National Review Panel

Review undertaken in respect of a serious incident involving a child known to the child protection system: W

March 2011

Review undertaken in respect of a serious incident involving a child known to the child protection system: W

March 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 in May 2010 and began its work shortly thereafter. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the Assistant National Director's Office and from there to the National Review Panel. The AND 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:

I. **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.

II.

III. **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.

IV. **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.

V. **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.

VI. **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. Serious Incident: W

The matter under review is a serious incident, and fits within the criteria for a Desktop Review. A serious incident is defined in the HIQA guidance (p.2) as:

> 'A death or potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development'

In this case the incident was an accident whereby a young person aged 14 fell through the roof of a building near his home and was critically injured. He was known to Children and Family Social Services. 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.

5. Level and process of review

This was a desktop review. The records provided to the review panel were sufficiently clear and comprehensive to provide enough information to meet the terms of reference, and the involvement of the HSE child protection service prior to the event was of a reasonably short duration.

The review materials consisted of one case file, which contained the initial referral, initial assessment and case notes. A query was issued to the local area in respect of the circumstances in which the serious incident occurred and the information was provided by the social work team leader.

6. Terms of Reference

The terms of reference for this review were:

I. To examine the events leading up to the serious incident and determine whether action or inaction by HSE Child and Family Social Services was a contributory factor

II. To determine whether compliance with relevant procedures, standards and regulations relevant to the case was satisfactory

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

7. W

The young person who is the subject of the review is here given the pseudonym of W and is 14 years of age. W was the victim of a potentially life threatening accident in October 2010, very shortly after an initial assessment had been completed by the HSE due to concerns about possible neglect. At the time that the incident was notified to the National Review Panel, his condition was considered to be critical. Fortunately, he appears to have made a very successful recovery and has now returned to school.

W lives with his mother. His parents separated some years ago. He has a number of older siblings who have left home. He is half way through his secondary education, and has a number of friends and some extended family nearby. He is described as a likeable boy, who loves animals and enjoys outdoor pursuits.

8. Background and Reason for referral to the HSE

The HSE Children and Families Social Work Services had carried out an initial assessment of W, following an incident where his mother, here called L, had been found neglectful of a group of younger children whom she was minding temporarily. That incident was investigated by the Gardai, who reported it to the HSE. At the time, L had acknowledged that she had been 'stupid' and said she would never act negligently again. When the HSE social work department learned that she had a 14 year old child of her own, it was decided to follow up and assess if W's needs for safety and welfare were being adequately met. The file was opened on 20th June and the last entry before W's accident was 7th October, so the total involvement was under four months. The accident took place near his home.

9. Services involved with W and his family

Up to the time of his accident, the only services involved with W and his mother were his GP and his school. The HSE child protection services had become involved four months earlier, though it had taken some time to arrange a meeting between the social worker and W.

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

On assessment, it was ascertained that W's physical, emotional and psychological needs were being met by his mother. His school identified educational needs. The record shows that these were being met by his teachers with the support of his mother.

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

June 2010

The notification of child neglect in respect of W's mother, L, and the children she was minding was received by the HSE in June 2010. A home visit was attempted by a HSE social worker in mid- June, to see if W's needs were being adequately met, but nobody was at home. A second unsuccessful visit was made two days later and this time the social worker left a note to say that a further visit would be made the following week. L responded to this note by cancelling the appointment because of family illness, and undertaking to contact the social work department.

August and September 2010

No contact had been made by L to the HSE social work services by mid-July, and the team leader re-allocated the case for further social work follow up. The social worker made telephone contact with L in early August, to be told that W was away on holidays. In mid-September an unannounced social work visit was made and the social worker was made

aware that the family had moved. Telephone contact was attempted one week later and voicemail message left, and again two days later. Contact was successfully made by telephone at the beginning of October, and details of the new address given. An unsuccessful home visit was made on the same day. One week later, the social worker made two attempts to find L at home and was successful on the second occasion.

October 2010

On this occasion, L again expressed her remorse at her neglect of the other children who had been temporarily in her care. She gave permission for the social worker to meet with W and to contact the family GP and school. The social worker called the following day and met W both with his mother and on his own. She found him to be an engaging and happy child who enjoyed sports and music. He told the social worker that he was aware of that his mother had done 'something stupid'. The social worker had no concerns about his care. His school was contacted, and the principal described him as a likeable child who could achieve more academically; he was getting extra help in school and the principal described his mother as supportive. His GP was also contacted and had no record of any concerns about his health.

A few days later, W had an accident and sustained serious injuries. He was admitted to hospital and was said to be critically ill, on life support. The social work department were informed by the GP.

12. Analysis of involvement of HSE Children and Families Services

12.1 Response to initial referral

The referral from An Garda Síochána took place in early June but a face to face contact with the family was not achieved until early October. The fact that the initial notification was followed up pro-actively, conscientiously and persistently by the social work department is commendable. The record indicates that a number of unsuccessful attempts were made to contact the family at various points over the summer, and it is assumed that the fact that the referral was being pursued pro-actively rather than on the basis of actual evidence of harm meant that it lacked a certain amount of urgency. Nevertheless, had it been later discovered that W was in fact neglected and in need of services, a four month time lapse could have been significant.

12.2 Assessment

An initial assessment form was completed following the visit between the social worker, L and W.

