REPORT OF THE INDEPENDENT CHILD DEATH REVIEW GROUP

DR. GEOFFREY SHANNON AND NORAH GIBBONS

Department of Children and Youth Affairs
43-49 Mespil Road
Dublin 4

Tel: +353 (0)1 647 3000
Fax: +353 (0)1 667 0826
E-mail: contact@dcya.gov.ie
Web: www.dcya.ie

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PREFACE

This report has been written by Dr. Geoffrey Shannon and Norah Gibbons who co-chaired the review. The function of the Independent Child Death Review Group (ICDRG) is detailed in the Terms of Reference set out by the then Minister for Children and Youth Affairs in July 2010.[1]

The report does not make any findings in relation to any individual. This report is based solely on a review of case files provided by the HSE and on information obtained from Coroner's offices in a small number of cases where the ICDRG did not receive a Death Certificate from the HSE in respect of children/young people whose cases are reviewed in this report. Any implicit or explicit value judgements are being made solely on the basis of the available records.

In all relevant cases the Review Team has satisfied itself as to the cause of death. In line with the terms of reference issued to the Review Team deaths have been classified as either natural or unnatural.

Every care has been taken not to identify any of the children/young people who are the subjects of this report. In order to provide additional safeguards of anonymity the ICDRG has omitted the exact date or age when the child or young person died, and has not identified the area the child/young person came from. Moreover, the ICDRG has not generally included the cause of death or the circumstances of death in respect of the children and young people who are the subject of the review so as to preserve their anonymity.

The authors regret that in attempting to preserve their anonymity the children and young people have each been given a number. This device is used solely as a means of distinguishing each person for the purpose of fulfilling the remit of the review and is not intended to detract in any way from the individual child or young person. However, the authors recognise that it may be possible to identify some of the individuals concerned because of previous publicity or because of the uniqueness of individual cases. The authors appeal to commentators who may be able to identify individual children/young persons, not to do so publicly.

[1] Appendix 1.

The authors recognise and regret that the publication of this report may cause additional distress to family members and foster-carers as well as to the professionals who worked on the cases discussed. This is not our intention.

The deaths of children and young people are always tragic; particularly when these deaths have been the result of violence, suicide, neglect and failure to meet their needs on the part of those charged with their protection. The authors would like to extend their deepest sympathies to all of those affected by the deaths of these children and young people and by this report.

Nobody could fail to be affected by the circumstances surrounding the lives and deaths of some of these children and young people; particularly in those cases where chronic neglect played a significant role in the ultimate outcome.

In many of the cases reviewed and considered, the authors have noted the absence of the voice of the child. There are some notable exceptions but in many instances the professionals involved in the lives of many of these children have not recorded the wishes and feelings of the children.

Agencies have not been specifically named in the discussion of individual cases. This should not be interpreted as a criticism. In many cases, although their work is acknowledged generically, individual agencies could not be named without compromising the anonymity of the individual children/young persons concerned.

The authors have used the term HSE to refer both to the modern Health Service Executive and to its predecessor Health Boards.

All reports inevitably contain some errors. One unavoidable source of error in many of the cases discussed in this report has been the difficulties experienced in reading and interrogating poorly-kept and presented file records. Many records were handwritten and barely legible, files themselves were often incomplete, and important notes were scribbled on pieces of paper and data such as birth dates were entered differently on different forms. In many cases this may have led to errors appearing in the completed text although every effort has been made to prevent this.

ACKNOWLEDGEMENTS

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We also wish to acknowledge and thank the staff at the Independent Child Death Review Group:

Research: Deirdre McTeigue, Mary Gormley, Catherine Carty and Kerri McGuigan.

Administration: Geraldine Corcoran and Amanda O'Reilly.

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Ms Emily Logan, Ombudsman for Children

Health Information and Quality Authority

Coroner Service; specifically Dr. Dennis Cusack, Coroner for County Kildare

EXECUTIVE SUMMARY

OF

THE REPORT OF THE INDEPENDENT CHILD DEATH REVIEW GROUP

INTRODUCTION

The Independent Child Death Review Group ("ICDRG") received files relating to the deaths of 196 children during the period of 1 January 2000 to 30 April 2010 who were:

- in care within the meaning of the Child Care Act 1991 at the time of their death;
- in receipt of aftercare within the meaning of Section 45 of the Child Care Act 1991 at the time of their death;
- known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 at the time of their death

The breakdown of deaths over the ten year period amongst the 196 cases reviewed is:

Children in Care: 36 deaths

- 19 deaths from natural causes
- 17 deaths from non natural causes

Children & young people in Aftercare: 32 deaths

- 5 deaths from natural causes
- 27 deaths from non natural causes

Children & young people known to the HSE: 128 deaths

- 60 deaths from natural causes
- 68 deaths from non natural causes

Whilst individual case summaries relating to deaths arising from natural causes were not within the terms of reference of the ICDRG, nonetheless an overview of these cases is included in the report and review of each of these cases has informed the overall conclusions reached. The causes of death for the 84 children and young people who died of natural causes are shown at Table 1 below:

Table 1

- All Natural Deaths

Cause of Death	In Care	Aftercare	Known to HSE	Total
Asthma	1	0	1	2
Cancer	6	1	1	8
Complications from Development Delay	11	2	10	23
Sudden Child Death Syndrome	1	0	28	29
Complications from CF	0	0	2	2
Complications from Diabetes	0	0	1	1
Heart Problems	0	0	2	2
Genetic neurological condition	0	0	3	3
Stillborn	0	0	1	1
Undetermined/unknown	0	0	2	2
Miscellaneous	0	2	9	11
Total	19	5	60	84

In accordance with its terms of reference the ICDRG examined the files and reports of the HSE in respect of all 112 children who died from unnatural causes and a detailed and comprehensive case summary in respect of each child is set out in this report. In addition to providing an analysis of these files this report also summarises those aspects of good practice evident from the files, and also causes for concern. Table 2 below shows a breakdown of the non natural deaths in each of the three categories provided for in the ICDRG's terms of reference by year:

Table 2: All Non Natural Deaths by Year

Year	In Care	Aftercare	Known to HSE
2000	2	1	3
2001	1	0	6
2002	1	3	5
2003	2	1	4
2004	0	2	3
2005	1	4	8
2006	3	4	6
2007	1	4	12
2008	1	2	10
2009	4	4	4
2010	1	2	7
Total	17	27	68

The following is an overview of the child care system in Ireland together with a summary of the good practice and concerns that emerged during the conduct of this review. These concerns have informed both the learning identified from the review and the recommendations put forward by the ICDRG. Readers are advised to consider the detail as set out in the body of the report for a more thorough analysis of the issues.

