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

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 Child & Family Agency to the CEO and from there to the National Review Panel. The CEO 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. Child Death

This review is concerned with the death of a ten month old baby, here called Lucy, who was in the care of her mother, here called Rachel. The review has been undertaken because Lucy, her mother and her older sibling, here called Taylor, were known to HSE Children and Family Services. Rachel had spent periods of her childhood in the care of the HSE. Although the review is taking place because of Lucy's death, it was decided to broaden the timescale to cover the period between Rachel leaving care and Lucy's death. Rachel had received aftercare services from the time she was 18; these services were pertinent to the development of her parenting capacity so it was considered appropriate to include them.

5. Level and Process of review

This was conducted as a desktop review. The post mortem report on Lucy, a copy of which is included in the records provided to the review found the cause of death as follows; 'In the absence of any significant findings, death would be consistent with Sudden Unexpected Death in Infancy.' The report also noted that 'the deceased was well nourished.' The review noted from the records that the Coroner's secretary had confirmed that there would be no inquest.

The methodology used was a review of records only.The review was conducted by the chair of the National Review Panel, Dr. Helen Buckley and Michele Clear, panel member.

The records consisted of the following; two HSE social work files, HSE public health nursing records for Lucy and three files from the voluntary agency which provided aftercare, social work and family support services to the family for the period under review. These included one aftercare file, one social work file and a family support file. Extracts of the report were sent to key relevant staff and their responses were considered in finalising the report.

6. Terms of reference

To examine events from the time that Rachel left the care of the HSE up to Lucy's death with particular reference to the respective roles played by the HSE and the HSE funded voluntary agency providing after care, social work and family support services to her family

- To consider issues of interagency and inter-professional collaboration
- To examine the quality of services provided and levels of compliance with policy and standards of good practice
- To provide an objective report for the Child and Family Agency

7. Lucy and her family

Lucy was Rachel's second child; her sibling here called Taylor was two and a half years when Lucy was born. Rachel's former partner, here called Jay, was four years her senior and father to both of her children. At the time of her death at ten months, Lucy was living with Rachel and Taylor in private rented accommodation. Jay did not live with Rachel but had contact with his children. His mother was supportive of Rachel.

Rachel, one of a large group of siblings, had spent short periods in HSE care during her adolescence, as had some of her siblings, two of whom were still in care during the period under review. Her parents were separated. Rachel attended secondary school to Junior Cert level and went on to Youthreach, where she remained for three years. The report of a psychological assessment, undertaken when she was nearly 15 years of age, indicated that she had a learning disability at the lower end of the mild range.

After leaving care Rachel returned to live with her mother and some of her siblings. When she became pregnant with Taylor she decided to leave home and was assisted by her aftercare worker in finding accommodation. She had three changes of supported accommodation before moving into private rented accommodation with the support of her father. She and her children subsequently moved to another privately rented apartment in the same area towards the end of the period under review.

8. Background and reason for referral to Child and Family Services.

Rachel's family was known to the HSE since she was nine years old. Rachel was reported to have been neglected at home where daily care was poor and to have been hit by her mother on a regular basis. She spent brief periods in foster care during her adolescence.

When she was approaching her 18th birthday, Rachel was referred by the HSE social work department (SWD) to the aftercare service of a local HSE funded voluntary agency. An aftercare worker, here called Aftercare Worker 1 (AW1) was assigned to the case and started to work with Rachel before she left care. Rachel's case was subsequently closed to the HSE SWD. The voluntary agency continued to work with Rachel and her children throughout the period of the review, providing aftercare, social work and family support services to the family.

A child welfare and protection referral concerning Rachel's children was made to the HSE SWD when Lucy was nine months old, a month before her death. Rachel had just moved to a new apartment and her former landlady had become concerned about the care of the children on seeing the condition of the apartment Rachel had just left. Following contact with the voluntary agency and a joint home visit to Rachel by AW1 and the HSE duty social worker it was decided to continue with the support being provided by the voluntary agency and the HSE public health nursing service. The voluntary agency was advised to contact the HSE SWD again if concerned about the care of the children. The case was then closed to the HSE SWD; this decision was signed by the HSE social worker and the social work team leader. Lucy was found dead a few weeks later and the post mortem recorded her death as 'Sudden Unexpected Death in Infancy.

