National Review Panel

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

April 2011

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

April 2011

1. Introduction

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

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

2. National Review Panel

A national review panel was established by the HSE 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 Assistant National Director's Office and from there to the National Review Panel. The Assistant 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, recommendations and an action plan. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications

considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

- **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: M

This review is concerned with a five month old baby, here called M, who died in the care of his mother and father, here called A and J. The review has been held as A was known to the child protection services and had older children in foster care. Baby M was born with congenital abnormalities that were incompatible with life, though he in fact lived for five months. The timescale of the review principally covers the final months of A's pregnancy and the five month period of M's life.

5. Level and process of review

This was conducted as a desktop review. A death certificate included in the records identifies the cause of death as congenital developmental disorder, and a palliative nursing team were present when baby M died. There had been no evidence of any parenting concerns in respect of baby M. Nevertheless, there had been concerns about A's drug use and previously diminished parenting capacity. During the time that A and J were caring for M they were both being maintained on high doses of methadone and A was additionally prescribed benzodiazepines. As a result, there was a high degree of support and monitoring of their care of the baby.

The methodology adopted was a review of HSE records only, with the option of consultation with staff for the purposes of clarification. The review was conducted by the chair of the NRP, Helen Buckley. The records consisted of one folder with 81 pages containing copies of correspondence, case notes and reports of an inter-agency meeting and a child protection conference. It was not considered necessary to request any further records. Extracts of the report were sent to relevant key staff for verification of facts and their responses were considered in the final version.

6. Terms of Reference

The terms of reference for this review were:

I. To examine the events leading up to the death of Baby M and determine whether the level of support and monitoring provided by HSE Children and Family Services was adequate

II. To examine the level and quality of inter-agency coordination, communication and collaboration in the case

III. To provide an objective report to the HSE including an executive summary, conclusions and recommendations

7. M

M was born with significant brain, heart and kidney problems. He was not expected to survive his birth, but in fact lived for five months. It was known from twenty weeks gestation that his condition was terminal. M was the youngest of three children born to his mother A. His older siblings are in

the care of the HSE. The second of his siblings suffers from serious developmental difficulties. M was the first child of his father, J.

8. Background and Reason for referral to the HSE

A had been known to the HSE Children and Family Services for a number of years, and spent some time in residential care as a child. Her first two children are in the care of the HSE. A and her former partner, who has since died, had significant drug addiction problems and difficulties parenting their children. HSE Children and Family Services had initiated a number of attempts to enable A and her former partner to resume care of her older children which had failed. These were revived when A's former partner died, but A acknowledged her inability to resume caring for them at the time. During her pregnancy with M, A's drug addiction was treated with methadone and benzodiazepines. M's congenital abnormalities were diagnosed at 20 weeks gestation. It was assumed that he would not survive birth, but when he was born his condition defied medical expectations and a decision was made to discharge him to his parents with palliative care provided.

9. Services involved with M and his family

M and his parents received support from the following services:

- HSE Children and Family Services (Social Worker 1)
- HSE Public Health Nurse
- HSE Methadone Clinic
- Maternity hospital services, including consultant neonatologist, paediatric cardiologist, and social work services
- Community Drugs Liaison Midwife
- Palliative outreach care from a children's hospital
- Palliative care provided by a voluntary organisation
- GP
- Community Addiction Counsellor
- Hospice outreach care

10. Summary of child's needs throughout the case career

Baby M's primary need was for palliative care, including pain control. The principal risk was the combination of his complex health needs and his parents' potentially impaired capacity due to A's history and both parents' dependence on methadone. Due to the extraordinary demands placed on the parents' already diminished ability, a considerable amount of support was required to ensure that M's needs were met. As contact was being maintained between A and her older children, it was also necessary to provide support and practical arrangements in respect of access and direct work

with A's eldest child, P. Social work support was also being provided to A's younger child, D. D suffers from developmental delay and was not involved in contact visits with M.

11. Chronology of contact by HSE Children and Families Social Services

As outlined above, there was a long history of HSE social work involvement with A. Due to the circumstances of M's death, this review is only concerned with the period prior to his birth and the five months of his life.

December 2009 – February 2010

Social Worker 1 met with A and J to introduce herself in December 2009, and during January and early February she spoke with A a number of times on the telephone as the latter was extremely upset about the prognosis she had received in respect of her unborn baby and did not want to attend meetings. In the meantime, Social Worker 1 liaised with the community drugs worker, the drugs liaison midwife, access worker and the older siblings' foster carers. Social Worker 1 also kept in close contact with the maternity hospital in order to coordinate a pre-birth assessment and discharge plan. A home visit was conducted at the end of February, during which Social Worker 1 assessed the issues of concern that may arise should the baby be returned home, including history of addiction and diminished parental capacity.

