National Review Panel

Review undertaken in respect of the death of Susan, a child known to the child protection system

March 2014

1. Introduction

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

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

2. National Review Panel

A national review panel was established by the HSE and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the National Review Panel. The National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, 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.

4. Child Death

The review concerns a young child here called Susan, who died following an accident in her home. Susan had been in the care of the HSE from age six months to nine months. She was in the care of her parents at the time of her death. A coroner's inquest returned a verdict of death by misadventure.

5. Level and Process

This was a **concise review** as the involvement of the HSE services in this case was of relatively short duration. The review team consisted of three members: Dr. Helen Buckley, Ms Michele Clear and Mr Frank Martin. Dr Helen Buckley chaired the review.

Based on the case files provided to the review, the review team compiled a chronology from the date of the original referral to the HSE social work service by Garda contact when Susan was six months to her death when she was 15 months. Having read the case files, the review team members identified a number of people to whom they wished to speak.

Letters outlining the nature and purpose of the review and requesting an interview were sent to the following individuals:

- HSE Access Worker
- Gardai (three)
- Principal Social Worker
- Public Health Nurses, (four)
- Family Support Worker
- Family Support Service Co-Ordinator
- Allocated Duty Team Social Worker
- Child Care Manager
- Duty Social Work Team Leader

- Community Nursery Manager
- Family GP

Susan's mother Kate was invited, via a HSE social worker to meet the review panel but did not accept it. A second invitation was made in person by the chair of the review to both Kate and her husband but they declined to follow it up.

Prior to attendance at interview, each participant received written information outlining the purpose and process of the review. Participants were invited to submit a written statement concerning their involvement with the child prior to the interview. Nine written statements were received in advance of interview.

Individual and joint interviews were recorded and subsequently transcribed. These transcripts form part of the record considered by the review team. The Gardai were invited to meet the review team but were in the process of investigating the case so were unable to attend at that time. A garda later gave evidence at the Coroner's inquest and the content of this was noted by the review team. The family GP did not attend but sent a letter outlining his surgery's involvement with the family.

6. Terms of Reference

- To establish the facts with particular reference to the role(s) played by the HSE and other relevant services prior to the death of the young child concerned
- To review the HSE child protection service in the context of compliance with policy directions and key professional standards
- To consider issues of interagency and intra-agency cooperation and communication
- To prepare a report for the HSE which identifies opportunities for learning from this review and to make recommendations where relevant and appropriate.

7. List of services involved with Susan and her family

- HSE Social Work Department – the social work service became involved when Susan was aged six months. The case was allocated to a duty social worker who held it for five months. It was then wait-listed for allocation to a long term team but was never allocated.
- HSE Family Support Service – a family support worker was involved with the family for five months.
- HSE Public Health Nursing Service – four different public health nurses provided a continuous service from the time of Susan's birth.
- An Garda Siochana – A local garda was involved with the family initially and the case was subsequently followed up by a Child Protection garda.
- Community Nursery – Susan attended the nursery for five months.
- Family GP and Practice Nurse – Susan attended the GP's Surgery where she was seen by the practice nurse for her immunisations.

8. Susan

Susan was just a few months old when she first came to the attention of the Health Service Executive social work department (SWD) and was placed in care. She was the only child of her young mother, Kate. Before she came into the care of the HSE, she was cared for, over periods of time, by multiple adult carers, including her family and a number of family friends and acquaintances. Susan was returned from care to her family aged nine months, where she remained until her death, aged 15 months. Susan was described, by those who knew her, as a beautiful, happy, 'bubbly' child who was 'easy to give cuddles to' and who interacted well with both adults and children. Although Kate and her husband, Paul, were married, Susan was not Paul's biological child. He was, however, reported to have been very involved in her care. Neither Kate nor Paul came from Ireland and had no family here, nor wider community support.