9. Services involved with Rachel and her children.

- The principal service involved in this case for the period of the review was a HSE funded voluntary agency which provides a wide variety of services for a geographic region. It provided aftercare, social work and family support services to this family. The primary worker involved was AW1.
- The HSE Children and Families SWD was involved in making the initial referral to the voluntary agency and subsequently was involved as the need arose e.g. to provide supported accommodation and to respond to child welfare and protection concerns
- The HSE public health nursing (PHN) service was involved from Taylor's birth; three public health nurses were involved due to the family's moves.
- There were two family GPs again due to geographic moves.
- The HSE Area Medical Officer and Dental Services.
- Two residential services were involved; one ante and one post natal.
- Rachel attended Youthreach for part of the period under review.
- The community welfare service was involved.
- An Garda Siochana made a referral to the HSE by telephone following Lucy's death.

10. Summary of family's needs

On leaving care, Rachel was described as 'a very vulnerable young woman who requires a lot of support and encouragement but may not be capable of taking it'. Although her learning disability is not specifically mentioned in the social work referral to the voluntary agency, the review team assumes that she that she had specific needs related to it.

Rachel's primary need on leaving care was for a stable home, practical support for maintaining her Youthreach place and obtaining her entitlements, which was provided to her at the time. When she moved from her mother's home during her pregnancy with Taylor, she again required assistance with accommodation, ante natal care and continuing help with practical matters. After Taylor's birth she required a supportive place to care for her baby and help with parenting, which was provided. As Taylor grew, further help was needed at different stages of development. Lucy's arrival created more pressure for Rachel who had difficulty in managing Taylor's behaviour. There is nothing to indicate that Lucy's needs were not being met from her birth onwards and PHN records indicate that she made consistently good progress.

Rachel continued to need support with various crises that arose. At all stages of the period under review her need was for support services appropriate to her level of intellectual functioning to enable her to meet her children's need for 'good enough' parenting.

11. Chronology of contact between services and Rachel and her children

Rachel 18 years to 20 years

When Rachel was approaching 18, and her foster placement was coming to an end, she was referred by the HSE social work department (SWD) to the aftercare service of a local HSE funded voluntary agency. The review team has noted that no mention of her learning disability was made on the referral form, even though there was a tick box on the form which could have been used to indicate it. AW1 had been assigned by the voluntary agency to work with Rachel before the formal referral was made and the agency had been invited to attend her final Child in Care Review. Initially a HSE social worker and AW1 worked jointly on the case, the social worker retaining responsibility for contact with the foster family while AW1 assumed responsibility for direct work with Rachel, including assistance with applications for housing and different entitlements. Rachel returned to live with her mother after she left care.

AW1 had sporadic contact with Rachel during the next year in relation to social welfare entitlements and attendance at Youthreach. She then wrote to Rachel closing the case as Rachel had not been in contact with the service for the previous five months. Rachel was advised that she could link back with the service at any time till the age of 21 should she wish to do so and in fact AW1 became involved again soon afterwards to mediate between Rachel and her mother over her living arrangements.

