Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CHILD IN CARE DEATH REPORT

CHILD: YOUNG PERSON A

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 when 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. Methodology

Terms of Reference

a) To review the care provided to Young Person A from the time this young person came into contact with the HSE and its predecessor.
b) To review how the case was handled by 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.

2.2. Governing Legislation/Policy and Reports Considered by the Review Team

a) Child Care Act, 1991
b) Child Care (Placement of Children in Residential Care) Regulations, 1995
c) Children First, National Guidelines for the Protection and Welfare of Children, 1999

d) Report of the Working Group on the Treatment of Under 18 year olds Presenting to Treatment Services with Serious Drug Problems, Department of Health and Children and HSE, 2005

e) Establishing and Conducting Committee of Inquiry – A Practice Manual, The Health Boards Executive, 2004

2.3. Involvement of Agencies/Services

From the initial referral of Young Person A to the Health Board, 32 agencies/services were involved with Young Person A. This young person did not avail of all of these services. These included:

- Social work services - Young Person A had access to social workers for a number of years. In addition this young person had access to child care workers and support services. Social work services also contracted other services to provide support. Furthermore, Young Person A 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 - this comprised of school and additional educational supports provided by external agencies.
- Psychiatric, psychological and assessment services.
- Housing services - Young Person A availed of accommodation provided by the Health Board/HSE and accommodation also contracted from external services.
- Youth justice system.
- Young Person A 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 A was born in October 1987 and came into contact with the Health Board in 2000. Young Person A tragically passed away in September 2005, prior to reaching the age of majority. An

Inquest into Young Person A's death was held in 2006. The verdict was death by misadventure.

b) A wide range of services has been provided to Young Person A from the time this young person came into contact initially with the predecessor(s) to the HSE and subsequently with the HSE.

c) From 23rd September 2002 to 13th July 2004, residential services for Young Person A within the Crisis Intervention Services were provided under Section 5 of the Child Care Act, 1991.

d) While acknowledging the commitment of staff and the high level of activity in this case, the Review Team found an absence of formal integrated case and care planning both from a child welfare and protection perspective under Children First, National Guidelines for the Protection and Welfare of Children, 1999 and from a care planning perspective under the Child Care (Placement of Children in Residential Care) Regulations 1995 from 14th July 2004 when Young Person A was received into voluntary care.

4. OBSERVATIONS

a) Young Person A was accessing out of hours services 22 months before this young person was received into voluntary care.

b) This case exposes tragic systemic failures. Two different streams of services were involved in the care of Young Person A. These services were social work services and out of hours services. This resulted in a lack of singular assigned responsibility and a confusion of roles. An assumption prevailed that there was a lack of authority to take action, which lead to limitations in involvement. Consequently there was a lack of initiative and a fear of taking charge of the situation pertaining to this very vulnerable young person. There were inexcusable delays in providing essential services, a lack of case

management, a fragmented approach to this young person's care, and a lack of cooperative structure within the Health Board areas. There were ineffective meetings resulting in uncertainty as to whether concerns raised were dealt with. There was a failure to identify a solution to the care needs of this young person and, consequently a failure to provide that solution.

c) This case further highlights the erroneous approach of requiring the needs of the individual to fit within the services that are available, rather than the essential approach that must be adopted of ensuring that the service meets the needs of the individual. The application of certain criteria in determining the entitlement of this young person to access services led to Young Person A being denied access to services which were desperately needed.

d) Young Person A was very vulnerable and had been for a substantial portion of their life. The manner in which services were provided left this young person deprived of a sense of security and in a chaotic environment.

e) This chaotic environment left Young Person A exposed to a sub-culture, which exists among certain young homeless people and which educates impressionable and vulnerable children on how to avoid certain services and exploit other services to their own detriment. An example of this was the practice adopted of utilising the out of hours services which provided financial incentives if the child chose not to attend school or training courses.

f) 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 protection 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.

g) 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) That the draft HSE National Guidelines for Care Planning and Statutory Child in Care Reviews be signed off and circulated for adoption with a review date.
2) With regard to the provision of Crisis Intervention Services, that consideration be given to the implications of the following:
    a) Having all emergency placements in a city centre;
    b) Having only residential emergency placements as opposed to a mix of foster care, supported lodgings and residential placements;
    c) The practice of providing services under Section 5 of the Child Care Act, 1991 in particular for children under 16 years and especially for those who remain beyond short term in Crisis Intervention Services.

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	That the Draft HSE National Guidelines for Care Planning and Statutory Child in Care Reviews be signed off and circulated for adoption with a review	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. As part of this process a standardised care plan and review process is being implemented as outlined in the HSE

No	Recommendation	Status
	date.	National Service Plan 2009 and is ongoing in 2010.
2	With regard to the provisions of Crisis Intervention Services, that consideration be given to the implications of the following: a) Having all emergency placements in a city location	In line with "Youth Homelessness Strategy" (2001) which recommends that crisis services for young people should not be centralised in the city centre. Since January, 2009 ten emergency placements have been relocated from the city centre to a location in North County Dublin. In addition, the HSE is hoping to provide a broad range of options for Local Health Office Areas including the provision of emergency foster carers, particularly to cater for 12 to 15 year olds, which should obviate the need for emergency beds in the city centre.
	b) Having only residential emergency placements as opposed to a mix of foster care, supported lodgings and residential placements.	It is HSE policy to have a mixture of placement options available including foster care, supported lodgings and residential placements to meet the needs of young people who are out of home. It is the experience of service practitioners that, due to the sometimes challenging behaviour displayed by service users, foster carers are not disposed to providing support to this group of young people. However, the HSE is

No	Recommendation	Status
	c) The practice of providing services under Section 5 of the Child Care Act, 1991 in particular for children under 16 years and especially for those who remain beyond short term in Crisis Intervention Services.	developing Multi-Treatment Foster Care, Differential Response Model and Emergency Place of Safety Service to meet the individual needs of children. Section 5 of the Child Care Act, 1991 allows the HSE to provide accommodation for young people who are out of home. The Crisis Intervention Service endeavours to return these young people to their own home/extended family or arrange for an alternative care placement as near as possible to the young person's home.