Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CHILD IN CARE DEATH REPORT

CHILD: YOUNG PERSON B

APRIL 2010

1. INTRODUCTION

1.1. Purpose and Format of this Report

The purpose of this report is to:

- Establish the lessons to be learned by the Health Services Executive (HSE) in the practice of protecting and promoting the welfare of children.
- Learn from these lessons, to ensure ongoing improvement in the delivery of services to protect and promote the welfare of children.

The format of this report is to:

- Protect the dignity of this deceased young person.
- Prevent the details relating to their particular difficulties and the specific services, availed of by this young person from being disclosed.
- Make every effort to protect the identity of this young person from being disclosed.
- Prevent interference with the privacy of a child in its care or who was in its care.
- Ensure that the report contains nothing that might infringe upon this child's honour and reputation.

1.2. Death of a Child

The unexpected death of any child, under any circumstances is a tragedy. The death of a child in care in particular is a serious issue and is required to be investigated thoroughly, sensitively and fairly.

1.3. The *In Loco Parentis* Role of the HSE

The HSE acting *in loco parentis* has the responsibility of seeking the best possible outcomes for children in its care. Such a role encompasses three key elements:

- The statutory duty of the HSE to promote the welfare of children and young people who are in its care.

- Co-ordinating the activities of many different professionals, carers and partner agencies who are involved in a child or young person's life and taking a strategic, child-centred approach to service delivery.
- Shifting the emphasis from 'institutional' to 'parenting', defined as the performance of all actions necessary to promote and support the physical, emotional, social and cognitive development of a child or young person.

1.4. Key Objectives of Conducting Investigations and Inquiries into the Death of a Child

The HSE acknowledges that children can come into care with very complex needs, backgrounds and levels of difficulties and that their care can present challenges to the organisation, carers and staff.

There are a number of key objectives for the HSE in conducting investigations and inquiries into the death of a child, including:

- Seeking to understand the reasons for the death of a child and causal factors.
- Reviewing of all information and making effective recommendations and directions, insofar as possible, to prevent other deaths and keep children healthy, safe and protected.
- Improving communication and linkages with other agencies.
- Improving delivery of services to children and families.
- Identifying significant risk factors and trends in child deaths.
- Identifying required changes in policies, practices and procedures.

In essence the HSE seeks to understand the reasons for the death of a child and to address the possible needs of other children in care as well as the needs of all family members. The HSE also seeks to consider any lessons to be learned about how best to safeguard and promote children's welfare in the future.

1.5. Balancing the Needs of Investigative Requirements and the Needs of the Family

There is a need to keep an appropriate balance between statutory and investigative requirements and a family's need for support. There are complex interests to balance, including:

- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others.
- The accountability of public services and the importance of maintaining public confidence in the process of review.
- The need to secure full and open participation from different agencies and professionals involved.
- The responsibility to provide relevant information to those with a legitimate interest.
- The constraints on public information sharing if criminal proceedings are outstanding, in that providing access to information may not be within the control of the Review Panel.

1.6. Guidance to Conduct Reviews and Publish Reports

Reviews of significant incidents in regard to children have been undertaken by statutory child care authorities in Ireland on a number of occasions. However, available guidance as to when and how these reviews are conducted and subsequent reports generally deal with an individual child care case. Therefore, it is not possible to publish in full such a report where personal information may lead to the identification of any person and in particular vulnerable children/persons.

Recommendation 36 of the Ryan Implementation Plan 2009 states that the Health, Information and Quality Authority will develop guidance for the HSE on the review of serious incidents, including the death of children in care and detention. The *Guidance for the Health Service Executive for the Review of Serious Incidents, including Deaths of Children in Care* was published in March 2010 and sets out a standard, unified, independent and transparent system for the review of serious incidents and deaths of

children in care. It recommends that a national review process be set up, with the establishment of a National Review Team, including an independent chair and deputy chair. The Guidance also recommends that all deaths of children in care or children known to the child protection system should be notified to the Health, Information and Quality Authority, Social Services Inspectorate within 48 hours of the death occurring.

2. REVIEW DETAILS

2.1. Rationale

This review was established on a non statutory basis. The review was conducted entirely on the basis of the documentation provided covering the Heath Services involvement with Young Person B from 1983 to 2002. In addition relevant statutory provisions concerning child care as well as the publications of the Department of Health and Children, Department of Education and Science, the Social Services Inspectorate, the Special Residential Services Board, the EHB, the NAHB, ERHA and the HSE were reviewed. A wide range of investigations into childcare and specific child abuse cases that were conducted in Ireland were also incorporated into the review process. A similar process was undertaken in relation to the publications and statutory provisions from the UK and the Isle of Man. It is noted that the Eastern Health Board was replaced on 1st March 2000 by the Northern Area Health Board.

2.2. Methodology

Terms of Reference

a) To review the care provided to Young Person B from the time this young person came into contact with the HSE and its predecessor.
b) Review how the case was handled in different services/areas of the health system.

c) To make any recommendations from the findings.

d) To submit a report to the Local Health Manager, of the review, findings and recommendations.