9. Background and reason for contact with HSE child welfare and protection services.

Susan was referred to the HSE social work service when she was six months old. She had been left by her mother, Kate, in the care of another woman, by agreement. This carer found that she was unable to contact Kate and became worried. She brought Susan to a Garda station, and the Gardaí subsequently contacted the Out of Hours Social Work service, which placed Susan in an emergency placement. She was subsequently moved to another foster placement and remained there while the SWD worked with her mother towards moving her home.

10. Brief Summary of Susan's needs.

As outlined above, Susan's initial need was for a safe secure placement pending an assessment of her own and her family's circumstances. The social work records show that Susan's need for stable, consistent long term parenting, to enable her to form secure attachments was identified following assessment by her allocated social worker. Her family's need for support was also identified; staff who worked with Kate told the review team that they felt she might have been isolated and without links to the community.

11. Chronology of contact with services from the time Susan was 6 months to 15 months

Susan's admission to care

After the incident described in Section 9 above, Susan was received into care, under Section 12 of the Child Care Act 1991, [1] by the Out of Hours social work service. The case was transferred to the local social work department (SWD) and immediately allocated to a duty social worker. A standard intake record for child protection and welfare was completed and the case category listed as 'neglect'. An action

[1] Section 12 – Powers of An Garda Siochana to take a child to safety – provides that where a garda has reasonable grounds for believing that there is an immediate and serious risk to the health/welfare of a child, he/she may remove the child to safety and as soon as possible deliver the child into the custody of the HSE.

sheet recorded it as having a priority of 1 on a three point priority scale, (1 high, 2 medium and 3 low). On receipt of the referral, the allocated duty social worker and her duty team leader called to an address which had been located for Susan's mother, through the public health nursing service, but got no response. Notice, in writing, of an application by the HSE for an emergency care order, which was to be heard in the District Court that afternoon, was left by the social worker at the address.

An emergency care order, lasting three days, was granted to the HSE *ex parte* by the District Court. The allocated social worker and the Garda, who had invoked Section 12 of the 1991 Child Care Act, gave evidence before the District Court Judge. The social work records show that the following day Susan moved from her emergency foster family to a short- term foster family and was taken to a GP for a general medical examination. The case was categorised in the SWD as 'on- going risk of significant harm' and the allocated duty social worker started a placement plan.

The social worker and team leader called again to the family home and found Kate and her husband Paul present. Kate was initially resistant to meeting them but was persuaded to do so by her husband. The social worker also had meetings with other adults involved in Susan's life, including some of those who had cared for her for periods before she came into care and those who shared her family home.

On expiration of the emergency care order, an interim care order was granted for a month by the District Court. Susan's parents were present at the proceedings and did not oppose the granting of this order or subsequent extensions to the order.

The SWD proceeded to assess the case by completing the necessary paper work. The allocated duty social worker continued to carry out network checks; she spoke to the family GP and the practice nurse, who advised that nothing of a child protection nature had previously come to their attention.

According to social work records, contact visits between Susan with her family started nine days following her reception into care. An access worker[2] was allocated to the case. Supervised access visits took place in the local health centre of Susan's foster family, approximately three times a week for two hours.

Just over two weeks after Susan came into care, a statutory Child in Care Review was held. Following a decision of the Child in Care Review, a routine developmental examination was arranged by the PHN

[2] The role of the access worker is, in consultation with the allocated social worker, to arrange, and supervise if required, access visits with their families for children in care. The access worker ceases to be involved once a child leaves care.

from the foster family's local health centre following contact from Susan's original PHN who had attended the Child in Care Review. An earlier routine developmental examination had been carried out before she came into care.

An initial assessment was completed. Susan's needs were identified as follows: "Susan requires consistency to ensure she can develop a secure attachment with her primary carer". The social worker recommended that Susan and Kate should spend time together in a residential placement, in order to assess Kate's long term parental capacity. Sanction for this was not granted by the principal social worker (PSW), for professional rather than financial reasons. The PSW's view was that it was not warranted as the allocated social worker had no concerns about Kate's day to day care of Susan. Furthermore the PSW had reservations concerning the geographical locations and nature of some of the residential services proposed.