March 2010

Baby M was born in early March 2010. Social Worker 1 liaised with the maternity social worker and the foster carers of A's older children to arrange visits, and visited A in hospital. She also initiated plans for a child protection conference in order to coordinate the support that would be required if M was to be discharged. It seems that the actual discharge was determined according to a medical/clinical plan rather than a child protection and welfare plan, and this caused some tension at the time between the maternity hospital and the HSE social work service. Plans for palliative care had been set in motion by the maternity services between the children's hospital, a voluntary organisation and the hospice. Social Worker 1 visited the family home in mid March and continued to liaise with all the professionals involved. She had facilitated a visit to the hospital by P, A's eldest child. The second child, who had developmental difficulties, was not included in contact visits with baby M.

A professional meeting was held in late March which was attended by the GP, the palliative care team from the Hospice and the care team from the voluntary organisation, as well as the maternity social worker and Social Worker 1. This meeting was set up to discuss the support plan at this stage and into the future and consider both risks and protective factors. The current level of support was reviewed, and roles and responsibilities clarified and allocated. The conclusion at the time was that A and J were coping well but that baby M's condition may deteriorate and put them under further pressure.

A child protection conference was held at the end of March, attended by all involved professionals and A and J. It was decided to seek funding for extra night time nursing support and day time family support and concluded that parents were coping well. It appears that this request was granted.

April 2010

Close coordination of services was evident from the records. Social Worker 1 liaised with all professionals and spent time with A's eldest child P, explaining that baby M was very unwell and preparing her for what was likely to happen. Social Worker 1 also facilitated A and J to visit J's parents with the baby. When concerns were expressed by the professionals involved that A and J appeared particularly under pressure at one point which coincided with the outset of holiday period, Social Worker 1 organised a contingency plan to ensure M's safety.

May 2010

Coordination of support and monitoring continued and Baby M's condition was relatively stable. Social Worker 1 facilitated access between A, M and A's older child, P, and liaised with other professionals. Nursing support from the voluntary organisation was increased.

June 2010

Social Worker 1 met with A in early June, and again in late June and had telephone contact in between as well as contact through access visits with P. Baby M's condition remained relatively stable and his parents appeared to be coping well. Social Worker 1 continued to liaise with other professionals.

July 2010

Social Worker 1 met A and J and had a further appointment in late July which A was unable to keep. The couple gave positive feedback about the support they were receiving. Liaison continued between Social Worker 1 and other professionals. M's condition began to deteriorate.

August 2010

M passed away in early August. Bereavement support was made available for A and J.

12. Analysis of involvement of HSE Children and Family Services

12.1 Initial response

Though there was a long history of contact between A and the HSE Children and Families Services, Social Worker 1 was new to the case. Her induction to it was planned and carried out sensitively in the very difficult circumstances where A had been told that her baby's life chances were seriously compromised. The records show evidence that Social Worker 1 made contact with all the relevant professionals and managed to meet with A when she was ready. She also met with A's eldest child P and their foster carers. While it was uncertain at this stage if A and J would be taking the baby home, there was evidence in the record of forethought and planning in relation to this.

12.2 Assessment

There are several references in the record to a pre-birth assessment, which was to be conducted because of concerns about A and J's dependence on methadone, and A's previous contact with services due to deficits in her parenting capacity. There is no evidence in the record of a formal assessment being carried out, though a case note made three weeks prior to M's birth states that

the 'SWD's assessment currently is that the baby cannot be discharged home'. A note made a week later indicated that part of the assessment involved examining the physical condition of the home which was considered to be satisfactory. It was also noted that because of current difficulties with the baby's health that the assessment would not be continued that day. However, there is no further evidence of assessment even though there was a possibility that the baby would be discharged to the care of his parents.

The record shows that the monitoring which later took place in this case was well managed and that Social Worker 1 was diligent in maintaining oversight. Nevertheless, in a situation as complex as this one with many known risks, and the possibility that there were also unknown risks, it would be reasonable to expect a comprehensively recorded assessment.

12.3 Compliance with regulations

Notwithstanding the lack of a recorded comprehensive assessment, the interventions in this case appeared from the records to be in compliance with Children First. As Section 12.5.3 will show, the absence of supervision notes implies a breach of national policy.

12.4 Quality of Practice

12.4.1 Interaction with child and family

Social Worker 1 was the principal professional involved from the HSE Children and Families Services. She had direct contact with A, J and M as well as A's eldest child and their carers but she also had an important coordinating role and maintained good oversight. The record indicates frequent and regular contact between Social Worker 1 and the rest of the professional network. When a potentially risky period was predicted, she managed to put a contingency plan in place.