Description of the Procedures Followed

- All records pertaining to this child's case were examined.

2.3. Involvement of Irish Agencies/Services

From the initial contact with the Health Board, a total of 23 services and agencies were involved with Young Person B. These included:

- Social work services - Young Person B had access to social workers for a number of years. In addition this young person had access to child care workers, support and aftercare services. Furthermore Young Person B had access to out of hours services which provided support and accommodation.
- Health services - these provided a broad range of services, both general and specific.
- Educational services - these comprised of school and additional educational supports provided by external agencies.
- Psychiatric and psychological services.
- Housing services - this young person availed of accommodation provided by the Health Board and accommodation also contracted from external services.
- Guardians *ad Litem.*
- Youth justice system.
- Young Person B also availed of a number of other services that cannot be identified in this report in order to protect the honour and reputation of this young person.

3. KEY FINDINGS

a) Young Person B was born in 1983. Concerns were raised regarding the care of Young Person B in 1983. For six years, Young Person B and the family lived in another jurisdiction. Shortly after their return to Ireland,

Young Person B was voluntarily placed in the care of the Health Board in 1998. Young Person B reached the age of majority in May 2001. Young Person B was in receipt of aftercare services provided by the Health Board. Young Person B tragically passed away in January 2002. An inquest into the death of Young Person B was held in 2002. The verdict was death by misadventure.

b) This report highlights the missed opportunities presenting over Young Person B's lifetime when Young Person B came to the notice of the child protection services. There was a lack of a systemic review of key areas of Young Person B's life and behaviour, in particular with regard to what should be the most appropriate care and therapeutic response for this young person.

c) Young Person B needed support, stable living arrangements with experienced staff supported by relevant expertise. The response provided met some of Young Person B's needs some of the time and at times provided for none of this young person needs.

d) It is recognised that Young Person B was one of about 20 children who at the time had similar care needs. The shortfall in expertise that emerges from this case could have been significantly supplemented by the use of existing knowledge and the pooling of available skills.

e) Services provided to Young Person B were disjointed and fragmented. There was a lack of integration. A number of the services that were provided to Young Person B were wholly inadequate.

f) There were significant investments of time, resources, report writing, liaison and interaction with other services by the Health Board in trying to provide the best care for Young Person B, but the delays in providing the type of accommodation recommended within six months of this young person being admitted to care allied to the resultant multiple accommodation arrangements contributed to a loss of therapeutic focus and integrated professional skills that were required to properly meet Young Person B's needs.

4. OBSERVATIONS

a) In total there were five instances between 1983 and 1987 where concerns should have been properly considered in a formal child protection framework, as provided for in the Guidelines on Non Accidental Injury to Children 1983, which sets out the procedures for the identification, investigation and management of non accidental injury to children. There was no documentation to show this occurred. These concerns began to emerge from the time Young Person B was only eight months old and were raised by a public health nurse, later by hospital staff, then by educators and family.

b) Young Person B moved from this jurisdiction and back again on a number of occasions. As a result there are gaps in files and files concerning this young person were closed from time to time. When Young Person B was fourteen years old a social worker was appointed who met this young person on an almost weekly basis and developed a plan based on the available accommodation options to address this young person's needs. This proved the start of a more structured and continuous process of social work involvement that had purpose, context and direction and which lasted for approximately twelve months. The social worker was focused with clear thinking on the presenting issues and worked hard to follow up on the decisions taken with respect to this young person's care. Young Person B subsequently moved out of the jurisdiction and the file was closed. However this young person subsequently returned to the jurisdiction and required accommodation to be provided.

c) The way in which various types of accommodation were provided, including B&B services, did not demonstrate a cogent interlinking of Health Board responsibilities towards a child in care, and potentially exposed this young person to greater risks. The termination of residency in certain accommodation was so unplanned as to appear chaotic, and in another instance was unprofessional and unacceptable. Another type of accommodation provided was opportunistic rather than related to any structured care plan, and there were no stated expectations as to desired outcomes. In some accommodation, rules were imposed by staff in an ad hoc manner responding to the most

recent crisis, and issues were not managed in any therapeutic manner or according to any sourced therapeutic plan. The independent living accommodation that was provided to Young Person B was of a very poor standard, with instances of frozen pipes, blocked toilets and drains, defective shower, and a ceiling that collapsed due to defective plumbing.

d) Harmful activities with which Young Person B became involved in did not result in the calling of a case conference under the provisions of the Child Abuse Guidelines 1987, which set out the procedures for the identification, investigation and management of child abuse. Available highly specialised professional advice and professional services expertise in Ireland and the UK was not sought to address certain specific needs of this young person. These needs were never looked at systemically with a clear plan.

e) Although the response of the psychiatric and psychological services in providing care, diagnosis and advice was clear and sensitive, a delay of over two years in obtaining a psychological assessment undoubtedly led to delays in ensuring the needs of this young person were addressed and that the care was based on full information.

f) There were in excess of forty social workers involved to a greater or lesser extent in the care of this young person. Although the work and commitment of many are to be commended, responses to this young person's needs were ad hoc rather than being a long term structured service.