Approximately five weeks after Susan came into care, a child protection case conference was scheduled to take place to share information and discuss a plan for Susan. The child care manager, the allocated social worker, her team leader and Susan's parents arrived for the conference at the scheduled time, but as the GP and PHN had conveyed their inability to attend, a decision was taken not to proceed with the meeting in their absence. The SWD had been unable to make contact with the relevant Gardaí to issue an invitation to the conference. The PHN had sent a brief report, which indicated that Susan's development was within the normal range. There was no reference in the report to any child welfare or protection concerns. The child care manager was of the view that it was not necessary to reschedule the case conference at this stage as Susan was the subject of an interim care order and the social worker had compiled all relevant information from the other services involved. The child care manager recommended that the SWD make a determination for the immediate future of Susan without the requirement to revert back to a case conference at that point.

Plans for interventions with Susan and her family

From the interviews and material available to the review team, it is clear that subsequent interventions in the case continued on the basis that Susan would be reunited with her mother and her mother's husband. However, there is no actual record on the files of a formal decision in this regard. Notwithstanding this, it appears to have been understood by all parties involved that Susan would be reunited with her family after a period of assessment. The social worker and her team leader told the

review team that they believed Kate was capable of caring for Susan, that she wanted Susan home and that she was willing to engage with services.

Referrals were made by the allocated social worker for a family support worker and a community nursery place for Susan in anticipation of her return home. The social worker sought financial assistance for the nursery fees, but was unsuccessful. The nursery, however, agreed to reduce the fees in light of the family's circumstances. The family support worker and her supervisor were introduced to the family by the allocated social worker and an introductory meeting was held at the nursery.

The HSE had made an application to the District Court for a supervision order but withdrew it as both the allocated social worker and her team leader believed that it would not enhance Susan's welfare; her family were cooperating fully with the HSE and Kate in particular found the court proceedings very difficult. The District Court Judge queried the withdrawal; he was given reassurances by the HSE that supports were to be provided to the family and their willingness to cooperate with these was confirmed to the Court by their solicitor. Legal proceedings in the Court ended at this point.

Susan's contact with her family was increased prior to her return home. The access worker who had managed Susan's contact with her family while in care visited the family home prior to her discharge from care. During the visit, she talked to Kate about child safety issues pointing out, for example, an overflowing rubbish bin which she felt could pose a risk to Susan.

Susan's return home

Susan returned home after three and a half months in care. The family support worker began to work with the family and Susan started attending the nursery. A supervision sheet on the case file refers to 'family support plan in place' and re prioritised the case from priority 1 to priority 3 i.e. low priority.

A family support plan was outlined in a report prepared for the District Court and included the following; a family support worker, a place in a community nursery and a social work service. The plan was not broken down in terms of timing of individual inputs, length of service to be provided or expected outcomes.

Subsequent to Susan's return home, she was admitted to a children's hospital with a viral infection and discharged five days later. The social worker and a public health nurse from the family's local health centre made a joint home visit. Public health nursing visits were increased as Susan had lost some weight.

The public health nurse reported that Susan quickly regained weight. Susan resumed attendance at the nursery.

The case records note information provided by Kate in the course of a phone conversation with the family support worker to the effect that she was minding a child for another family. On a subsequent visit by the family support worker to the family home, Kate arrived, late for the appointment, with Susan together with the child she was minding. Both the nursery staff and the family support service made contact with the allocated social worker with concerns regarding the number of days Susan missed at the nursery and the family support worker's difficulty in engaging Susan's family.