OVERVIEW OF THE CHILD CARE SYSTEM IN IRELAND

The child care system in Ireland is governed by the Child Care Act 1991 ("1991 Act"), as amended. It imposes a positive mandatory obligation on the HSE to *"promote the welfare of children in its area who are not receiving adequate care and protection".* In carrying out this function the HSE is obliged to take such steps as it considers necessary to identify children not receiving such care and protection and coordinate information from all relevant sources concerning those children. If the HSE is of the view that a child requires care and protection that he/she is unlikely to receive unless a court order is made, then it is the duty of the HSE to apply for such an order in respect of that child.

Each and every child and their circumstances are unique. Therefore the level of HSE involvement will vary from case to case. To that end the 1991 Act provides a range of options available to the HSE in carrying out its functions. In identifying whether a child ought to be placed into the care of the HSE, the HSE can interact with the parents and family and assist them as may be appropriate. If, however, the HSE is meeting resistance in that regard it can seek a Supervision Order from the court. This allows the HSE to visit the child periodically, as ordered by the court, so as to ensure that his/her welfare is being adequately cared for.

If the welfare of the child cannot be properly cared for within the family then that child should be placed in the care of the HSE. To that end the parents of the child may agree to voluntarily place the child into care. If they are not so agreeable the HSE can, depending on the circumstances, seek an Emergency Care Order or Interim Care Order. These Orders are limited in duration, but if a child is to be placed into the care of the HSE more permanently (including up until the age of 18 years) then a Care Order can be applied for. When a child is placed into care the HSE has like control over the child as if it were his parent. Where a child requires special care and protection the HSE may apply to the High Court for a Special Care Order which may result in the child being placed in a secure unit for his/her own protection. The HSE does not have powers to detain a child in a placement unless a Special Care Order has been granted by the High Court.

Whilst in the care of the HSE the welfare of the child is paramount. When a child reaches maturity, or is to leave the care of the HSE, the HSE may assist him/her by way of the provision of aftercare which may involve continuing visits by social workers, supporting completion of educational or training courses or arranging suitable accommodation.

It is against this backdrop that the following report is to be considered. The 196 children referred to in this report all interacted with the child care system summarised above. The purpose of this report is to examine, amongst other things, whether this system met the welfare needs of these children.

Many of the children the subject of this report had experiences and difficulties before coming into contact with the HSE which are not encountered to the same extent in the general child

population and cognisance must be taken of this fact when evaluating the case summaries in this report. That said, the ICDRG concludes that the majority of the children the subject of this review did not receive an adequate child protection service.

The review covers deaths of children and young people from 2000 to 2010. Even in the case of deaths occurring at the end of this period much interaction with these children and their families took place at an earlier time. While it is clear that significant work has been undertaken to improve services both over this period and since, the ICDRG has sought to identify learning that can form the basis of a robust child protection system.

DEATHS OF CHILDREN & YOUNG PEOPLE IN CARE

As set out above, "in care" relates to the voluntary placement of a child in the care of the HSE or the placement under an Emergency Care Order, Interim Care Order, Care Order or Special Care Order issued by the courts. The circumstances where the HSE is required to intervene and take a child into care are complex and varied but by their nature they are adverse. They can relate to the absence of or lack of attachment to a stable parental figure or exposure to traumatic life events like loss, separation, abuse or serious neglect. In some cases issues such as alcohol, drug abuse or domestic violence that seriously impacts on consistent parenting will have posed a risk to the child's welfare. The impact on a child of early trauma, abuse or neglect is far reaching and poses challenges for their healthy development and the care interventions needed to address their needs. For some children the cumulative adverse experiences of their early years are of considerable significance for their subsequent outcomes, even where intervention by social services follows. It is also the case that the decision to take a child into care in order to promote their welfare must be based upon a balanced assessment of risk since such action itself carries with it risk of disruption and potentially harmful affects on the child's development where the placement does not fully meet the child's needs.

There are over 6,000 children in the care of the HSE at any one time. Over 90 per cent are placed with foster carers with the remainder in residential care.

In total the ICDRG examined the files of 36 children and young persons who were in the care of the HSE at the time of their death. Nineteen of these deaths were due to natural causes – the

causes of these deaths are summarised at Table 1 above - and 17 were due to non natural causes. The age breakdown of these 17 children at the time of death is shown in Table 3 below.

Table 3: Non Natural Deaths of Children in Care

- Age at Time of Death

Age at Time of Death	Number of Deaths
< 4 years	0
4 years	1
5 years	0
6 years	0
7 years	1
8 years	0
9 years	0
10 years	0
11 years	0
12 years	1
13 years	0
14 years	2
15 years	2
16 years	4
17 years	6
Total	17

It is very apparent from this information that most of these deaths took place during older adolescence, with over 80 per cent occurring at ages 14 years or over. This trend is also evident in relation to the death of young people in after care and children known to the HSE.