g) A secure base was required to give this highly vulnerable young person a sense of normality and security. The lifestyle adopted by this young person put this impressionable child at high risk. However there was a lack of special care facilities as expertise was not readily available in Ireland, despite intensive recruitment efforts. The financing of such units and the willingness of managers to deliver on the projects was not a stumbling block but constraints existed from the actual construction of the projects.

h) A breakdown in placements for Young Person B was principally related to the need to care for the needs of the wider numbers of children in

residence as distinct from there being any unwillingness to care for this young person. Certain troubled behaviour led to restrictions on the accommodation facilities that became available to this young person. It must be concluded that the actual scope and range of services provided to this young person was unacceptable in the therapeutic context and also in the essential services of accommodation, care and food.

i) There appears to have been an absence of clear and unique care plans as required in accordance with the Child Care (Standards in Children's Residential Centres) Regulations 1996. In some instances it appears that it was left to this young person on their own initiative to find and arrange certain healthcare needs.

j) The intervention of the court, while highly critical of the Health Board, and the appointment of a Guardian *ad Litem* were positive steps in ensuring more appropriate care would be provided to this young person. There is a lack of a recorded response to queries and concerns raised by the Guardian *ad Litem*. The lack of a recorded response is not of itself a significant failing. However, if it impeded the provision of best care then it clearly must be identified as a major problem.

k) Section 4 of the Child Care Act, 1991 imposes a duty on the HSE to take a child into its care where it appears that the child requires care or protection and that the child is unlikely to receive that care or attention unless the child is taken into its care. The HSE has a duty under this section to maintain the child in its care so long as it appears that the welfare of the child requires it. Section 5 of the Act mandates the HSE to take such steps as are reasonable to make available suitable accommodation for homeless children.

l) In this case the HSE failed to adequately address the care, protection, and accommodation needs that this vulnerable young person desperately needed.

5. RECOMMENDATIONS

1. All recommendations made in respect of a child in care should be documented clearly stating the expected outcome with the prerequisite actions and responsibilities by the named responsible professionals accompanied by the action timeline appropriate to the circumstances of the case.
2. At all times while a child is in care there should be a personal care plan in place that is monitored, managed and adjusted as required by a designated responsible professional.
3. The availability of a multi-disciplinary working team to support the transition of a child into care is integral to good practice and should be a planned feature of the pre-admission process.
4. It is vital that case conferences are managed by experienced case managers and achieve clarity in the decisions taken, clarity as to the actions required to give effect to the decisions, who is to give effect to decisions and ensuring that all decisions are implemented in a synchronised and timely manner.
5. Within all centres and services which must be inherently fit for purpose there should be a comprehensive series of policies addressing the issues of the dignity of all children and staff and the manner through which these are given effect, monitored and managed.
6. All professional insight, knowledge and expertise should be promptly shared between all involved in caring for the child and transported into a clear programme for a child in care.
7. The availability of child care workers to work alongside a child admitted to care is highly desirable.
8. The availability of supported lodgings across all geographic areas thus enhancing service localisation opportunities is most desirable.
9. B&B accommodation should not form any part of the care arrangements for any child in state care, irrespective of their age or care status. Accommodation provided for children in care must meet

basic standards at least equivalent to those specified by HIQA and where a stand alone special circumstance unit is urgently required it should be urgently assessed as to its compliance with these standards by HIQA staff.

10. Proper planning for the movement of a child who is in care is a prerequisite to fulfilment of the statutory responsibilities and should be overviewed and signed off at a designated senior management level.
11. Where practical dilemmas arise relating to the care of children and how an individual's needs are to be balanced against a group's needs this should be considered as part of the review of the individual care plans, the philosophy of the centre and the sum of the available expertise.
12. All staff engaged in care under whatever employment system or care provision process for children should be properly Garda vetted.
13. All Centres should have a clear statement of philosophy underpinned by working policies known and understood by all who work there and who have reason to refer there. A nominated manager, external to the actual service, should have accountability for ensuring that such frameworks are in place and actively used.
14. Pre-admission planning and regular monitoring and management meetings when a child is placed in care are processes that should be diarised, recorded and acted upon in a systematic manner.
15. The desirability of having the capacity to deploy a rapid care group from within existing resources, to meet urgent and demanding care need should be examined.
16. Clear and accurate communications - especially when bad or negative news has to be conveyed - are fundamentally important and must be well managed. Where services cannot be delivered as promised by an agency, it should be the responsibility of the agency to inform the service user at the earliest practicable opportunity and certainly before the service user presents at the service.
17. Where a placement is sought that presents specific care requirements and behavioural issues beyond the capacities of the service such additional external professional supports as may be required should be

made available to the service to support the achievement of the care objectives for the child.