There is a record in the social work file dated approximately two months after Susan's return home that the case was to be put on a waiting list for allocation to the long term social work team. This signifies that the family were still considered to require a social work service. However, the categorisation of the case had at this stage changed to 'low priority' which implied that while the case was awaiting long term allocation, only child protection concerns would be responded to by the duty social work team. A further assessment[3] was conducted which included contact with the nursery that Susan was attending. It recommended 'continued assessment and monitoring' and noted that there was 'ongoing risk of significant harm'. The main risk identified was the tendency for Susan's mother to disengage from supports. It also noted that there were no current concerns about Susan being cared for by other adults apart from her family, that she was making progress at home and had a good bond with her mother.

Susan's mother withdrew Susan from the nursery in the early summer. The nursery understood that the family was moving to another area. The family support worker, in consultation with the duty social worker, continued to try, without success, to engage Kate and agree which tasks should be the focus of the service.

The allocated duty social worker continued to have some responsibility for the case, although it was no longer officially allocated to her, as it was on a waiting list for transfer to a long term team. The family support service was withdrawn a month after Susan stopped attending the community nursery. Giving the reason for closure as "a lack of commitment by the family and difficulty in identifying a role for the family support service", further stating that the service had 'no concerns' regarding Susan's care".

[3] A further assessment is similar to an initial assessment but carried out in greater depth and over a longer period.

A newly assigned local public health nurse made two visits to Susan and her family. On her first visit she brought the Child Safety Awareness chart. This is normally given to parents at their first visit but as this PHN had not done the initial visit herself, she brought it with her at this stage. This chart covers safety in the home. The PHN's second visit took place ten days before Susan's death following an accident in her home.

12. Analysis of the involvement of the HSE Children and Family Services

12.1 Social Work response to the initial referral

The initial response of the duty social work team to the referral was immediate and appropriate. The case was allocated to a duty team social worker and given a high priority. Necessary immediate legal action was initiated; the child's family was located and interviewed by the allocated social worker and her team leader. Evidence for the District Court proceedings was gathered. An initial assessment was carried out and recorded. A placement plan was drawn up by the allocated social worker the day after Susan was taken into care which noted the time frame for the drawing up of a care plan. Susan was transferred from her emergency foster home to short-term foster carers and had a standard medical examination. An access worker was assigned to the family and regular access started.

12.2 Assessment

A standard initial assessment template was completed and a further assessment template, which includes a section titled 'core assessment framework'. The assessment accurately identified Susan's need for stable relationships to allow her form secure attachments. The further assessment record identifies the need for 'a consistent primary carer to ensure she develops a secure attachment'. Her parent's backgrounds and current circumstances were taken into consideration as part of the overall assessment. Assessing her parent's needs, apart from a general need for support, and their ability to meet Susan's needs in the long-term proved more difficult, notwithstanding the efforts of the social worker and her team leader to do this. Information concerning the family was limited despite the social workers attempts to gather a fuller picture. The review team has noted a number of factors that could have been the focus of a more in depth assessment:

- The fact that, in her early life, Susan was often left in the care of others, some of whom did not know her

- Kate's history and her experience of being parented as a child
- Kate's current circumstances and her reluctance to accept that she needed to engage with services

The review team believes that the SWD's assessment of Susan's family lacked comprehensiveness largely due to the family's reluctance to provide information and. as a result could have been over optimistic. It is acknowledged here that the social work practitioners who were interviewed disagreed with the review team's opinion.

Additionally, the review team believes that a fuller assessment, beyond observation at visits, of Kate's relationship with Susan, was indicated but not done and that the recommended residential assessment would have been valuable in indicating the quality of attachment between Susan and her mother. The PSW speculated to the review team that, in hindsight, a psychological assessment might also have been helpful. Other options such as a Marte Meo[4] assessment could have been considered. The review team notes, however, that the family's cooperation would have been necessary for any of this to have taken place and would have been difficult to attain.

It is also noted that once the agreed services were in place and Susan had returned home, the family's reluctance to engage with services limited their involvement. It meant the family support plan was based on an incomplete assessment and also curtailed the potential role of the community nursery.