21 years to 22 years

Rachel contacted her Aftercare Worker to tell her that she was five months pregnant and that she wished to move out of home. AW1 assisted her to move into pre-natal accommodation where she remained until Taylor was born. AW1 then assisted Rachel and Taylor to move into a mother and baby residential unit offering a high level of support. Rachel and Taylor remained there for three months during which time three review meetings were held, attended by staff of the service, Rachel, and AW1. Taylor's paternal grandmother attended the final review. Following this, Rachel and Taylor moved in with Taylor's paternal grandmother, with the intention of moving on to more independent or semi independent accommodation. Taylor's father was living at home. This situation became difficult and it became necessary for Rachel and Taylor to leave. AW1 sought unsuccessfully to get a suitable place for them. AW1 then negotiated with the HSE to financially support them in a semi supported lodgings situation. Although the professional view was that they needed a reasonably high level of support, Rachel decided after a few months to move into private rented accommodation with her father's help. The case was later closed to the aftercare service, with the knowledge of the HSE SWD. Rachel's father offered his ongoing support and this was seen as a positive factor. The public health nursing service continued to see Rachel and Taylor.

23 years to 24 years

A few months later Rachel contacted AW1 to tell her that she was due to have another baby in four months time. Lucy was born later that year and AW1 provided ongoing support and material help. The PHN record noted that Rachel had a good rapport with Lucy, and her first developmental examination indicated that she was 'gaining weight normally, bright and alert.' Other medical checks were satisfactory.

When Lucy was four months old, a review meeting was arranged by the voluntary agency, attended by AW1, the PHN and Rachel, to address two principal concerns which were that Rachel was

struggling to manage Taylor's behaviour and that the two children were observed frequently in their buggy for long periods of time and in town with Rachel. Extra help with parenting was proposed at the review and it was agreed that Rachel would be referred to the voluntary agency's social worker, here called SW2. SW2 began to work with Rachel on her parenting skills, particularly in respect of Taylor's toilet training and temper tantrums. At the same time, the PHN followed up on Lucy's developmental checks and Rachel's own dental appointments. A further review meeting was held three months later and positive progress was noted, Rachel was spending less time in town and more time at home, the children were observed less in their buggy, Taylor was attending sessions at a crèche and any missed appointments were explained. It was agreed that same level of support would be continued. The following month, Rachel met with the AW1 and told her that Jay (the children's father) had been charged with a serious offence. Rachel was very distressed by this and was planning to move house because of it. AW1's records note deterioration in the conditions in Rachel's home. A month later Rachel told AW1 that she no longer wanted to work with SW2 because she interpreted the support being offered as a criticism of how she was caring for her children. She turned down AW1's offer of help with her house move, saying that her family would be helping her.

AW1 and her line manager met with Rachel to discuss their concerns about herself and her care of the children which, in their view, had deteriorated again over the past four to six weeks. They believed that Jay's situation was still causing her a lot of distress. Rachel acknowledged this and her difficulties in managing Taylor's behaviour, which she believed was related to a speech delay.

A support plan was proposed. It was also agreed with Rachel that the family support manager in the voluntary agency would contact the HSE social work team leader to let them know about the concerns and advise them about the plan. It was further clarified that if Rachel did not comply with the plan a formal referral to the HSE SWD would be made.

This information was communicated to the HSE SWD who in turn informed AW1 that Rachel's former landlady had been in touch with them to report her concerns about the children, based the condition of the apartment which Rachel had just left, which she said was extremely dirty and unhygienic. A HSE social worker and AW1 visited Rachel three days later. The file notes that the home was untidy and Rachel was finding Taylor's behaviour difficult to manage. Rachel, after some persuasion, recommitted to the previously agreed support plan. The next day the family support worker, here called FSW1, from the voluntary agency met Rachel to agree a plan of action and a start date for the following week.

The SWD logged the referral as 'child welfare' (parents who lack parenting ability), and closed the case on the basis that it was being managed by the voluntary agency. The tick box on the intake form for 'parents with a learning disability' was not selected.

PHN notes for this period show that Lucy's 7/9 month developmental examination had taken place at eight plus months; that her primary immunisations were complete, and she was beginning to sit up. Her hearing was retested in the month of her death, and proved normal. At that appointment it was also noted that Lucy was beginning to crawl. As the family had moved area and therefore had a different PHN service, the new PHN was introduced to AW1 and FSW1 at a meeting which was also attended by Rachel. Previous concerns and difficulties were covered and a visiting and meetings plan for the PHN agreed with Rachel.