The causes of the non natural deaths are shown at Table 4 below:

Table 4: Non Natural Deaths of Children in Care

- Cause of Death

Cause of Death	In Care
Asphyxia (accidental)	1
Drowning (accidental)	1
Drug Related	5
Suicide	5
Road Traffic Accident	3
Unlawful killing	2
Accidental fall	0
Head injuries (cause unknown)	0
House Fire	0
Unknown	0
Total	17

Ultimately and tragically the efforts to protect these children failed. A key issue to be emphasised is the vulnerability of these children. There are elements of good practice evidenced on some of the files reviewed. A considerable range of services were made available and there were certainly efforts made to intervene and build relationships in order to address the underlying vulnerabilities of these children. However, while good practice was adhered to in some cases, the fact remains that its application was sporadic and inconsistent. In many cases these children engaged in ever more risk taking during adolescence with tragic outcomes. The earlier and more consistent presence of good practice would have increased the chances that these children might have overcome their vulnerabilities, although it is not possible to conclude that the death of the child or young person would have been ultimately prevented. Notwithstanding this a uniform and structured approach to the provision of child care provides the best opportunity to manage and mitigate risk in the lives of such vulnerable children and young people.

The ICDRG has identified 12 indicators of good practice. In some, but by no means the majority of cases, there is evidence of:

Good Assessment, Risk Identification and/or Planning in Place

Care Plan in Place

Care Plan Followed and Reviewed or Planning Completed

Good/Consistent Care Provided by the Social Work Department

Childcare Regulations Followed

Good Record Keeping

Good Social Work Supervision/Support

Good Foster Care

Support for Family/Foster Carers

Good Interagency Cooperation

Appropriate Follow-Up after Child's Death

Review of Death

Each and every child or young person entering into the care of the HSE ought to be provided with a high standard of care commensurate with his/her needs. There are professionals and areas within the HSE which have demonstrated that they can achieve such standards, but sadly there are other parts that do not. Thus whilst the evidence of good practice is to be commended its absence in respect of other children or young persons is a cause for concern.

Summary of Concerns

In 12 of the 36 files there was evidence of delay in taking the child into care. Once welfare concerns in respect of a child warranting placement into care have been identified it is vital that the HSE moves expeditiously to ensure that this is done so as to avoid any further harm to the child. Once in care it is imperative that a care plan is developed for the child, no such plan appeared on the file of 15 of the children or young people concerned. A care plan provides for consistency in the provision of care for a child. In addition, appropriate procedures should be followed once a child is taken into care, e.g. the child should undergo a medical examination. In 9 of the files examined there was no evidence that the child underwent such an examination upon being received into care by the HSE.

It is acknowledged that social workers assigned to a child may be reassigned for a variety of reasons, however, in 11 of the files examined there was evidence of difficulties in relation to the

consistency and appointment of social workers to a child. Furthermore, in 10 of the files examined there were evident difficulties in locating suitable placements for a child. These two issues coupled with the lack of a care plan seriously undermine the ability of the HSE to properly care for a child in care.

As there may be inconsistency in the personnel assigned to a particular child it is imperative that a clear reporting structure is put in place so that any social worker who may be subsequently assigned to a child can read the file and be in a position to meet the needs of that child immediately. In 15 of the 36 files examined there was evidence of a poor standard of record keeping and incomplete records. Critical incident reports are to be completed in the event of a serious incident occurring whilst the child is in care. The death of a child would be such a serious incident. There was no such report in 26 of the 36 files examined. The recording of such incidents is critical as it allows the HSE to consider whether the child is being provided with the appropriate level of care or whether further additional services are required. In that regard 5 of the files examined evidenced a failure to pursue appropriate services for a child so as to deal with the particular issues of that child.

In addition to a proper recording structure being put in place, social workers must also be properly supervised by their Team Leaders. It is important that social workers are provided with adequate supports so as to enable them to carry out their duties to the best of their ability. Furthermore, if there is to be inconsistency in the assignment of social workers at least the Team Leader should be able to provide some consistency in terms of management and direction in respect of the care being provided to a particular child.

DEATHS OF YOUNG PEOPLE IN AFTERCARE

As explained above, when a child reaches maturity or is to leave the care of the HSE the HSE may assist him/her by way of the provision of aftercare which may involve continuing visits by social workers, supporting completion of educational courses or arranging suitable accommodation. Such aftercare is provided under Section 45 of the Child Care Act 1991. A young person entering aftercare will not be under the same degree of supervision from the HSE as when he/she was in care. Since young people who are 18 years or over are legally adults, the

approach to aftercare provision must be informed by the wishes of the young person; otherwise there is less liklihood that the young person will engage with the HSE.

In total the ICDRG examined the files of 32 young people who were in aftercare at the time of their death. The causes of death for the five young people who died from natural causes are shown in Summary Table 1 above.

The ages of the 27 young people who died from non natural causes are shown below (Table 5). This age range reflects the point in their lives when many young people in the long term care of the HSE leave care. However, the age when these deaths took place adds further weight to the conclusion reached above that there is heightened risk for children who have been taken into care as they go through later adolescence and emerge into adulthood.

Table 5: Non Natural Deaths of Children and Young People in After Care - Age at Time of Death

Age at Time of Death	Number of Deaths
18 years	11
19 to 23 years	16
Total	27

The causes of the non natural deaths are shown at Table 6 below:

Table 6: Non Natural Deaths of Children and Young People in After Care - Cause of Death

Cause of Death	Aftercare
Asphyxia (accidental)	1
Drowning (accidental)	0
Drug Related	14
Suicide	7
Road Traffic Accident	3
Unlawful killing	1
Accidental fall	0
Head injuries (cause unknown)	0
House Fire	0
Unknown	1
Total	27

In some of the cases reviewed 12 indicators of good practice identified by the ICDRG specific to young persons in aftercare were found to be evidenced:

Good Assessments, Risk Identification and Aftercare Plan

Aftercare Plan Followed and Reviewed or Planning Completed

Good/Consistent Care Provided by the Social Work Department

Appropriate Placement/Support

Good Social Work Supervision/Support

Regulations Followed

Good Interagency Cooperation

Good Foster Care

Support Provided to Family/Carers

Good Record Keeping

Appropriate Follow-Up after Child's Death

Review of Death

Again, whilst there is evidence of good practice being adhered to in some cases, the fact remains that its application was sporadic and inconsistent. A uniform and structured approach to the provision of aftercare is essential. Each and every young person who has been cared for by the HSE and is about to leave that care ought to be provided with the services and supports necessary to make the transition. Some areas within the HSE provide such services and supports to a high standard, but sadly the evidence over the period reviewed shows that others do not. Thus whilst the evidence of good practice is to be commended its absence in respect of other young persons in aftercare is a cause for concern.

