National Review Panel

Review of the death of a young person known to Children and Family Services

December 2012

Review undertaken in respect of the death of Mathew, a young person known to the child protection system

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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 Health Service Executive 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 Health Service executive or a Health Service Executive 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 Health Service Executive 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 Health Service Executive. When a death or serious incident fitting the criteria above occurs, it is notified through the Health Service Executive 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 staff, parents, families and children, and site visits. A report will be produced which will contain 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 Health Service Executive services prior to the incident has been long in direction (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 Health Service Executive 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 Health service Executive 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 Health Service Executive 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. Death of young person here referred to as Mathew

This review was concerned with a child who died at the age of six years as a result of a hereditary condition diagnosed at birth. The child referred to here as Mathew suffered from a rare brain disorder. Mathew was five years old when concerns for his welfare were first referred to the Social Work Department (SWD). The case was notified to the National Review Panel because Mathew had been known to the Health Service Executive (HSE) Social Work Children and Family Services during the period prior to his death.

5. Level and Process of Review

This was conducted as a desktop review by Ceili O'Callaghan, Independent Child Care Consultant. The methodology adopted was a review of Health Service Executive Social Work records only. The timeline considered by the review was the eighteen month period between the initial referral and Mathew's death.

6. Terms of Reference

- To review the services provided to Mathew for the duration of his short life.
- To determine whether compliance with relevant procedures, standards and regulations was satisfactory.
- To examine inter-agency and inter-professional relationships.
- To provide an objective report to the Health Service Executive including an executive summary, conclusions and recommendations.

7. Background and reason for referral to Health Service Executive Children and Family Services

Mathew was five years old when concerns for his welfare were referred to the Social Work Department (SWD) by his General Practitioner due to serious difficulties in the relationship between his parents. Social work assessment concluded that the couple experienced a high level of conflict, aggression and significant levels of disagreement about Mathew's medical treatment.

8. Services Involved with Mathew

Mathew had a full complement of hospital medical services, palliative care, community support and primary care services as well as social work input from the HSE Children and Family Services.

9. Summary of Mathew's needs and how they were met

Mathew's primary needs were related to his medical condition. In addition, there were concerns about his welfare and safety. These concerns stemmed from difficulties in the parental relationship and their subsequent and potential impact on Matthew.

10. Chronology of Contact between Mathew, his family and the Health Service Executive Children and Family Social Work team

The first referral was received by the SWD when Matthew was five years old. The referral was processed on the same day and an initial assessment commenced. Following assessment, the family engaged with the social work service. The social worker set out to explore the full extent of the family's support needs. At that time Mathew was in receipt of services from his GP, paediatrician, public health nurse and voluntary support services within the community.

Approximately three months later, the social worker was informed that Mathew had been admitted to hospital. Some issues arose a number of weeks later in respect of parental consent to various aspects of Mathew's medical care. This created concern about Mathew's health and welfare and, following legal advice, the social worker explored alternative care options.

For the next few months, Mathew remained in hospital. Arrangements were put in place to enable both of his parents and his extended families to visit him in a way that avoided possible clashes.

In the meantime a professionals' meeting concluded that it would not be safe to discharge him to the care of his parents because of the high level of acrimony between them. It was considered that conflict may prevent them from focusing their full energy on Mathew's welfare. It was noted that the conflict between them needed to be addressed as a matter of urgency in order to reframe the focus back on Mathew.

The allocated social worker clearly explained to Mathew's parents the rationale for the decisions reached at the meeting, including decisions in respect of his treatment. She tried to work with both parents to promote the welfare of their child without recourse to legal action, but was unsuccessful. The SWD were concerned that each parent was, in different ways, struggling to accept medical advice with regard to day-to-day management of their son's condition. On that basis, the SWD took the view that the HSE should assume responsibility for all aspects of decision making pertaining to the development and implementation of Mathew's care and decided that an application for a care order should be progressed. Their plan for Mathew included measures to prevent both parents from having contact with each other, thus reducing the overt conflict between them. When the case went before the District Court, both parents consented to the order.

Continued placement in hospital was not judged by the SWD to be ideal for Mathew, but it was considered that a foster placement would be difficult to manage given the level of disagreement between his parents. An optional residential placement in a hospice-type setting was planned, but Mathew died before it could be put in place.

Mathew died the following month. The records show that a written plan, known as a 'death and dying plan' had been negotiated with both his parents as to how his death and the period beforehand, would be managed. The social worker assisted both families in the enactment of the plan, and enabled them to spend time with Mathew prior to and after his death.

11. Analysis of involvement of Health Service Executive Children and Family Services

11.1 Initial Response

The initial response to the referral of this case was timely and efficient. Although the concerns were considered to be 'welfare' rather than child protection and therefore of a less risky nature, the SWD nonetheless processed the referral on the day it was received.