Sadly, Lucy died a week later. The post mortem report recorded the cause of death as 'sudden unexpected death in infancy.' The file indicated the Gardai's intention to send a notification to the SWD because of the physical condition of the house when they called after Lucy's death. However there was no Garda notification in the records submitted to the review although the records continue for some time after Lucy's death. The review team would have expected that an inquest might have pursued the Gardaí's concerns. The coroner was notified of Lucy's death as a matter of routine but decided against holding an inquest.

12. Analysis of the involvement of the HSE Children and Families services and of other services with this family.

12.1 Response of the HSE and the voluntary agency to referrals

This review concentrates on contact from 2005 onwards when Rachel was referred to the voluntary agency for an aftercare service.

The referral from the HSE SWD to the voluntary agency, which was funded by the HSE to provide an aftercare service, was appropriate and made in a timely manner. Rachel had reached her eighteenth birthday and needed alternative services and supports to prepare her for independent living. AW1 was immediately assigned to the case and the transfer of responsibility from the HSE was managed smoothly and with flexibility between the two services. After the initial transfer period the voluntary agency took full responsibility for the case and only contacted the HSE SWD as and when the need arose, e.g. when Rachel needed supported accommodation following the birth of Taylor and when concerns arose with regard to Rachel's care of her children. The HSE responded appropriately and with flexibility when contacted by the voluntary agency.

12.2 Assessment

The children's needs were accurately assessed but Rachel's ability to meet her children's needs and the supports that she would require were harder to identify, beyond the very practical. A report in the records of a psychological assessment carried out when Rachel was nearly 15 indicates that she had been diagnosed at 12 with a severe language disorder which meant that there was a five year gap between her ability and her chronological age at the time. The psychological assessment concluded that Rachel "processes information at a very superficial level and therefore often fails to move beyond the initial stage of carrying out the functions that promote learning and understanding this results in difficulties in remaining focused and subsequent information loss that occurs from this. In addition, Rachel has a tendency to give up easily when a solution to a problem is not apparent. These difficulties can lead to a loss of confidence and self-esteem"……."repeated explanations in addition to overlearning will be necessary if Rachel is to make progress with school syllabus".

Reports of Rachel's period in Youthreach, where she reportedly had difficulties completing the daily tasks of getting up on time, having her breakfast and arriving at the youth centre reflected the findings of the psychological assessment. While it was noted in the HSE SWD referral to the aftercare

service that she was a 'vulnerable young woman who requires a lot of support and encouragement but may not be capable of taking it', there is no reference to the psychological assessment, nor the specific aspects of Rachel's learning disability that may have been informative in respect of support plans for her and later assessments of her parenting capacity. While the later assessments of her parenting capacity highlighted her limitation, her need for ongoing support, as well as her difficulties in communication and mistrust of professionals, the first explicit references to her learning disability and its implications were recorded only after Lucy's death. A note on the social work file following the joint visit between the HSE SWD intake social worker and AW1 points out that 'mum presents as a lady who may have a learning need and limited capacity' indicating a lack of awareness that this had already been diagnosed.

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.

12.3 Compliance with regulations

Rachel was an adult when the period of this review started. The aftercare provision provided for her was well within the spirit of Section 45 of the Child Care Act 1991, which does not impose a duty on the HSE/Child and Family Agency to provide aftercare but rather gives it permission to do so.

Once her first child was born Children First became the relevant policy and this was complied with when child welfare and protection concerns arose. Relevant forms were completed by the HSE; consultations held; assessments made and appropriate action taken i.e. referral back to a voluntary agency for a family support service with referral back to the HSE if necessary.