Summary of Concerns

In some cases no aftercare at all was provided to young persons who left the care of the HSE. This is a very serious cause for concern. In other cases aftercare was offered but solely at the option of the young person. Such an abdication of duty on the part of the HSE is unacceptable, and fails to properly meet the welfare needs of these vulnerable young people. Whilst the age of maturity of a young person for legal purposes is clearly defined it does not necessarily accord with the actual maturity of that young person. The HSE is statutorily charged with the duty of caring for young people in care. A young person who leaves care cannot be said to be necessarily capable and competent to care for themselves. The statutory provision for aftercare should be strengthened by placing a mandatory statutory responsibility on the HSE/Child and Family Support Services Agency to ensure adequate supports are in place for vulnerable young people leaving the care system. Therefore if a young person refuses to engage in aftercare the HSE should not automatically accept this and close their file. Whilst it is the right of an adult to refuse aftercare, any such refusal ought to be considered and informed. To that end the HSE should take steps to guide a young person to making a considered and informed decision. Such steps taken by the HSE ought to be recorded in the file so that in the event of the file being reviewed it will be evident as to what steps the HSE followed to ensure the welfare of the young person. The steps to be taken will vary depending on each case, however, the objective will be same and that is to ensure that the young person is making a considered and informed decision. Counselling and advisory services ought to be offered by the HSE in that regard. In addition, the young person ought to be informed of the option of returning to the HSE for aftercare assistance in the event of a change of mind.

There is a fear that when young people leave the care of the HSE and go into aftercare that they are almost forgotten about. This fear is based on a number of concerns arising from the files examined. Eight of the files could only be described as being in complete disarray with little or no recording as to what happened when the young person entered into aftercare. In 3 other files it was impossible to assess what work had been done with the young person in aftercare. The recording process undertaken by the HSE in respect of the young persons in aftercare left a lot to be desired and thereby giving rise to serious concerns as to whether the HSE was properly carrying out its duties in respect of these young people.

The failure to keep proper records may stem from the inconsistency in social workers or aftercare workers assigned to these young people. In 3 of the files no worker was assigned which gives rise to the obvious question as to how these young people were expected to access aftercare services.

A young person entering aftercare will not be under the same degree of supervision from the HSE as when he/she was in care. Therefore it is critical that the HSE identify and provide the necessary support services for such a young person when in aftercare so as to meet the particular needs of that young person. This is a particular cause for concern in respect of mental health issues. Interagency cooperation is essential so as to ensure that a global approach is taken to meeting the welfare needs of a young person in aftercare. In 5 of the files examined there was a lack of such cooperation.

Mistakes have to be learned from. Questions need to be asked when a young person dies whilst in aftercare. Surprisingly out of the 32 files examined no review of the death of the young person is recorded or planned. The concerns raised in this report are largely systemic in nature. A lack of clear procedures, reporting and supervision amongst HSE staff is evident. This needs to be remedied immediately throughout the child care system so as to help prevent the further deaths of children and young people in care.

DEATHS OF CHILDREN AND YOUNG PEOPLE KNOWN TO THE HSE

Of the 196 files furnished to the ICDRG 128 related to children and young people who were known to the HSE before or at the time of their death. The ICDRG's terms of reference specify

that known to the HSE in this context is within the meaning of the HIQA guidance to the HSE of 20 January 2010. The HIQA guidance defines "known to the HSE child protection system" as child protection cases which are open or which have been closed in the past two years.

It is worth noting that HSE figures indicate that reports to the HSE's child protection services are of the order of 27,000 or more annually, although it is noted that these figures may include a number of referrals from different sources in respect of the same child. Of these over 15,000 cases per annum are considered to potentially concern welfare issues, physical abuse, sexual abuse, emotional abuse or neglect while subsequently approximately 2,000 of these cases have such concerns confirmed.

The HSE's powers in relation to children which come to its attention are different from those children in its care, although its overarching duty to promote the welfare of children not receiving adequate care and protection extends to all children. In such cases the HSE has not been given either voluntarily or, on its application, by the determination of a court the power to act *in loco parentis.*

Of the 128 deaths in this category 60 of these children and young people died of natural causes as shown in Table 1 above. Sixty eight died of non natural causes and their age ranges are shown in Table 7 below. The tendency for most of the deaths to be in the older age range is somewhat less pronounced than that seen in respect of children in care, although over half do occur at 13 years and over.

Table 7: Non Natural Deaths of Children Known to the HSE

- Age at Time of Death

Age at Time of Death	Number of Deaths
<1 year	6
1 year	11
2 years	
3 years	
4 years	10
5 years	
6 years	
7 years	0
8 years	5
9 years	
10 years	
11 years	
12 years	
13 years	7
14 years	7
15 years	9
16 years	9
17 years	4
Total	68

The causes of death amongst the 68 children and young people who died from non natural causes are shown at Table 8 below.