18. Fundamental courtesy such as returning phone calls should be regarded as a sine qua non of all care services and all care plans.
19. Where a child is placed in the care of the HSE, a copy of the Order entrusting or committing the child to the care of the Health Board should be available at every placement and be a part of the standard information provided to all professionals with involvement for the child in care.
20. In the event of a service not being required for a short period of time it is desirable that a formal appraisal be undertaken of the necessity or otherwise for continuing to have it available for its primary purpose.
21. Children with a difficult educational record involving prolonged absence from the formal education system should be provided with a formal educational psychological assessment.
22. In the event of a cessation of services by a provider, be this involuntary or planned, the relevant key professionals involved in the care of the child should meet and review the issues arising, as a consequence of the closure and must be incorporated into the future care plans for the child.
23. All future service agreements should include a requirement that all cases presenting to services must incorporate a planned handover and review process, and have clear processes for managing waiting lists and clarity as to the factors that will form part of the decision making process as to the grant or refusal of services and the timelines appropriate to these elements.
24. Where adult services are required after a child leaves care they should be seamlessly introduced into the leaving care and after care plan for the child.
25. Where physical assaults occur they should be appropriately recorded from a health & safety perspective as well as from a therapeutic view. Careful risk analysis should be undertaken of such occurrences and a clear protocol in relation to involving the Gardaí is desirable.

26. Balancing staff safety and care requirements is a demanding role that is not unique to child care settings. There is a substantive body of knowledge and expertise within the wider care systems. Such expertise should be made available on an on-going basis to staff in care situations such as arose in this case.
27. The importance of consistent external management oversight of risk situations and their amelioration cannot be overemphasised.
28. Where there are siblings of a child in care it is desirable that their child protection requirements are also assessed to ensure their safety.
29. Management should satisfy themselves that the appropriate steps are taken to ensure the shortcomings identified in this case cannot reoccur.
30. Where there are concerns that a child in care has been sexually abused a formal review of the issues should always be undertaken in accordance with the child protection policies in currency at the time.
31. Allegations and/or concerns of a child being involved in prostitution whether or not in statutory care should always be the subject of a formal referral to the Garda authorities and be immediately considered by the care services in the context of the child protection policies and procedures.
32. A protocol for dealing and engaging constructively between the Guardian *ad Litem* and care professionals should be developed so as to provide the most constructive and dynamically effective and productive relationship and where there are multiple Guardian a*d Litem* involved in a case a working process that minimises the need for replication of information giving should be put in place.
33. Where a child in care presents with drug misuse issues, these should be promptly explored and assessed in a formal case review process. Where expertise is not available within or to the immediately responsible professionals, management should ensure that such is made available and integrated within the overall care plan for the child.
34. The need for residential care for young people who misuse drugs and for existing residential facilities to re-examine their policies in this regard

as was recommended in the 1998 Eastern Health Board Annual Review of Adequacy of Child Care services is endorsed by the conclusions of this report.

35. Priority access for homeless children to psychiatric and psychological services should be provided.
36. All requisite documentation relating to a child in care should be integrated into each child's file and properly signed and dated.
37. Where complaints are made a comprehensive record should be made of the investigation, the outcomes and actions taken.
38. Case closure should only occur when a systemic review of all the interactions between the child, their family network and professionals within and without the health service has occurred to ensure that all matters are properly addressed and completed prior to closure.
39. Services working with children in care should work and be managed in a coherent, integrated, focused, planned needs led service provided in a non adversarial manner directed at achieving the best interests of the child as the primary and sole focus of their work.
40. An examination of the strategic and policy considerations of the needs of individual children whose needs cannot be met within conventional or available settings without being so disruptive of the needs of other children in the same care settings should be undertaken to ensure that the individual rights of each child are upheld.
41. Services for children in care require vigilant management ensuring through audit, structured case reviews, appraisal and feedback from all involved in receiving and delivering the service that the service is being provided to acceptable standards of care and practice.
42. Every effort should be made to avoid costly legal cases being taken with regard to the provision of services for children in care. Where feasible non adversarial processes should be used to ensure the best interests of the child are achieved. Conflicts where they arise should preferably be resolved in a facilitative, mediated or arbitral manner.
43. When a child in the care of the HSE dies, a formal review of the case in its entirety independent of the services should be undertaken.

44. The operation of the policy regarding children in care absconding or going missing could be usefully reviewed in the light of experience and insights acquired since its original introduction.
45. Conflicts between the policies of different sections of the HSE must be resolved by management in the best interests of the child.
46. This case emphasises the requirement to examine how the needs of children whose needs cannot be met within conventional settings can be best provided.

6. RESPONSE

6.1. Gaps in Service

Some aspects of work carried out by HSE staff in high profile individual cases relating to child protection have undermined the confidence which both the public and our own staff have in the services we provide. While failures may arise in any system, the HSE believes that the work done in our child protection services is delivered by deeply committed and hardworking professionals.

These findings, while generally acknowledging commitment of staff and the efforts made to address the complex needs of the young person involved, nevertheless, point to gaps in service provision, lack of communication between service providers, lack of clarity around care planning and formal protocols for same.