The social worker appeared to glean sufficient information on her meeting with W to provide reassurance that he was not a neglected child. However, the quality of the recorded assessment was not high and the information provided did not meet the standard that would be required for an informative or useful assessment. Information was entered under some, but not all, of the headings and did not provide any depth or analysis. For example,

the section on Family and Social Relationships merely gave a descriptive account of how W and his mother had moved to their present location but contained no information about the actual quality of his relationships. The assessment did not mention information that is in fact recorded elsewhere in the file regarding family history and social resources, and the analysis of L's parenting capacity does not indicate the basis on which the social worker formed a view. Overall the assessment does not draw information about W's safety and history from the information collected, which should have led to conclusions and an action plan if that was considered relevant.

The final section, entitled 'Welfare concerns outcomes' indicates that a social work service was offered and availed of, but it is very unclear precisely what this meant, whether the assessment represented the service, whether further services were offered or whether the case was closed. It is also not clear what the actual outcome of assessment was, and the section entitled 'Action on completion of Initial Assessment' was left blank. The assessment is signed off by the worker and team leader. However, the handwriting in the form does not match the handwriting of the social worker signing the form, but seems to be the writing of the worker who completed most of the case notes and undertook the home visits. The case notes provide a more informative account of W's situation than the assessment.

It is likely that the overall view implicitly gained from the assessment, i.e. that W's needs were being adequately met, was the correct view, and the assessment may have been a more thorough exercise than it appears to have been, but the manner in which it was recorded was not up to standard.

12.3 Compliance with regulations.

The regulations pertinent to this case are Children First which stipulates that all child protection concerns reported to the HSE must be followed up as soon as possible. In this case, the response to the initial notification by An Garda Síochána was pro-active in so far as no actual child protection concerns existed about W, but it was felt necessary to assess whether or not he was in need of services, given the fact that his mother was seen to have neglected other children in her care. The services in this instance were acting positively, in line with good practice, and showed considerable commitment to ultimately completing their task despite a number of delays and obstacles. To that extent they were in compliance with Children First. However, as the earlier section has indicated, a four month time lapse between receiving the referral and making face to face contact could have been hazardous had some significant concerns been present. Children First acknowledges that 'the assessment of a child protection concern can often be complicated by matters outside the control of the professionals involved and does not always represent the ordered process outlined in the National Guidelines' (8.10.3), nevertheless it goes on to say that the safety and welfare of a child must remain a priority throughout and the remainder of the tasks covered in the most efficient and expeditious manner possible'. In essence, this means that the good practice that was initiated should have been maintained by finding more creative ways of contacting the family.

12.4 Quality of practice

12.4.1. Interaction with child and family

Comment was made above in relation to the recording of the assessment. Apart from this, it appears from the record that frontline practice in this case was of a good standard. Recording of case notes is clear and informative. The persistence displayed by the team leader and the social worker in contacting L was impressive, and it appeared from the file that the interaction between the social worker and L was conducive to a trusting and constructive engagement which provided the necessary information.

12.4.2 Child and family focus

The social worker complied with Children First by the manner in which they interacted with the family, showed respect to L by informing her of the intention to contact the school and GP, and carried out the tasks without delay. The worker showed a commitment to child centeredness by meeting with W on his own, and displayed skill in also gaining his trust and obtaining the necessary information. The file notes indicate that W was at ease with the social worker and that they engaged well.

12.4.3 Recording

Apart from the aforementioned assessment form, recording of case notes is clear and informative. Entries were signed and dated.

12.5 Management

Involvement of the HSE in this case was of a short duration, but the fact that the case was notified swiftly by the Gardai, and received a prompt initial response are indications of good management of the system. The alertness of the team leader in noting the lack of follow up by L on her earlier undertaking to contact the department and the decision to allocate the case and ensure that the matter was resolved indicates good oversight. The only negative factor evident in respect of management is the fact that the team leader signed off on an incomplete and poorly recorded assessment.

12.5.1 Inter-agency collaboration

The social worker contacted the school principal and the GP as part of the assessment of W's needs. On each occasion there appears to have been a prompt and co-operative response. There was no evidence of any inter-agency difficulties or tensions.

13. Conclusions

W had a serious accident from which he sustained a significant and potentially life threatening injury. Thankfully he has made a good recovery and he and his mother are currently receiving support from the HSE. From what is recorded in the file, the review finds no link between the incident and any action or inaction on the part of the HSE Child and Family Social Services. The service responded pro-actively to a potential concern that had

been previously brought to their attention, and persisted admirably until the matter was resolved.

14. Key Learning Points

As points of learning, the review has commented negatively on the quality of recording in the Initial Assessment, which probably did not do justice to the work actually completed at the time. Additionally, it notes the long delay between initial referral and contact with the family. However, overall it appears from the records that the service provided to W was of a good standard.

15. Recommendations

The review makes two recommendations

15.1 Attention should be paid to the process of conducting and recording initial assessments, and by association, full assessments. It is also recommended that line managers sign off on assessments only when they reach the desired standard.

15.2 Where a decision is made to follow a referral with an initial assessment, a time-frame should be agreed between the team leader and social worker. Difficulty in contacting a family should be addressed by an exploration of other possible means of accessing them.

Signed: Helen Bailey

Date: 11 - 5 - 11