Table 8: Non Natural Deaths of Children Known to the HSE

- Cause of Death

Cause of Death	Known to HSE
Asphyxia (accidental)	3
Drowning (accidental)	3
Drug Related	11
Suicide	16
Road Traffic Accident	11
Unlawful killing	13
Accidental fall	2
Head injuries (cause unknown)	2
House Fire	5
Unknown	2
Total	68

Having examined all 128 of the files the ICDRG identified 12 indicators of good practice that would be expected in respect of files relating to children or young persons known to the HSE and found the following to be present:

Risk assessment and planning in respect of children and young people

There was evidence of quick and appropriate reaction by the HSE in respect of concerns relating to particular families. Where risk assessments were carried out there was evidence of consistent follow up from services thereby demonstrating the positive effect risk assessments may have. There was also clear evidence of excellent decision making processes and follow through in some cases, including taking steps to bring the matter before the courts. Where there were agreed plans in place regular reviews were conducted, again demonstrating the necessity to plan in advance in order to provide appropriate care and support for a child or young person.

The voice of the child or young person

The voice of the child is often a vital factor to be taken into account as it may enable the HSE to obtain a true account as to what is happening in the family. This was evident in some cases. Relations with school counsellors and other persons who may interact with children regularly and with whom children might confide should be promoted.

Prompt follow up on referrals

Where concerns are expressed it is critical that the HSE follow up on these in a prompt manner so as to prevent any future or further harm to the welfare of the child. Such prompt follow ups were evident in some cases.

Support to family

An examination of the files demonstrates that often the support and assistance offered by social workers to families is resisted by parents despite what might be in the best interests of a child. Yet, through the sheer determination on the part of social workers evident in a number of files such supports were provided. In a number of cases clear support services were provided ranging from parenting courses, securing accommodation, addiction services, respite care and family support workers. The persistence of individual social workers in this regard is to be commended.

Support to family or guardians post death of child or young person

This was evident in some of the files examined.

Child protection concerns identified and discussed

In a number of cases child protection plans were put in place and followed up by child protection case conferences. There is evidence to show that where appropriate planning and reviews took place the system did enable the appropriate protection mechanisms to be put in place within the family unit, sometimes with the added authority of a Supervision Order. In appropriate cases interim care orders were obtained.

Supervision

Professional supervision of HSE staff was evident in a small number of the files examined.

Interagency cooperation

Good interagency cooperation and good communication between services was evident amongst the cases examined. These cases show that where professionals work together the level of support and services provided to a child tend to meet the needs of that child. Positive learning opportunities were evident in cases where there was a high standard of interagency work.

Record keeping and files

Amongst the files examined there were those which could be said to be of a high standard in terms of presentation, organisation and recording.

Critical incident report

A critical incident report was completed in a number of of the files examined.

Need for appropriate accommodation

In some cases there was a lack of appropriate accommodation to meet identified needs and the evidence shows that the social work teams involved constantly sought to address the situation.

<u>Summary of Concerns</u>

Of particular concern in a number of files is the fact that the HSE was aware of drug and alcohol abuse within a number of families, in particular by parents, which must as a natural consequence have given rise to concerns as to the welfare of the children, yet the HSE closed their files in a number of these cases despite the drug and alcohol abuse continuing. Children are vulnerable by their very nature and not to continue to attend to these issues and the implications for their welfare is to expose them to too great a risk of harm. Risk indicators such as this were not followed up adequately, or at all, by the HSE in a number of the files. In some cases no social worker was assigned to these families.

For some reason a number of the files evidence particular difficulties for the HSE in dealing with children who suffered from mental health difficulties, or who lived in a household with parents who suffered from such difficulties. Greater links between the HSE's child welfare & protection services and child and adolescent mental health services need to be forged so as to provide proper support and services to children in such situations.

The lack of resources within the HSE to provide appropriate support and services to these children is evident from the files provided to the ICDRG. A particular concern evident from the files is the lack of out of hours social work services. This is coupled with an overuse of the duty social worker in respect of a number of cases instead of assigning a particular social worker to each case. This is simply not an acceptable standard of care provision.

Suitable accommodation arrangements must be made available to children and young people who present to the HSE as being homeless. Similarly such arrangements must be made available for mothers and children in an environment that precludes substance abuse. A failure to provide necessary services is evident in a number of the files examined. In other cases there was delay in providing the necessary services. Often this was due to lack of resources but in some cases it was due to poor communication. In one case a child had to wait over a year to obtain an appointment with a psychologist.

The files demonstrate an evident problem with communications within the HSE and between the HSE and others. In a number of cases there was a failure within the HSE to discuss cases in full and review the options available for a child or his/her family. These communication problems are further exacerbated by the lack of professional supervision or supports for social workers. There is also evidence of the failure of HSE departments in one region to communicate with the department in another region following the child moving to that region. Some files also show that the HSE failed to communicate issues of serious concern, including assaults, to the Gardai or delayed in doing so in some cases. Sadly and perhaps most worrying is the failure on the part of the HSE to communicate properly with the child in question or his/her family. The focal conduit through which an improvement is to be made to the welfare of a child must be through communicating with that child's family. If that cannot be done then serious doubts must arise as to the effectiveness of any steps taken by the HSE thereafter.

REVIEW OF EMERGING ISSUES

The opportunity to review 196 case files – albeit those with the most tragic outcomes – has provided the ICDRG with a unique insight into both the difficulties experienced by some of the most vulnerable children in our community and the issues to be addressed by child welfare and protection and other services.

Table 9 below summarises some common issues found by the ICDRG to reoccur in a number of the cases reviewed. The nature of these issues was such as to be a factor which contributed to the problems experienced by the children and young people and the difficulties in addressing their needs. The identification of the potential impact of these factors, particularly in combination, should inform any risk assessment of a child's welfare.