12.3 Compliance with Regulations

Susan's reception into care by the HSE Out of Hours service following the invocation of a Section 12 by a garda and the application by the HSE the District Court for an emergency care order were in compliance with legislation as were the subsequent applications to the District Court. The Child Care (Placement of Children in Foster Care) Regulations 1995 were complied with, in so far as Susan had a medical examination on coming into care, a statutory Child in Care Review was held within a month of her placement in foster care, a placement plan and a care plan were drawn up and the social worker saw Susan regularly. The Care Plan, however, was produced after the Child in Care Review, so it could not be reviewed at the meeting. Visits by the social worker are not recorded separately on the file.

[4] Marte Meo is a method of enhancing parenting, using video to record daily activity involving interaction between parents and children. The video is used as an educational tool, whereby sessions are played back, discussed and reflected upon by the family and professionals.

Notification of Suspected Child Abuse including garda notification forms were completed and arrangements made for a child protection case conference to be held in compliance with *Children First 2011* guidance. The case conference did not take place. The social worker and her team leader were aware of the reasons for the decision by the CCM not to reconvene the child protection case conference. The CCM told the review team that the decision was also based on the fact that there was no significant immediate risk to Susan as she was in care and also subject to care proceedings. A consequence of this decision was, however, that one of a number of opportunities to make a formal written plan for Susan, which would have required a review of progress at a later stage, was missed. The absence of any formal written plan contributed to the case having a low priority on the waiting list for long term allocation. The PSW confirmed that cases with a child protection plan are given a high priority, priority 1, on the waiting list, as are children with a supervision order.

12.4 Quality of Practice

12.4.1 <u>Interaction with the child and family</u>

The allocated duty social worker and family support worker both put considerable effort into building a reasonable working relationship with Susan's mother and her husband. It was acknowledged from an early stage that Kate and her husband wanted to have Susan returned to their care and they cooperated with the plan that was proposed to them for family support and a nursery placement. The social worker and her team leader made a reasonable professional decision, at the time, to instruct the HSE solicitor to withdraw the application for a supervision order as the family was fully co-operating at this stage and they were aware of the stress caused to the family by the court proceedings.

The three PHNS who had involvement with the family found the parents co-operative, before and after Susan's period in care. One PHN had contact only with Susan and her foster carers. The review team notes that all possible age-related core visits [5] were carried out, with additional visits as required.

One of the outcomes anticipated by the social worker when planning for Susan's return home was that relationships with the family support worker and nursery staff would develop and that the family would find them supportive. However, the review team considers that Susan's parents used avoidance tactics (being late, forgetting appointments, not bringing Susan to nursery) to avoid meeting staff once she had

[5] The five core public health nursing visits as outlined by one of the PHNs interviewed are as follows; at birth notification, the three/four month development check, the seven/nine month development check, the eighteen/twenty month visit and the three year visit.

been returned to them. This was not explicitly acknowledged by the SWD but resulted in a tapering off of contact.

By mid-summer, as a result of the family's withdrawal from support services, neither the family support service nor the nursery was involved; the public health nurse continued to visit and this service was accepted by the family. The case was on a waiting list for allocation to a social worker on the long-term team and listed as low priority. The review teams' opinion is that the case was now in a lacuna and should have either been allocated or closed, in consultation with the family, the PHN and the GP, on the understanding that were further concerns to arise the case would be re-opened.

12.4.2 Child and Family Focus

The main focus of both the social worker and the access worker was on the day to day care and welfare of Susan. They observed Susan and her family at access visits and home visits, and sought information from the family support worker and nursery. However, the files and interviews gave the review team a very limited picture of what daily family and community life was like for both Susan and her parents. It is not clear what their immediate and longer term needs were nor how these might be addressed.