6.2. Children and Family Services

Children and Families Services are focused on promoting the welfare of children under child care legislation – mainly the Child Care Act, 1991 and the Children Act, 2001. The overarching policy direction comes from the UN Convention on the Rights of the Child which Ireland ratified in 1992. A wide range of services are provided including child health, adoption and fostering, family support, residential care and child welfare and protection services. The overall focus of Children and Families' services reflect the message of the Office of the Minister for Children and Youth Affairs Agenda for Children's Services 2007. This highlights that family support as

the basis for enhancing children's health and welfare. Over time, the focus of our services to protect children will be to further enhance family support services. This is known to be a much more effective means of truly protecting children from harm. Child protection services will always be required, however, and so the HSE is moving immediately to strengthen those services across all our Local Health Offices.

6.3. Regulations, National Standards and Inspections

In some areas of our services for children and families, well regulated systems exist, with clear national standards and lines of reporting and governance.

Services for children in residential and foster care are subject to Regulations and National Standards. These services are monitored and inspected by the HSE and the Health, Information and Quality Authority, Social Services Inspectorate and inspection reports are published. The quality of these services is therefore transparent and open to scrutiny by the relevant authorities and the public.

In child protection, for historic reasons, we do not have a national set of standards against which we can measure and demonstrate the strength of those services, or properly identify and address the gaps that may exist. However, this will be addressed with the development of standards and the commencement of inspections of Child Protection and Welfare Services by the Social Services Inspectorate of the Health, Information and Quality Authority by 2011. In the interim the HSE will build on the significant work done by the Task Force on Children and Families to standardise and enhance our services for children. Child protection services are provided on the basis of legislation but have not been subject to regulations or national standards. Where the intervention of the Court is required in serious child protection cases, all aspects of the case are subject to the scrutiny of the Judge.

In the past there has been a lack of consistency in how our services operate across the 32 separate Local Health Offices. While the lack of consistency in services does not imply that they are weak or inappropriate, it does make them difficult to compare, and that has made it difficult for us to evaluate the state of our services. It has also mitigated our ability to provide the required reassurance to the public and to government that our services provide effective protection to children at risk.

The HSE is aware of the urgent need to ensure a high level of standardisation and consistency of child protection services across the country so that there is a high level of public confidence in them and in 2009, established the Task Force on Children and Family Services to address this issue.

6.4. Children and Families Task Force 2009

The 2009 Task Force on Children and Family Services was set up to address this inconsistency in services, and to implement, for the first time, a unified standardised approach to all child protection services in Ireland. It has identified and developed:

- A single standardised approach to a duty social work and intake system, meaning that all 32 areas will deal with all referrals to the social work departments using the same methodology.
- An Assessment Framework which will lay out a step by step approach to dealing with each referral to or contact with all social work departments.
- Standardisation in how care plans and care planning is carried out, at what intervals, and to what detail.
- Protocols to ensure uniformity of approach and to demonstrate accountability.
- Standardisation of all business processes in child and family services.
- Once off identification of outstanding or unresolved child protection issues.

- Standardisation and dissemination of all existing policies and the identification and development of new ones as required.
- Clarification of governance arrangements in child care and protection systems.
- Training and Supervision Policies agreed and implemented.
- A detailed baseline survey of services which described practice across a range of key areas and clearly evidenced the lack of standardisation, the variation in definitions used and the urgent need for standards in all areas of practice.

Many of the parts of this overall project were either already in train under the former National Steering Committee, or planned and set out in the HSE's 2009 Service Plan.

The Task Force examined all child protection and welfare processes nationally, and carried out extensive consultation with hundreds of professional and managerial staff in our child protection services.

This gives us a clear and very comprehensive set of procedures and protocols that our staff will follow, from initial referral through to closing a case. Each element and each step in the child protection process has been strengthened and standardised, taking the best practice in place and applying it nationally.

Clarity has also been brought by the Task Force on governance issues, producing a written set of roles and responsibilities for each staff member involved in the child protection journey – supported by measurement and reporting on how services are performing. It supports the requirement for a National Child Care Information System. This is a proposed national IT system to support the Child Protection and Welfare Service, which will provide accurate and timely child care information and allow that information to be easily shared.

There are high and often unavoidable risks inherent in managing children and family services, and the HSE must ensure that we can respond effectively to the needs of vulnerable children. The Task Force's programme of work will make sure that all of the HSE's 32 Local Health Offices are operating their Child and Family Services in the same way, to the same standards and in a safe and well regulated environment. Bringing consistency to our services will bring higher standards, better information, and more effective services for children and families.

7. IMPLEMENTATION AND MONITORING

The appended table sets out the recommendations from this report and a summary of the progress in relation to the Health Service Executive's response to each one.

