship developed between herself and her key worker, who was the aftercare worker from the voluntary agency, and it has also found that Rachel was listened to, and her views were respected.

The review has found that management of the case in terms of allocation and interagency collaboration was good, and staff appeared to be well supported. The files were well kept.

The review has noted that none of the records provided to it mention Rachel's learning disability, or the effect that it might have had on her ability to process information, until shortly before Lucy's death. It is not clear whether being more explicit about Rachel's level of functioning would have resulted in any different supports being offered or approaches being taken but it might have made some of her behaviour more understandable to those working with her. It is possible that those working with Rachel were well aware of her specific needs and the best ways to meet them, but the fact that the learning disability was not explicitly referenced in any later assessment could also mean that its precise implications were not always taken into consideration.

Overall, the review found that there was no link between the services offered to the family and Lucy's very sad death. It has identified a number of learning points and made one recommendation, outlined below.

Key learning points identified

While not of direct relevance to Lucy's death, this case illustrates the importance of identifying the connections between a parent's learning disability, their parenting capacity, and their ability to understand and apply the guidance provided by family support services. This issue is highlighted in research which indicates that while the identification of children's needs may have improved, understanding how issues such as parental learning disabilities, still requires more attention, (Cleaver et al, 2011)[1]

Page 75 of the HSE Child Protection and Welfare Practice Handbook 2011 offers the following guidance 'In circumstances where a parent/carer has a learning disability, it is likely there are a number of professionals involved from different services. It is important that these professionals work together within inquiries and assessments to identify any links between the parent's learning disability, their parenting and the impact on the child. Any assessment should include an understanding of the needs of the family and individual children and an identification of the services required to meet these needs. It must be recognised that a learning disability is a lifelong condition. Assessments must therefore consider the implications for the child as they develop throughout childhood since children may exceed their parent's intellectual and social functioning at a relatively young age'.

The same handbook on page 76, outlines the following areas for consideration of the impact of having a disability on the parent/carer's parenting ; parent/carer's own experience of being parented and of receiving services as a child, size of family, extent of parent/carer's knowledge about healthcare, child development, responding to emergencies and discipline, support systems available to and used by the parent/carer and their family, parent/carer's relationships, financial situation, parent/carer's cognitive ability, language and/or communication skills, parent/carer's

[1] Children's Needs – Parental Capacity, Hedy Cleaver, Ira Unell, Jane Aldgate, London TSO 2011

general physical health and mobility and expectation and responsibilities on child to play a caring role.

In this case, it had been noted that Rachel had difficulty processing information. Crittenden (1993)[2] has highlighted a strong connection between a parent's method of processing information and their ability to care for children. She points out that unless a worker responds to a parent in a way that connects with their method of cognitive reasoning, interventions are less likely to be effective. In a more recent publication, McDaniel and Dillenburger (2013)[3] provide examples of how behaviour-analytic parent education can be used to develop individualised programmes to help parents – particularly those who are vulnerable – to care for their babies or young children. They hold that many parents with intellectual disabilities can learn to look after their children with appropriate supports. For these parents in particular parent education programmes are most effective when strategies are based on concrete rather than abstract concepts, for example through modelling rather than instructional techniques. They have developed programmes for neglect prevention including practice tools for basic child care tasks, routines, home safety, home hygiene, and parent child interaction. One of the lessons for practice to emerge from their work is that 'home hygiene emerged as a key indicator and benchmark for child neglect. The key learning point here is the importance of attending to information on any issue impacting on parental functioning, such as learning disability, and using the available evidence to inform plans and interventions.

Recommendation

No inquest was held on this case. The review team noted the Coroner's Act, 1962, Part III, Section 17 which imposes a duty on the coroner to hold an inquest where, among other circumstances, a death may have occurred 'suddenly and from unknown causes' and Section 19 which gives the coroner discretion with regard to holding an inquest where, in the coroner's opinion, the post mortem shows that an inquest is not necessary. The review team recommends that the Child and Family Agency seeks to clarify with the Coroner's Service in what circumstances an inquest is deemed not necessary where the post-mortem finding is 'sudden unexpected death in infancy'.

Dr. Helen Buckley,

Chair, National Review Panel

19th August 2014

[2] Crittenden, P. (1993) Characteristics of neglectful parents. An information processing approach. *Criminal Justice and Behaviour,* I20:27-48

[3] McDaniel, B. And Dillenburger, K. (2014) *Child Neglect and Behavioural Parent Education,* Lyme Regis