12.4.2 Child and family focus

The issues in this case were very sensitive and required careful handling. For example, balancing the requirement for vigilance in respect of potential parental neglect or relapse into drug misuse against the need to support A and J in caring for their dying child would have been quite challenging. The records indicate that this was well managed. Social Worker 1 was direct with A and J about their methadone maintenance and its associated risks, as well as A's past history of failing to meet her older children's needs, but she managed to convey her concern in a supportive manner. Social Worker 1 showed sensitivity in not crowding A and J, who had to deal with a lot of coming and going in their home but used other means of keeping in touch with them and maintaining watchfulness. Social Worker 1 also used the opportunities presented to enable A's eldest child to understand what was happening and to get to know M.

While the records give a lot of detail about A, there is very little about J, her partner and M's father. There are indications that he had at one point been a problem drug user who has recently been maintained on methadone, but no other detail that may indicate either risky or protective characteristics other than general comments about his supportiveness. A more comprehensive assessment could have elicited fuller information about him which, given that he and A were M's sole carers for a considerable period each day, would have been enlightening and may have been significant.

12.4.3 Recording

The quality of recording in the case was good. The notes were typed and dated to indicate that they were contemporaneous. They provided a clear sense of events as they unfolded including the actions of Social Worker 1 and indications of future planning. As noted above, there were no supervision notes.

12.5 Management

12.5.1 Allocation

The notes indicate that the case was allocated to Social Worker 1 when concerns arose about A's pregnancy. As her two older children were in the care of the HSE it is assumed that this case was already open.

12.5.2 Inter-agency meetings or cases conferences

There were two child protection meetings, a 'professional' meeting and a child protection conference a few days later. Both were attended by all the relevant professionals and the child protection conference was also attended by J and A. Both meetings were recorded in detail with clear aims, conclusions and actions.

12.5.3 Supervision

There is no record of supervision having taken place in the case, apart from one note referring to a discussion with the team leader. A case such as this one which required a high level of surveillance, inter-agency and inter-professional collaboration and sensitivity to the parents would have required supervision to support the social worker and to ensure that the case plan was working efficiently with no gaps or shortfalls in service. It is possible that supervision occurred but in the absence of a record this cannot be assumed.

12.5.4 Policy

Where concern exists about the imminent birth of a child in vulnerable or complex circumstances, a formal policy of collaboration between the maternity and community based services would be important. It does not appear as if such a policy exists in this area.

12.5.5 Inter-professional and inter-agency collaboration

There is evidence of some very good inter-agency cooperation in this case. The record indicates that the maternity hospital was instrumental in putting together the care package, but there were a number of other strands to the case that needed to be synchronized. Such coordination and communication is traditionally difficult to sustain in the medium to long term, but the record indicates that Social Worker 1 managed to achieve it efficiently and continued to maintain good oversight of the different interventions.

Inter agency cooperation around discharge and after-care would be a primary consideration in a case such as this, and as the previous section outlined, the medical/clinical aspects of the case tended to take precedence over the child protection issues at the time M was discharged from the maternity hospital. Given the risks involved in the case, this could have had serious implications.

13. Conclusions

13.1 The level of support provided to A and J to enable them to care for M until his death appears from the records to have been high. At different points during the baby's short life there were concerns about his parents' ability to cope and the records indicate that these concerns were addressed each time by the provision of extra night and day time support. The records also indicate that Social Worker 1 maintained good oversight of the case.

13.2 The level of level and quality of inter-agency coordination, communication and collaboration in the case appeared to be of a good standard. This review recognises the challenges associated with coordinating the mix of services required in this case, and notes the commitment of all those involved and the efficiency of Social Worker 1 in keeping lines of communication open.

14. Key learning points

14.1 Although the case was well managed, the lack of a formal and comprehensive assessment prior to or following the birth of M meant that information that may have been significant could have been missed. It cannot be assumed that the previous history on the file was sufficient to cover current risks[1]. The social worker carried out a partial assessment, but the records only show it as an assessment of the physical environment, not parenting capacity. It also meant that information about M's father was missing. It is not clear whether or not he was known to Children and Families Services prior to the involvement of Social Worker 1, but once M was discharged from hospital, J carried significant responsibilities. In light of the identified risks, it would have been important to assess his parenting capacity. The tendency to marginalise fathers is well evidenced in social work and child protection literature[2]; practitioners and line managers need to be aware of the potential for it to occur.

14.2 The tensions that existed around the discharge of Baby M from the hospital demonstrate the need for more formal protocols between community based and hospital based services.

14.3 The review has found the practice of Social Worker 1 to be generally of a high standard. However, it notes the lack of supervision records, which is not only contrary to HSE national policy, but deficient in a case such that involves balancing risk against compassion for bereaved parents and

---

[1] Munro, E. (2008) *Effective Child Protection*, London: Sage

[2] Ferguson, H. & Hogan, F. (2004) *Strengthening Families through Fathers,* Dublin: Department of Social and Family Affairs http://www.fsa.ie/fileadmin/user_upload/Files/foreword.pdf

the provision of a safe environment for a terminally ill infant. Additionally and importantly, the welfare of a worker involved in such a case needs attention.