No	Recommendation	Status
1	All recommendations made in respect of a child in care should be documented clearly stating the expected outcome with the prerequisite actions and responsibilities by the named responsible professionals accompanied by the action timeline appropriate to the circumstances of the case.	The HSE Task Force, Children & Families Services was established in February, 2009 to accelerate the development a national unified and standardised approach for children. As part of this process a standardised care plan and review process is being implemented as outlined in the HSE National Service Plan 2009. This is ongoing in 2010.
2	At all times while a child is in care there should be a personal care plan in place that is monitored, managed and adjusted as required by a designated responsible professional.	A standardised Care Plan is being implemented in line with the HSE National Service Plan 2009, ongoing in 2010. Care Plans for children in care are developed, managed and monitored by the individual

No	Recommendation	Status
		Social Work Departments.
3	The availability of a multi-disciplinary working team to support the transition of a child into care is integral to good practice and should be a planned feature of the pre-admission process.	Multi-disciplinary team working will be greatly enhanced by the development of Primary Care Team & Health & Social Care Networks which is being facilitated by the implementation of the Transformation & Integration of Services Programme.
4	It is vital that case conferences are managed by experienced case managers and achieve clarity in the decisions taken, clarity as to the actions required to give effect to the decisions, who is to give effect to decisions and ensuring that all decisions are implemented in a synchronised and timely manner.	Child Protection Conferences are chaired by the Child Care Manager, Children & Families services. The conference is asked to facilitate the sharing and evaluation of information to outline a child protection plan following comprehensive assessment and identify tasks to be carried out by professionals in line with Children First. The Principal Social Worker has responsibility to ensure that all decisions arising from a case conference are implemented. A standardised approach to child protection planning and case conferencing is being implemented as recommended by the HSE National Task Force for Children & Families Services.
5	Within all centres and services	All Children's Residential Centres

No	Recommendation	Status
	which must be inherently fit for purpose there should be a comprehensive series of policies addressing the issues of the dignity of all children and staff and the manner through which these are given effect, monitored and managed.	adhere to the *National Standards for Children's Residential Centres,* 2001. It is HSE policy that all Centres are monitored by designated Monitoring Officers who ensure compliance with policies and procedures. In addition the Health, Information and Quality Authority, Social Services Inspectorate inspects HSE Children's Residential Centres to ensure compliance with the National Standards.
6	All professional insight, knowledge and expertise should be promptly shared between all involved in caring for the child and transported into a clear programme for a child in care.	The care planning and review process ensures information sharing between all professional staff involved in the care of the child is in accordance with the *National Standards for Children's Residential Centres*, 2001 and the Child Care Regulations, 1995.
7	The availability of child care workers to work alongside a child admitted to care is highly desirable.	All HSE children residential centres are staffed by professionally qualified social care workers.
8	The availability of supported lodgings across all geographic areas thus enhancing service localisation opportunities is most desirable.	Supported Lodging services are available and will continue to form part of the continuum of care.

No	Recommendation	Status
9	B&B accommodation should not form any part of the care arrangements for any child in state care, irrespective of their age or care status. Accommodation provided for children in care must meet basic standards at least equivalent to those specified by HIQA and where a stand alone special circumstance unit is urgently required it should be urgently assessed as to its compliance with these standards by HIQA staff.	Children are no longer accommodated in B&B accommodation. The HSE monitoring process monitors stand alone units in accordance with Regulations, Legislation and National Standards.
10	Proper planning for the movement of a child who is in care is a prerequisite to fulfilment of the statutory responsibilities and should be overviewed and signed off at a designated senior management level.	A standardised care planning and review process is being implemented as recommended by the HSE Task Force and outlined in the HSE National Service Plan 2009. Care Plans are monitored and signed off by Social Work Managers.
11	Where practical dilemmas arise relating to the care of children and how an individual's needs are to be balanced against a group's needs this should be considered as part of the review of the individual care plans, the philosophy of the centre and the sum of the available expertise.	The completion of Risk Assessments is part of the admission process for all children entering residential care. Identified areas of concern are monitored on an on-going basis through the review process. Risks are assessed and evaluated on an on-going basis.

No	Recommendation	Status
12	All staff engaged in care under whatever employment system or care provision process for children should be properly Garda vetted.	All staff working with children are vetted by An Garda Síochána in accordance with the Child Care Regulations, 1995.
13	All Centres should have a clear statement of philosophy underpinned by working policies known and understood by all who work there and who have reason to refer there. A nominated manager, external to the actual service, should have accountability for ensuring that such frameworks are in place and actively used.	All Children's Residential Centres have a clear statement of philosophy as outlined in their purpose & function. Each Centre is managed by a qualified and experienced manager. Children's Residential Centres are monitored by designated officers independent of the Centres, and are inspected by the Health Information and Quality Authority, Social Services Inspectorate to ensure compliance with national standards.
14	Pre-admission planning and regular monitoring and management meetings when a child is placed in care are processes that should be diarised, recorded and acted upon in a systematic manner.	Pre-admission planning and regular monitoring and management meetings take place when a child is received into care. All activity concerning a child is recorded and held on file and forms part of the review process.
15	The desirability of having the capacity to deploy a rapid care group from within existing resources, to meet urgent and demanding care need, should be examined.	Care placements are planned and delivered on a Local Health Office basis. Local Health Offices have access to regional alternative care committees and to HSE resources where required in meeting care needs in the best interests of the child.