12.4 Quality of practice

12.4.1 Interaction with Rachel and her children

The transfer of responsibility for Rachel from the HSE SWD to the voluntary agency when she left care was well planned and carried out. AW1 became involved even before the formal referral was made and quickly established a good working relationship with Rachel that endured and developed for the period under review. During the initial phase when Rachel was moving between different places, AW1 had frequent, sometimes daily, contact with her. When Rachel was not making use of the aftercare service and did not require other services, the case was appropriately closed but AW1 was available to respond when Rachel returned to the agency looking for help.

When Rachel became a parent, different services were offered to her by the voluntary agency, in conjunction with the HSE PHN service, as the need arose. Rachel was offered family support services including a parenting course, a mother and toddlers group, a play workshop and sessional crèche places for both children. A lot of support was provided, including transport, to facilitate Rachel and

Taylor's attendance at these services which would have been sporadic in the absence of intervention. She was also given a social work service followed by a family worker in response to increasing concerns about her care of the children. Additional practical supports were provided which Rachel readily accepted and often requested herself, for example; accommodation, clothing, transport, emergency help with shopping, a voucher for fuel. Reviews, which included the HSE PHN, were held by the voluntary agency to deal with concerns about the family as they arose. These interventions were all indicative of a good quality service.

The public health service was involved with the family from the time of Taylor's birth; altogether three PHNs were involved in providing the service, partly because Rachel moved areas. Transfer of records between areas was smooth. All routine developmental checks were carried out for Lucy, with additional contacts and visits as required. Her immunisations were up to date. The PHNs worked very well with the voluntary agency and within the child health service with two GPs and an area medical officer. Appointments for the children and important dental treatment for Rachel were followed up by the PHN.

The child welfare and protection referral was dealt with in a timely and appropriate manner by the HSE SWD and AW1. Increasing concerns about Rachel's ability to care for her two children were followed by an increase in the support being provided e.g. the allocation of a voluntary agency social worker and later a family support worker.

12.4.2. Child and Family Focus

Rachel was listened to and her views respected insofar as possible given the child welfare concerns. She was included in decisions, responsibilities were explained, child welfare concerns outlined clearly and the role of the HSE social work department with regard to child protection was made explicit. While Rachel was glad to accept practical help, she was less open to the "talking" and "learning" supports offered, e.g. the voluntary agency social work service and the parenting classes.

From the records it is clear that following Lucy's birth AW1 saw the children regularly, both in the voluntary agency's offices and on home visits. Her focus was on both Rachel and her children. She provided very practical help for Rachel e.g. by responding to Rachel's request to bring her some things she needed as Rachel did not want to take the children out in stormy weather. She also advised on matters relating to the children, for example, dressing the children in appropriate clothing and taking Lucy out of the buggy to roll on the floor.

Rachel is reported to have been very scared of services and suspicious of social workers. From the start she feared that Taylor would be taken into care. She is reported to have said that social workers did not help her when she was young. However, it is clear from the records that a strong respectful working relationship developed between Rachel and AW1 and that she was trusted by Rachel. Rachel contacted her when she needed help and had no difficulty making her views felt. Though sometimes not in agreement about her need for the supports being offered, Rachel was generally open to persuasion by AW1 about the decisions made regarding the care of her children.

12.4.3 Recording

The voluntary agency aftercare file is typewritten and includes records of all contacts, meetings, referrals to other agencies, copies of letters. It is generally clear and easy to read. The PHN cards and notes for Lucy record all clinic visits and home visits, telephone contacts, failed appointments,

contacts with other HSE personnel and other agencies, observations re her progress, immunisations and advice given The notes are handwritten in line with usual PHN recording practice for cards and notes and are easy to follow.

The HSE SWD files include records of the child welfare and protection referral and its follow up, including completed, signed and dated child welfare and protection forms, case notes . Records are handwritten but are general easy to follow. Of note is the absence on the files of any explicit reference to Rachel's learning disability until after the child welfare and protection referral was received and the joint visit carried out.

12.5 Management

12.5.1 Allocation of staff and services

AW1 was assigned promptly to the case by the voluntary agency and remained involved with Rachel for the period under review including being available, with the agreement of the family support manager, when the case was closed to the aftercare service. Other staff members from this agency were assigned to the case as the need arose i.e. a social worker and a family worker. Colleagues covered for AW1 when she was on annual leave.