The PHN service, involving four different PHNS, was very child focused in that the service followed the child from home through a move to foster care and back home again. Child health records followed the child, her immunisation programme was followed up and core visits completed as well as additional visits as required. A PHN colleague covered the case pending the assignment of a new PHN to the area so that there was no gap in the service.

12.4.3 Quality of recording

The social work team leader told the review team that 'standardised business process'[6] templates are now in use in the area. She said that the initial assessment template was now on their computer system. Prior to this no assessment tool was used in the area which now uses a Core Assessment Framework. Forms and templates completed by the allocated social worker were countersigned by her team leader. Regular monthly supervision sheets were completed and signed by the allocated social worker and her

[6] The 'standardised business process' was part of the National Child Care Information Project, now the NCCSI (The National Child Care Information System) which identified standard social work 'business practice' nationally and produced a suite of templates to capture these processes.

team leader and put on the social work file. Reasons for key decisions in the case were recorded in writing, for example the reason for the decision not to reconvene the child protection case conference was sent to the social work team leader in an e-mail from the child care manager and the reasons for the decision with regard to the residential assessment were also sent in writing by the principal social worker to the team leader. There is no written record of the decision to return Susan to her parent's care and no written plan or contract apart from the Placement and Care Plans.

12.5 Management

The main guidance in use in the area was reported to be Children First 2011. The HSE Child Protection and Welfare Practice Handbook 2011 was also reported to be used.

12.5.1 Capacity of the SWD and equity of workload

The duty social work team leader and the principal social worker described how the duty social work team was in difficulties at the time of this case. The volume of referrals coming to the team far exceeded its resources to deal with them and the team's ability to transfer cases to long term teams, in the agreed time frame of three months was extremely limited. The review team was told that around the time Susan was first referred to the SWD, ten cases were accepted for transfer to long term but never transferred. The review team was also told by the duty social work team leader that in January 2012, 52 cases were due to go on to long term but were blocked as colleagues were unable to transfer cases to the Children in Care teams. The review team notes that some teams were able to limit the number of referrals accepted by the team while the duty team was expected to accept all referrals to it.

To resolve the pressure on intake a management decision was made to divide the team into two geographically based duty teams. A second team leader was assigned to lead one of the newly created teams. Due to unforeseen circumstances this plan did not work out and the original team leader reverted to being responsible for both teams. The creation of two teams and subsequent return to one team placed further demands on the team.

A new long- term team was established to ease the pressure on the duty system but did not pick up Susan's case as had been expected by the duty team due to a lack of clarity about the role of the new team. The review team has noted a lack of of equity in the way the different social work teams in the area were expected to manage the demands placed on their respective teams. The duty social work team had no control over the amount of referrals it was expected to take up but was not able to transfer

cases in line with agreed policy, as long term teams, at the time of this case, did not take up cases on the waiting list. Moreover the duty social work team retained responsibility for cases on the waiting list, in that the files remained with the duty social worker team leader and the team also had responsibility for assessing any new child protection concerns that arose in those cases.

12.5.2 Management oversight

The PSW was aware of Susan's case and had discussed it, during supervision, with the duty social work team leader. She confirmed to the review team that the concerns in this case were less about Kate's capacity to provide basic care and more about her attachment to Susan. The review team notes that although there was management oversight of this case it did not prevent the case from ending up in a lacuna, although technically it continued to be open.

12.5.3 Parents acting as carers of children outside the immediate family

The review team notes from information received during interviews that another child was being minded by Kate at the time of Susan's accident. The SWs and PHNs who spoke to the review team said that they rely on Children First 2011 rather than any specific guidance when assessing situations where a family, with a child in care or about whom there are child welfare and protection concerns, is minding children from other families. Decisions are appropriately made on the basis of individual professional judgement. While the review team appreciates that situations may differ and a rigidly standardised approach may not be desirable, it notes an absence of any guidance on how to deal with these eventualities.