No	Recommendation	Status
16	Clear and accurate communications - especially when bad or negative news has to be conveyed - are fundamentally important and must be well managed. Where services cannot be delivered as promised by an agency, it should be the responsibility of the agency to inform the service user at the earliest practicable opportunity and certainly before the service user presents at the service.	This is managed through Service Level Agreements and monitoring of agreed targets and outcomes.
17	Where a placement is sought that presents specific care requirements and behavioural issues beyond the capacities of the service such additional external professional supports as may be required should be made available to the service to support the achievement of the care objectives for the child.	Additional supports are put in place as required to support a placement and to ensure the achievement of the care objectives. The outcome for the young person is also dependent on their willingness to engage with the services provided and every effort is made by staff to encourage them in this regard.
18	Fundamental courtesy such as returning phone calls should be regarded as a sine qua non of all	Fundamental courtesy is maintained at all times in keeping with good practice.
19	Where a child is placed in the care of the HSE, a copy of the Order entrusting or committing the child to the care of the Health Board should be available at every placement and be a	A copy of the Care Order is held on the child's file and is not routinely provided to all professionals involved with the child. A copy of the Care Order is held on record at each residential placement.

No	Recommendation	Status
	part of the standard information provided to all professionals with involvement for the child in care.	
20	In the event of a service not being required for a short period of time it is desirable that a formal appraisal be undertaken of the necessity or otherwise for continuing to have it available for its primary purpose.	A National Protocol for the establishment of Special Arrangements is in place which provides for their review as often as required.
21	Children with a difficult educational record involving prolonged absence from the formal education system should be provided with a formal educational psychological assessment.	The National Educational Psychological Service provides formal assessments for children. It should be acknowledged that often the difficulty is not about an assessment being undertaken but is rather whether the young person is prepared to engage in the assessment process and what can be done if they don't.
22	In the event of a cessation of services by a provider, be this involuntary or planned, the relevant key professionals involved in the care of the child should meet and review the issues arising as a consequence of the closure and must be incorporated into the future care plans for the child.	The provision of services by voluntary providers is covered by the Service Level Agreement. In the event of a cessation or closure of services key professionals involved meet and review the issues in relation to the future care planning for the child.
23	All future service agreements should include a requirement	This is managed through Service Level Agreements and monitoring

No	Recommendation	Status
	that all cases presenting to services must incorporate a planned handover and review process and have clear processes for managing waiting lists and clarity as to the factors that will form part of the decision making process as to the grant or refusal of services and the timelines appropriate to these elements.	of agreed targets and outcomes.
24	Where adult services are required after a child leaves care they should be seamlessly introduced into the leaving care and after care plan for the child.	As part of the *Ryan Implementation Plan* (2009) the HSE will ensure that care plans for all young people who are 16 years and older includes an aftercare plan that identifies key workers in other health services to which a young person is referred. Investment for the provision of aftercare services has been identified in the HSE National Service Plan 2010.
25	Where physical assaults occur they should be appropriately recorded from a health & safety perspective as well as from a therapeutic view. Careful risk analysis should be undertaken of such occurrences and a clear protocol in relation to involving the Gardaí is desirable.	There is a system in place to record and monitor serious incidents. These are notified to the Monitoring Officer for Residential Care. An Garda Síochána are notified regarding all criminal matters. Significant events are reported to the Serious Incident Management Team.
26	Balancing staff safety and care requirements is a demanding role	Staff are regularly supervised within line management structures.

No	Recommendation	Status
	that is not unique to child care settings. There is a substantive body of knowledge and expertise within the wider care systems. Such expertise should be made available on an on-going basis to staff in care situations such as arose in this case.	Additional support and expertise is made available as required. HSE management are fully supportive of staff teams who require extra supports in the management of clients displaying challenging behaviour. This is balanced with the risk to the child/young person and the statutory child protection responsibility of the HSE.
27	The importance of consistent external management oversight of risk situations and their amelioration cannot be overemphasised.	The HSE has recently commenced the implementation of a National Quality & Risk Management Framework. The management of risk situations is also supported by the undertaking of risk assessments and the recording and monitoring of serious incidents.
28	Where there are siblings of a child in care it is desirable that their child protection requirements are also assessed to ensure their safety.	The HSE investigates all child abuse referrals and in the event that one child is being placed in care the risk to siblings remaining within the family unit is assessed by the Social Work Department.
29	Management should satisfy themselves that the appropriate steps are taken to ensure the shortcomings identified in this case cannot reoccur.	The recommendations in this report have been discussed at the National Steering Group for Children & Families to ensure the shortcomings identified in this case do not reoccur.
30	Where there are concerns that a child in care has been sexually abused a formal review of the	Sexual abuse concerns regarding children in care are dealt with in accordance with *Children First,*

No	Recommendation	Status
	issues should always be undertaken in accordance with the child protection policies in currency at the time.	*National Guidelines for the Protection and Welfare of Children*, 1999.
31	Allegations and/or concerns of a child being involved in prostitution whether or not in statutory care should always be the subject of a formal referral to the Garda authorities and be immediately considered by the care services in the context of the child protection policies and procedures.	When child protection concerns/allegations are brought to the attention of the HSE, formal notification is made to An Garda Síochána in line with *Children First, National Guidelines for the Protection and Welfare of Children*, 1999.
32	A protocol for dealing and engaging constructively between the Guardian *ad Litem* and care professionals should be developed so as to provide the most constructive and dynamically effective and productive relationship and where there are multiple Guardian *ad Litem* involved in a case a working process that minimises the need for replication of information giving should be put in place.	The Children Acts Advisory Board recently published guidance on the engagement of Guardians *ad Litem* titled '*Giving a voice to children's wishes, feelings and interest.*' (May 2009). The HSE is committed to following the guidance.
33	Where a child in care presents with drug misuse issues, these should be promptly explored and assessed in a formal case review process. Where expertise is not	The HSE provides access for children in care to Consultant Child & Adolescent Psychiatrists with expertise in substance misuse within available resources.