Table 9: Prevalence of Certain Issues Amongst Cases Reviewed

Factor	Children in Care	After Care	Known to HSE	Total
Alcohol in home	6	13	18	37
Drugs in home	5	5	9	19
Physical or sexual abuse	7	14	13	34
Neglect	6	15	23	44
Bereavement	3	4	3	10
Domestic violence	4	11	15	30
Mental illness experienced by parents/guardians	4	5	13	22
Children experiencing severe behavioural problems (largely undiagnosed)	5	9	8	22
Problematic alcohol use by child/young person	4	7	6	17
Problematic drug use by child/young person	8	13	8	29
Criminal activity: family and child/young person	7	11	11	29
Non school attendance	6	5	9	20
Homelessness	1	12	10	23

The following are amongst the issues most worth particularly highlighting:

Resilience and early exposure to adverse experiences – In reviewing many of the case histories the ICDRG discovered that the problems that faced a number of these children began early in life. Children and young people admitted to care tend to come to the attention of the HSE after a serious incident or series of incidents giving rise to concerns as to their welfare. In a large number of cases the child has already been subjected to negative experiences and influences before coming to the attention of the HSE. The child/young person has not had an opportunity to build up their own resilience and to learn positive coping mechanisms. This is likely to place the child's welfare at risk. A number of steps are taken in order to protect one's own welfare, these steps may be categorised as detection, recognition, protection and coping. So as to protect one's welfare from negative influences it is first necessary to detect and recognise the negative influence in order to avoid same. It is essential that the appropriate risk assessments are conducted immediately upon a child or young person coming into care. The self-protection skills of a child need to be assessed and any deficiences in same need to be addressed immediately through the construction of an appropriate care plan in which the appropriate services are identified and provided to the child.

Adolescence – the identification of many of the deaths examined as occurring in adolescent years is important. Some element of risk taking may be a feature of young people emerging into adulthood but in the cases reviewed the judgment and tolerance of risk was extremely problematic. More effective engagement around this issue with children in care or known to child protection services is likely to be critical to achieving improved outcomes. A more effective approach to influencing behaviour amongst adolescents with complex needs and vulnerabilities is an issue not just for child protection services but for all of those involved with young people e.g. schools, youth services, mental health services, the justice system and others. It is critical that all these services work together.

Alcohol – in reviewing many of the case histories which are the subject of this report the ICDRG cannot help but be struck by the adverse consequences for the welfare of many of these children posed by alcohol. In some but by no means all of the cases alcohol contributed to children being exposed from their earliest years to poor parenting, neglect, abuse and

psychological trauma. Some of these children and young people never recovered and went on themselves to engage in problematic alcohol and substance misuse. The complexity of many of such cases in many instances goes well beyond the single issue of alcohol but addressing other underlying issues is made very much more difficult where serious misuse of alcohol is the established pattern. It is wholly unrealistic to assume that the social work profession or any other - no matter how well trained, supervised and supported by best practice - can remedy the damage for younger family members of serious alcohol misuse other than in a very limited and partial way. Failure on the part of society to comprehensively address the alcohol problem as a major threat to the proper functioning of individuals, families and communities is to leave child protection systems to deal with insurmountable consequences.

Multi Service/Agency Requirements:

The nature of the factors highlighted in Table 9 above highlights the requirement for a range of services and professionals to be involved with these families and to coordinate care in respect of the children and young people. Such inter disciplinary and inter agency work is not simple and poses challenges for children's services in all countries. However, this issue has emerged repeatedly in child protection reviews conducted in Ireland and it is imperative that improvements are achieved in the interests of children and young people. In particular, review of these cases has emphasised the importance of linkage between child protection and welfare services and mental health services, addiction services, education and justice.

Other Issues: Most, if not all, of the issues highlighted above demand careful assessment; planning; communication; continuity of care; review; timely and comprehensive supports for children and young people, carers and professionals and excellent information management – often across multiple agencies or service settings. We pay particular regard to these issues in formulating our recommendations in the next section.

RECOMMENDATIONS

Recommendation for Future Child Death Review Unit

The report examines in detail the various different forms of child death review units in a number of different jurisdictions so as to recommend the establishment of a Child Death Review Unit ("CDRU") in the Republic of Ireland based on best practice around the world.

First and foremost it is recommended that a CDRU be established in Ireland. It ought to be independent of the agency responsible for child protection, i.e. the HSE. It is recommended that the new unit be established within the Department of Children and Youth Affairs. Other models, such as incorporation within the Office of the Ombudsman for Children, are also possible. The CDRU should automatically have the power to investigate the death of any child or young person in the care of the HSE or in aftercare and those known to the HSE. Such a review ought to examine the circumstances in which the child or young person came into contact with the HSE and the circumstances leading up to and giving rise to his/her death. Recommendations ought to be made where required and an annual report published to the Oireachtas. A register of the deaths of such children and young persons should also be maintained.

Operation of In Camera Rule

So as to enable the CDRU carry out its task in a proper manner the operation of the *in camera* rule must be addressed so as to allow for transparency and accountability in child care cases. Information gathered in child care proceedings must be the subject of review and reporting, whilst all the time protecting the identity of the child and family members, so as to ensure that our child protection system is operating properly. In addition there must be a free flow of information shared between agencies involved in child protection services so as to ensure consistency in the level of protection provided to vulnerable children.

Reform of Child Protection

A root and branch reform of the child protection system in Ireland is required. The ethos needs to change to one whereby each and every person involved takes responsibility for his/her role in promoting the welfare of children and ensuring their protection. Thorough and comprehensive

audits need to be conducted of the systems and procedures operating in the child protection system.

Many of the concerns raised in this report arise from systematic failures. Proper procedures need to be put in place and adhered to once a child comes into contact with the HSE. Some basic yet essential steps need to be followed. The following is a sample of such steps:

i. Conduct a risk and mental health assessment in respect of the child.
ii. Intervene at the earliest stage when warranted.
iii. Put in place a care plan for the child as soon as possible having regard to the results of the risk assessment.
iv. Ensure regular and clear communication between the HSE and families.
v. Seek the assistance of the courts where necessary, e.g. Supervision Orders.
vi. Assign a social worker to the child and avoid constant changing of social workers.
vii. Identify appropriate placements for the child.
viii. Identify the necessary services to meet the needs of the child and refer the child to those services promptly.
ix. Conduct regular care reviews.
x. Ensure that adequate professional supervision and support is in place.
xi. Ensure that all those who work within the child protection system have sufficient knowledge of the child protection legal system.
xii. Complete critical incident reports when required.
xiii. Keep proper records in respect of the child.
xiv. Create and maintain a proper information management system.
xv. Promote interagency communication, cooperation and support.
xvi. Provide adequate supports for foster families.
xvii. Provide suitable aftercare provision.
xviii. Review and audit systems on a regular basis.