12.5.2 Interagency and interprofessional collaboration

During the period under review three review meetings took place between the voluntary agency and the residential post natal service, after Lucy's birth two review meetings took place between the HSE PHN service and the voluntary agency. Joint meetings were held with Rachel and AW1, the PHN and FSW1. There was a joint home visit by the HSE intake social worker and AW1

There was regular good communication between the front line staff of the voluntary agency and the HSE PHN service. There was also appropriate and effective communication between the relevant managers in the HSE social work service and the voluntary agency.

The case was subject to ongoing review, both inter and intra agency. Meeting were held in house in the voluntary agency with AW1 and the family support manager and also with SW2 and FSW1 A colleague filled in when AW1 was on leave and some visits involved AW1 and an aftercare colleague.

Contact between the HSE SWD and the voluntary agency was appropriate and effective. The HSE SWD responded promptly to requests from the voluntary agency for services e.g. the supported lodgings arrangements and the voluntary agency contacted the HSE to give general progress reports and to outline child welfare concerns as these arose. For the period under review this case did not reach the level where a child protection case conference was deemed necessary in line with Children First requirements.

12.5.3 Supervision

While no supervision records were provided or indeed requested for the review it is clear from the files that front line staff were supported by managers. There are notes of consultations between AW1 and the family support manager, of consultations between one of the PHNs and the assistant director of nursing, and records signed jointly by the HSE intake social worker and the social work team leader.

12.5.4 Policies

There were no references on the files to any policies being used but staff involved were clearly aware of and working under Children First: National Guidance for the Protection and Welfare of Children, although it was not explicitly mentioned. Child protection and welfare forms were completed by the HSE social work staff and the voluntary agency was clear about its responsibility to inform the HSE when there were child welfare and protection concerns.

13. Conclusions

The reviewers acknowledge the sadness experienced by Rachel and her family, and all the professionals involved with them, on Lucy's death. The review has reached the following conclusions:

- There was no link between the services offered to this family and the death of Lucy.
- The case demonstrated much good practice such as; a timely and appropriate referral from the HSE to the voluntary agency, a well organised transfer, joint working, good communication between the HSE SWD and PHN services and the voluntary agency and within both agencies, positive and prompt responses by the HSE SWD to the voluntary agency and from the voluntary agency to the SWD. A wide range of appropriate services were offered to Rachel and her children, and flexibility in responding to gaps in services was demonstrated.
- Rachel was supported and listened to, consulted about services, confronted appropriately about child welfare concerns and insofar as possible, given these concerns, her wishes with regard to how and what services she and her children received were taken into account.
- The case was opened and closed effectively, roles and responsibility were clarified and made explicit
- There were good examples of joint working within the voluntary agency and between the voluntary agency and the HSE.
- Trust and respect were evident from the records, between Rachel and AW1 and between the voluntary agency and the HSE at both frontline and management levels. AW1 developed and maintained a very positive working relationship with Rachel, while keeping her children's needs in focus; she was responsive to Rachel's reasonable requests and very skilled in finding and accessing services.
- Recording on the aftercare file was good, all contacts were recorded, meetings and decisions were minuted and circulated, referrals for services were followed up in writing outlining the reason for the referral and providing relevant information on a need to know basis.
- More explicit reference to and consideration of Rachel's learning disability could have given those working with her more insight into her capabilities with regard to meeting her children's needs and in identifying what supports other than those provided, if any, might enable her to do so.

14. Key Learning points

This review notes that Rachel parented her children to the best of her ability with the support of the different professionals involved. It has found no direct connection between the quality of service offered to Rachel and Lucy and Lucy's sad death. However, it has highlighted some areas that are worth reflecting upon for the purposes of learning.

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 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

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

[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

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.

15. Recommendation

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

Date: 19th August 2014