12.5.4 Administrative support

The CCM told the review team that there was a lot of pressure on the administrative structures at the time that this case was active. This had an impact on the effective organisation of child protection case conferences and reviews. One of the PHNs confirmed to the review team that notice for the child protection case conference was short and that this was a general issue. Much of PHNs' work is scheduled in advance and cannot be easily reorganised. It was, however, acknowledged by the PHNS who attended the review that the length of notice given had improved in recent months.

To fulfil their role as outlined in Children First 2011 child protection case conferences require dedicated resources to undertake consultation and joint planning with all those expected/ required to attend.

12.5.5 Supervision of Staff

The allocated duty social worker had regular supervision with her team leader and decisions were recorded on a supervision sheet which was kept on the social work file. The social worker told the review team that she felt supported by her team leader and her colleagues. It is notable in this context that the duty social work team leader was managing a team that was overwhelmed by the demands on it and her success in supporting her staff is commendable.

All those interviewed by the review team from the social work service, spoke very positively and optimistically about a current new model of managing intake, with 'welfare' cases[7] being diverted to other relevant agencies. The review team was told that, since 2012, a significant number of welfare cases have been taken on by other agencies from the duty social work team.

12.5.6 Inter-agency and multidisciplinary collaboration

There were examples in this case of individual collaboration between the allocated social worker and the access worker, the PHN service, the nursery and the family support service. There was a meeting at the nursery attended by Kate and Paul, the allocated duty social worker, the nursery manager and a board of management member, prior to Susan's placement in the nursery. An introductory meeting also took place with Susan's mother, the allocated duty social worker, the family support worker and the family support service co-ordinator.

There was limited formal inter-agency or multidisciplinary collaboration. The only multidisciplinary meeting held on Susan's case was the statutory Child in Care Review, which included only HSE staff. Many of those interviewed highlighted the dearth of inter-agency and multi-disciplinary meetings and identified this as less than optimal practice. Some of those interviewed by the review team were also of the view that collaboration was the responsibility of all, rather than belonging to any one service.

13. Conclusions

The review team has reached the following conclusions:

[7] Cases managed by social work departments in Child and Family Services are categorised as 'child protection' or 'child welfare'. Welfare cases are those where children are considered to be in need rather than at risk.

- There was no link between the services offered to this family and Susan's tragic and accidental death

- The HSE Out of Hours and duty social work teams responded immediately and appropriately to the original referral. At that point, the social work services, the garda and the HSE public health nursing service worker worked well together to ensure the safety and welfare of Susan, albeit that very few inter-agency meetings took place.

- Susan's basic needs were correctly ascertained though her relationship to her mother warranted a more in-depth assessment. Her parents' needs and capacities were more difficult to ascertain with the result that plans had to be made in the context of limited information.

- There was no written plan or contract on file in respect of Susan's return home. This limited the potential for reviewing her family's compliance with the plan laid down by the SWD when she went home.

- Notwithstanding the above, appropriate services were put in place on Susan's return to her family. These finite community services were well-managed initially with the allocation of a social worker, an access worker, a family support worker, a community nursery place and the continuation of the public health nursing service. The reluctance of Susan's parents to engage with the family support service and the nursery limited their positive impact.

- Social work practice was well supported. However, the fact that the case remained on a waiting list without much prospect of allocation created a gap particularly when other services had withdrawn.

These gaps noted above contributed to the case being left in a lacuna but should be seen in the context of an intake and long term child protection system overwhelmed by the volume of referrals with no way of moving cases on to either long term child protection or child in care teams. The review notes and welcomes under "Update on Progress" from an internal review of the case, dated 14th May 2013, which was sent to the review team, the following; "An internal Case Transfer Process in now in place to ensure that long-term cases are transferred to the Child Protection Teams."