The factors set out above are not thought to be overly complicated in the context of a child protection system, however, the files as provided to the ICDRG demonstrate that these logical steps are not been taken in the majority of cases thereby giving rise to concerns in respect of the welfare of children who are in the child protection system. Obviously each case will present its own challenges, but it is thought that these steps will at least go some way towards identifying those challenges so as to enable the appropriate supports and services be provided to the child.

The death of any child is tragic. Many of the cases reviewed were from natural causes, others were unnatural and may have been preventable and still others were unnatural and not preventable. It is the earnest hope of the ICDRG that this review of the deaths of 196 children and young people between 2000 and 2010 involved with the care system will provide a basis on which to provide greater support and protection of such vulnerable children and young people in the future.

CHAPTER 1: INTRODUCTION

1.1 Establishment of Independent Child Death Review Group ("ICDRG")

In March 2010, the leaked publication of two reports comprising investigations into the death of young people while in the care of the State, sparked a national debate both about the lack of transparency within the child welfare protection system in Ireland and the failure of the system to adequately meet the needs of the children it aims to serve. The publication of the Report came on foot of a number of other reports which highlighted the ongoing gaps in child protection practice in Ireland and significant media coverage of a number of cases which evidenced the impact of the "broken" system on children and young people.

In response to calls for investigations into the number and circumstances of children who had died while in the care of or known to the Health Service Executive ("HSE"), then Minister of State for Children and Youth Affairs, Barry Andrews TD, announced the establishment of an independent group to examine the case files for these children. In so doing, the Minister aimed to restore transparency to the child protection system and to enable the learning and recommendations from these cases be shared in the interests of children and families, professionals and the wider public.[2]

1.2 Terms of Reference

The Independent Review Group on Child Deaths (ICDRG) was appointed in March 2010. The initial Terms of Reference for the Group were amended in July 2010 to adequately define the scope of the review and the cases it was established to examine.

1.3 Final Terms of Reference

The Independent Review Group on Child Deaths will examine existing information in respect of deaths of children over the period of 1 January 2000 to 30 April 2010 who were:

- in care within the meaning of the Child Care Act, 1991 at the time of their death;
- in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death;

[2] OMCYA Press Release, Independent Review into Deaths of Children in Care, 8 March 2010.

- known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 at the time of their death.

The Group will, as an initial step, seek to validate within the above categorisation the cause of death as being from natural causes or otherwise. The Group may seek to obtain additional information which, in the opinion of the Group, will assist it in the performance of this function.

In relation to children other than those who died from natural causes (and where the cause of death was so validated), the Group will examine existing reviews/reports completed by the HSE (or by others on behalf of the HSE) and, based upon this information, provide an overall report to the Minister for Children and Youth Affairs for publication which:

- provides on an anonymised basis key summary information regarding each child and the circumstances leading up to their death;
- focuses, in particular, on the relevant involvement of State services with the child and his/her family;
- examines the strengths and weaknesses of such involvement;
- in so far as lessons were or can be identified from these reports/reviews, including common issues presenting, make recommendations as to how child protection responses can be strengthened; and
- if considered useful, comment on the nature of the reports/reviews available for its consideration.

The Group is also required, following completion of the task set out above and as a separate function, to make itself available to interview families of the deceased who may wish to have the opportunity to air their views and following such interviews to present to the Minister an anonymised synopsis of such interviews.

The Review Group is to report to the Minister for Children and Youth Affairs by year end 2010.

1.4 Categorisation of Deaths and Terms of Reference

The files received and reviewed by the ICDRG comprised of the natural and unnatural deaths of children and young persons in the care, in the aftercare and known to the HSE. In light of the

Terms of Reference of the Review Group, however, it is not possible to include individual case summaries relating to deaths arising from natural causes. The Terms of Reference entitle the Review Group to examine the information provided on the deaths of children occurring between the relevant dates and to validate the determined cause of death. The body of the Report contains an overview of the natural deaths of children and young people in the care of the HSE, in the aftercare of the HSE and known to the HSE.

1.5 Delay

The ICDRG was initially hopeful that it could report to the Minister for Children and Youth Affairs by year end 2010. In the event, ongoing delay in providing the information required to complete the review, the need for legislative change perceived to be required by the Government to secure the provision of the files to the ICDRG from the HSE and the large number of cases and files subsequently supplied to the ICDRG rendered the initial deadline redundant. The condition of the files, the absence of any death certificates for a large number of children in the initial information supplied made a challenging task more difficult to undertake.

1.6 Receipt of Files

Following the establishment of the ICDRG, there was considerable confusion in relation to the numbers of children who had died while in the care of or known to the HSE. Initial figures reported by the HSE fell far short of the actual number of cases subsequently uncovered by the HSE. Once cases had been identified there was significant delay in the handover of the files to the ICDRG. This was in part due to legal confusion regarding the transfer of confidential individual files. This confusion was addressed by the passing of the Health (Amendment) Act, 2010 which provided the necessary legislative mechanism for the provision of information by the HSE to the Minister. Moreover the 2010 Act was intended to create a "safe channel of communication" for sensitive information from the HSE to the Minister.

The HSE began sending files to the ICDRG in July 2010, with the final files arriving in October 2010. However, many files were incomplete and the ICDRG requested missing components from the HSE on an ongoing basis, specifically death certificates and reports from coroners, which continued to arrive throughout the period of the review. The piecemeal manner in which the HSE provided the information endured throughout the review and significantly hampered the review team in producing this report.