11.2 Assessment

The assessment was comprehensive and centred on Mathew's needs in the context of his family. Efforts were made to work in partnership with both parents. The assessment considered all aspects of his care needs: medical, developmental, emotional and psychological. The social worker was direct in her approach and explicit with regard to concerns.

11.3 Appropriateness of care order

As noted earlier in this report the option of working with both parents to promote the welfare of their child in the absence of a care order was fully explored to no avail, therefore the application to the court for a care order was, in the opinion of the reviewer, the correct course to take.

11.4 Compliance with regulations

The review found a high level of compliance with Children First. Child Care Regulations are not applicable in this case as Mathew's death closely followed his reception into the care of the Health Service Executive.

11.5. Quality of practice

11.5.1. Interaction with child and family.

Mathew appears to have had one allocated social worker throughout his involvement with the service. This facilitated consistency and clarity. Given the level of parental conflict, consensus was difficult to reach in all aspects of this case. All efforts were made by the SWD to negotiate and mediate with Mathew's parents with regard to different aspects of his medical and parental care, to no avail. The social worker managed the difficulties and continued to provide parental support. Her practice remained child centred while recognising the difficulties faced by both parents. It is not evident from the file if the social worker had a personal relationship with Matthew but it is very clear that she was aware of all his needs.

It appears from the records that the plan negotiated with Mathew's families about the management of his last hours of life and his death was both developed and enacted with skill and sensitivity by the social worker.

11.5.2 Child and family focus

The focus of intervention was principally on Mathew's needs, but it was also responsive to the needs of his parents. While the social worker challenged behaviours that impacted on Mathew, she remained sensitive to the fears and anxieties of his parents as well as the sense of grief that they were experiencing.

11.6. Management

11.6.1 Inter-Agency Meetings

There is evidence to show that a number of inter-agency meetings took place during the period of Mathew's involvement with the SWD. Decisions made are clearly recorded and the reasons for holding them are easily identified. The records show that the exchange of multi-disciplinary views was facilitated at the meetings, and that this informed the decisions reached.

11.6.2 Quality of Record Keeping

The standard of case file recording was excellent. The assessment process and difficulties encountered were easily identifiable. The records were written in a professional, anti-oppressive and inclusive manner. While maintaining a professional approach the social worker gave honest accounts of decisions made.

11.6.3 Supervision

Although there is no direct evidence of social work supervision in the file, there is evidence of the social work team leader's presence, involvement and decision making recorded on file. It is clear that the team leader was actively involved and had oversight of the case. Resources appear to have been used efficiently.

11.6.4 Inter Agency Co-Operation

There is evidence of good inter agency cooperation in this case; in fact it provides a particularly good example of medical and social services working in partnership to meet a child's needs.

12. Conclusions

The review acknowledges the very sad event of a young child's death and appreciates the impact this must have had on his family and those that knew him and worked with him.

The review concludes that the social work practice in this case was of a high standard, and that the intervention of the HSE was appropriate. The SWD managed to prioritise the needs of the child yet provided a service to both parents. The assessment conducted was equitable, in the context of the fractious nature of parental conflict.

13. Key Learning Points

This review provided excellent examples of positive child protection work. The following points were noted as examples of good practice:

13.1 Case file notes are clear and detailed. They are easily read and respectfully depict the difficulties negotiating familial conflict while keeping Mathew's needs at the forefront. Case file notes also reflect, with honesty, the reality in that Mathew's placement in a hospital was not ideal, but the best option in the circumstances.

13.2 Multi-disciplinary meetings were utilised to develop a community based plan that would meet Mathew's needs.

13.3 A written 'death and dying' plan on the social work file detailed how Mathew's death could be managed. This had been negotiated with both parents. The notes indicate that this process was managed skilfully and with appropriate sensitivity.

13.4 Social work records depict the delicate nature of the case and the painful issues involved for both parents. Decisions made are clearly outlined including the process which led to them. For example the decision made not to place Mathew with foster carers was based on the fact that the high level of access would be difficult to manage and that it was unreasonable to expect foster carers to referee the ongoing and protracted nature of the parent's disputes.

13.5 There was a full complement of multi-disciplinary involvement in this case. The SWD demonstrated negotiation, mediation and facilitation skills. Multi-disciplinary work was monitored and managed by regular professionals meetings which ensured the sharing of information.

13.6 Care plans on file devised by Mathew's medical support team are detailed, and child centred and demonstrate collaborative practice. Social work records at the time of Mathew's death and subsequent funeral portray an approach that was respectful, and prioritised Mathew's dignity.

14. Recommendation

The review makes one recommendation: that supervision notes are kept on social work files.

Signed: Ceili O'Callaghan **Date:** 4/12/'12

Ceili O' Callaghan

Member National Review Panel

Signed: Helen Buckley **Date:** 4-12-2012

Dr Helen Buckley

Chair National Review Panel