14. Key Learning

The review team has noted the following points for consideration by the area, and by Children and Family services generally:

- Multidisciplinary and interagency collaboration is fundamental to the provision of child welfare and protection services; it does not happen automatically but requires strategic planning and ongoing attention. This case has demonstrated the importance of joint coordination of child protection conferences with clarity about the expectations held of various attendees and attention paid to details such as the most convenient location and provision of sufficient advance notice. It is noted that guidelines for the conduct of child protection conferences have been recently issued by the Child and Family Agency which cover the matters of location and the notice required. The guidelines also specify that a quorum of two professionals from different professional groups, services or agencies that have direct contact with the child and family must be present in order for the conference to proceed. It may be necessary to clarify with invitees, when inviting them, that their presence is essential.

- Susan's parents' needs and their ability to care for her in the long term proved very difficult to assess, despite the best efforts of the allocated social worker and her team leader to do so. The value of peer cultural support for the family was recognised by the SWD and the social work file notes that some gaps in information about the family because of cultural difficulties that the family had with sharing such information. The SWD did not have any readily available sources of relevant cultural advice. The HSE Child Protection and Welfare Practice Handbook 2011, offers some guidance appropriate to aspects of this case. Under *Messages from Research*, p. 86, the point is made that "In the wider context of social isolation, it is important to ask the question as to where this family sits in the wider community and how do they access support." On p.89 guidance is given on child protection in a multicultural context, including that the practitioner "take advice on the cultural context and work sensitively with the child and family, keeping the child's safety and welfare as their primary concern".

- Although this point was disputed by the social workers involved, the review team felt there was probably a level of over optimism in the assessment of Susan's parents' capacity, largely because of the lack of available information and the family's avoidance of contact once Susan had been returned to them. The HSE Child Protection and Welfare Practice Handbook 2011, at p. 84 notes

under the heading in *Messages from Research* that 'practitioners may become overly optimistic, focusing too much on small improvements made by the family rather than keeping the family's full history in mind. The handbook further comments, under *messages from research*, (page 82) "-'disguised' or 'false compliance'" involves a parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. (Reder et al, 1993). They are not overtly rejecting 'contact' from professionals and/or other outside agencies, but rather using 'avoidance tactics'(e.g. have another appointment, forgot appointment, letter of appointment arrived late, being available at unsuitable times)." This describes some of what took place in this case.

- The review team notes that the services involved with the family confirmed in reports and in evidence that there were no further child protection concerns when Susan returned home. The case remained on a waiting list with little prospect of allocation. No valid social work purpose was served by this. The practice and/or policy in the SWD of leaving cases open to the social work service without any service rather than closing and reopening cases if necessary should be given consideration with regard to the effect this has on families and other services involved with the family.

- Social work records indicate that friends cared for Susan when she was one week old for two weeks and subsequently for two and a half months on and off. Although the family were unknown to the SWD at the time, it is important that staff are aware of the Private Foster Care provisions of the Children Act 2001 and any implications ensuing from them. Section 3.11, p. 120, of the HSE *Child Protection and Welfare Practice Handbook 2011*, which was being used by the area, deals with the issue under the heading of Private Foster Care.

- Only a limited picture of the daily life of this family was available in the files. The *Child Protection and Welfare Practice Handbook* (page 102) which was in circulation while this case was active, highlights the importance, in assessment, of having a sufficient sense of the child to be able to describe their average day, and draws on the *Framework for the Assessment of Vulnerable Children and Their Families* (Buckley et al, 2006) to illustrate how this may be achieved.

- The practitioners interviewed by the review team pointed out the absence of any specific guidance in respect of situations where a family about whom there are child protection and welfare concerns is minding children from other families. This is an issue worthy of consideration

as the different contexts in which it may arise could vary considerably. It could be addressed in future revisions of practice guidance.

15. Recommendation

The issues that have arisen in this very sad case have been addressed under Learning Points (above). The review team makes one recommendation that has national relevance as follows:

- Child safety programmes and advice provided by child protection and welfare practitioners should be reviewed in line with emerging evidence about accidents to children in the home.

Dr. Helen Buckley

Chair, National Review Panel

28th March 2014