15. Recommendations

The review makes the following three recommendations:

15.1 The implementation of a standard assessment format in the area

15.2 The development of a formal protocol between HSE Children and Families Services and maternity hospitals to ensure that pre-birth consultations take place when vulnerable service users are due to give birth, and to ensure that agreements are adhered to.

15.3 Implementation of the HSE national supervision policy.

Signed: Helen Buckley

Date: 13-5-11

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

April 2011

Executive Summary

1. Introduction & Background

This review is concerned with a five month old baby, here called M, who died in the care of his mother and father, here called A and J. The review has been held as A was known to the child protection services and had older children in foster care. Baby M was born with congenital abnormalities that were incompatible with life, though he in fact lived for five months. A death certificate included in the records identified the cause of death as congenital developmental disorder, and a palliative nursing team were present when baby M died. There had been no evidence of any parenting concerns in respect of baby M. Nevertheless, there had been concerns about A's drug use and previously diminished parenting capacity. During the time that A and J were caring for M they were both being maintained on high doses of methadone and A was additionally prescribed benzodiazepines. As a result, there was a high degree of support and monitoring of their care of the baby. The timescale of the review principally covers the final months of A's pregnancy and the five month period of M's life. The terms of reference were:

I. To examine the events leading up to the death of Baby M and determine whether the level of support and monitoring provided by HSE Children and Family Services was adequate

II. To examine the level and quality of inter-agency coordination, communication and collaboration in the case

III. To provide an objective report to the HSE including an executive summary, conclusions and recommendations

Method

The methodology adopted was a review of HSE records only, with the option of consultation with staff for the purposes of clarification. The review was conducted by the chair of the NRP, Helen Buckley. The records consisted of one folder with 81 pages containing copies of correspondence, case notes and reports of an inter-agency meeting and a child protection conference. It was not considered necessary to request any further records. Extracts of the report were sent to relevant key staff for verification of facts and their responses were considered in the final version.

Findings

The level of support provided to A and J to enable them to care for M until his death appears from the records to have been high. The supports were provided by a number of services, including the maternity hospital, the family's GP, the palliative care team attached to the children's hospital, and the Hospice, the HSE public health nurse and the HSE social worker, who key-worked the case from a child protection perspective. At different points during the baby's short life there were concerns about his parents' ability to cope and the records indicate that these concerns were addressed each time by the provision of extra night and day time support. The records also indicate that the HSE social worker maintained good oversight of the case.

The level of level and quality of inter-agency coordination, communication and collaboration in the case appeared to be of a good standard. It seems that decisions around the discharge of Baby M from the maternity hospital following his birth were determined according to a medical/clinical plan rather than a child protection and welfare plan, and this caused some tension at the time between the maternity hospital and the HSE social work service. Overall, however, this review recognises the challenges associated with coordinating the mix of services required in such a case, and notes the commitment of all those involved and the efficiency of the HSE social worker in keeping lines of communication open.

Key learning points

Although the case was well managed, the lack of a formal and comprehensive assessment prior to or following the birth of M meant that information that may have been significant could have been missed. It cannot be assumed that the previous history on the file was sufficient to cover current risks[1]. The social worker carried out a partial assessment, but the records only show it as an assessment of the physical environment, not parenting capacity. It also meant that information about M's father was missing. It is not clear whether or not he was known to Children and Families Services prior to the involvement of Social Worker 1, but once M was discharged from hospital, J carried significant responsibilities. In light of the identified risks, it would have been important to assess his parenting capacity. The tendency to marginalise fathers is well evidenced in social work and child protection literature[2]; practitioners and line managers need to be aware of the potential for it to occur.

The review has found the practice of the HSE social worker who key-worked the case to be generally of a high standard. However, it notes the lack of supervision records, which is not only contrary to HSE national policy, but deficient in a case such that involves balancing risk against compassion for bereaved parents and the provision of a safe environment for a terminally ill infant. Additionally and importantly, the welfare of a worker involved in such a case needs attention.

---

[1] Munro, E. (2008) *Effective Child Protection*, London: Sage

[2] Ferguson, H. & Hogan, F. (2004) *Strengthening Families through Fathers,* Dublin: Department of Social and Family Affairs http://www.fsa.ie/fileadmin/user_upload/Files/foreword.pdf

Recommendations

The review makes the following three recommendations:

The implementation of a standard assessment format in the Local Health area

The development of a formal protocol between HSE Children and Families Services and maternity hospitals to ensure that pre-birth consultations take place when vulnerable service users are due to give birth, and to ensure that agreements are adhered to.

Implementation of the HSE national supervision policy.

Signed: Helen Buckley

Date: 13-5-11