No	Recommendation	Status
	available within or to the immediately responsible professionals, management should ensure that such is made available and integrated within the overall care plan for the child.	
34	The need for residential care for young people who misuse drugs and for existing residential facilities to re-examine their policies in this regard as was recommended in the 1998 Eastern Health Board Annual Review of Adequacy of Child Care services is endorsed by the conclusions of this report.	The HSE provides access for young people who misuse drugs to Consultant Child & Adolescent Psychiatric staff with expertise in substance misuse. Access to residential services for children with addiction issues is provided as required and within available resources.
35	Priority access for homeless children to psychiatric and psychological services should be provided.	Psychiatric and psychological services are provided to homeless children as required within available resources.
36	All requisite documentation relating to a child in care should be integrated into each child's file and properly signed and dated.	All documentation relating to children in care is properly integrated into their social work file and is signed and dated. A separate record is held in the children's residential centre which is signed and dated by child care staff.
37	Where complaints are made a comprehensive record should be made of the investigation, the outcomes and actions taken.	All complaints are handled in accordance with the HSE's procedures.

No	Recommendation	Status
38	Case closure should only occur when a systemic review of all the interactions between the child, their family network and professionals within and without the health service has occurred to ensure that all matters are properly addressed and completed prior to closure.	Case closure only takes place following review and approval by a Social Work Manager.
39	Services working with children in care should work and be managed in a coherent, integrated, focused, planned needs led service provided in a non adversarial manner directed at achieving the best interests of the child as the primary and sole focus of their work.	The delivery of services to children in care is planned and managed in a coherent, integrated, focused manner which is needs led and is directed at all times to meet the best interests of the children in our care. This work is overseen by a child care management team which may comprise of Child Care Manager, Principal Social Worker & Alternative Care Manager. They receive advice and support from the General Manager and Local Health Manager as required.
40	An examination of the strategic and policy considerations of the needs of individual children whose needs cannot be met within conventional or available settings without being so disruptive of the needs of other children in the same care settings should be undertaken to ensure that the individual rights of each	The planning and development of services is influenced by need. Services are delivered along a continuum of care e.g. Special Care, High Support, Residential Care, Foster Care, Supported Lodgings, Outreach, and Family Support Services.

No	Recommendation	Status
	child are upheld.	
41	Services for children in care require vigilant management ensuring thorough audit, structured case reviews, appraisal and feedback from all involved in receiving and delivering the service that the service is being provided to acceptable standards of care and practice.	There are monitoring systems in place to ensure compliance with standards and to identify any deficits in services. This monitoring is both internal and external and is overseen by the following: Social Care Managers, Alternative Care Manager, Principal Social Worker, Monitoring Officer, Registration & Inspection and Health Information and Quality Authority, Social Services Inspectorate. Action Plans are made accordingly to address the issues requiring attention.
42	Every effort should be made to avoid costly legal cases being taken with regard to the provision of services for children in care. Where feasible non adversarial processes should be used to ensure the best interests of the child are achieved. Conflicts where they arise should preferably be resolved in a facilitative, mediated or arbitrational manner.	Every effort is made to engage with families prior to initiating court action. Family Welfare Conference Services are offered where appropriate to facilitate this.
43	When a child in the care of the HSE dies, a formal review of the case in its entirety independent of the services should be undertaken.	In line with the 'Children First National Guidelines' (1999) a review of all cases takes place. The HSE is currently implementing HIQA *Guidance for the Health Services Executive for the Review of Serious*

No	Recommendation	Status
		Incidents including Deaths of Children in Care launched in March 2010.
44	The operation of the policy regarding children in care absconding or going missing could be usefully reviewed in the light of experience and insights acquired since its original introduction.	A Joint Protocol between An Garda Síochána & the HSE titled '*Children Missing from Care*' was developed in January, 2008.
45	Conflicts between the policies of different sections of the HSE must be resolved by management in the best interests of the child.	The HSE Task Force, Children & Families Services was established in February, 2009 to accelerate the development of a national unified and standardised approach for children's services. Work is underway to develop national policies/standards across children's services.
46	This case emphasises the requirement to examine how the needs of children whose needs cannot be met within conventional settings can be best provided.	The HSE is committed to developing a continuum of services to meet the individual needs of children through a range of services. Services such as Differential Response Model, Multi-dimensional Treatment Foster Care & Outreach High Support are currently being developed.