1.7 Establishment of the Office

The offices of the ICDRG were established in June 2010. Office space was acquired through the Office of Public Works ("OPW") in a building with the appropriate level of security in place to safeguard files. The ICDRG recruited three research assistants and one administrative assistant to support the processing and safe storage of files. A proforma form was drafted to ensure consistent collection of the relevant data from each of the files acquired by the ICDRG, allowing for adequate analysis of cases while ensuring the confidentiality of the children involved.

On receipt of the initial files from the HSE, in July 2010, the research team and the ICDRG began work to compile the relevant details of each case using the standardised form prepared. This work continued until year end 2010 at which point the research team finished working with the ICDRG. A part time researcher then began work to follow up on information missing in particular cases and support the compilation of details for analysis. The ICDRG undertook the analysis of the facts of each case and compiled the report outlining this analysis and the requisite learning to be taken from the cases reviewed in accordance with the Terms of Reference.

This report outlines the incidences of the death of 196 children and young people:

- in care within the meaning of the Child Care Act, 1991 at the time of their death;
- in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death; and
- known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 at the time of their death.

Under these three headings, the cases are further categorised according to whether a child's death was as a result of natural causes or unnatural causes and broken down into the age categories of children. The report then outlines the learning to be taken from the cases presented. At the end of each chapter there is a section outlining examples of good practice and also noting concerns observed on the files received by the ICDRG; in all instances, these are mentioned only where particularly noteworthy. This means that if it is noted that the ICDRG observed, for example, good record keeping on a number of files; it is not implied the remaining files necessarily showed evidence of poor record keeping. Not every aspect is commented on in relation to every file.

Chapter 5 covers the position in a number of countries in relation to how the deaths of children are dealt with in that jurisdiction, considers the *in camera* rule and the provisions of the Data Protection Acts 1988-2003 and finally the report offers a number of recommendations that arise from the review and the international experience.

The death of any child is tragic. As will be seen in the cases outlined many of these deaths were from natural causes, others may have been preventable and still others were unnatural and not preventable. In respect of some cases there are criminal proceedings still outstanding or it is not clear if charges will be initiated in the future.

It is the hope of the ICDRG that this review of the deaths of 196 children and young people between 2000 and 2010 involved in the care system will provide sufficient impetus for the necessary reforms in the child welfare and protection system. While it is not possible to prevent the deaths of all children, it is hoped that the report's findings will contribute to the discourse on the improvements that should and must be made in the best interests of children.

CHAPTER 2: CHILDREN IN THE CARE OF THE HEALTH SERVICE EXECUTIVE ("HSE")

PART 1: NATURAL DEATHS OF CHILDREN AND YOUNG PEOPLE IN CARE

Overview

The ICDRG received and reviewed the child and family records for 19 children and young people who were determined to have died of natural causes while in the care of the HSE between 2000 and 2010.[3] While the Terms of Reference preclude the ICDRG from publishing case summaries in this category it was necessary to review the files to determine the cause of death. This review, however, provided a rich seam of information and this is reflected in the higher level learning in Part 3 of this chapter.

The overview provided below divides the category of natural deaths into three sections:

Section 1: Children Aged 5 and under.
Section 2: Children Aged between 6 and 12 years.
Section 3: Young Persons Aged between 13 and 17 years.

At the end of Chapter 2: Part 1, a number of graphs show a breakdown of figures and percentages in relation to the natural deaths of children and young people in care.

[3] Initially, the ICDRG were provided with the child and family records for 23 children in this category however two of the children had died following road traffic accidents and were recategorised as non-natural deaths. One child died following a drowning accident and was recategorised as a non-natural death .The remaining young person died at the age of 20 and was recategorised as an aftercare death.

Section 1: Children Aged Five and Under: Eight Children

This section provides an overview of the cases of eight children who died of natural causes while in the care of the HSE.

Age at Time of Death

- Three were under 1 year old;
- Three were aged between 1 and 3 years old; and
- Two were 5 years old.

Placement at Time of Death

- All eight children were placed with foster parents at the time of their death.

Length of Time in Care

- The three children aged under 1 year were in care from birth or shortly after.
- The three children aged between 1 and 3 years of age were in care from birth or shortly after.
- One child aged 5 years was in care for two years.
- One child aged 5 was in care for four years.

Length of Time Known to the HSE

- One child was known to the HSE for 5 months.
- Two children were known to the HSE for 9 months.
- One child was known to the HSE for 2 years.
- Three children were known to the HSE for 3 years.
- One child was known to the HSE for 5 years.

HSE Region

- One child was in the care of HSE Dublin Mid-Leinster Region.
- Five children were in the care of HSE Dublin North East Region.
- One child was in the care of HSE South Region.
- One child was in the care of HSE West Region.

Date of Death

- One child died in 2002.
- One child died in 2003.
- One child died in 2007.
- One child died in 2008.
- Three children died in 2009.
- One child died in 2010.

Gender

- 4 children were male.
- 4 children were female.

Section 2: Children Aged between 6 Years and 12 Years: 4 Children

This section provides an overview of the cases of four children who died of natural causes while in the care of the HSE.

Age at Time of Death

- One child was 8 years old.
- One child was 9 years old.
- One child was 10 years old.
- One child was 12 years old.

Placement at Time of Death

- Two children were placed with foster parents at the time of their death.
- One child was in residential care at the time of death.
- One child was in specially provided accommodation at her request.

Length of Time in Care

- Three of the children were in care shortly after their birth.
- One of the children was in care for 6 years.

Length of Time Known to the HSE

- One child was known to the HSE for 7 years.
- Two children were known to the HSE for 10 years.
- One child was known to the HSE for 12 years.

HSE Region

- One child was in the care of HSE Dublin North East Region.
- One child was in the care of HSE South Region.
- Two children were in the care of HSE West Region.

Date of Death

- One child died in 2001.
- Two children died in 2004.
- One child died in 2005.

Gender

- 3 children were male.
- 1 child was female.

Section 3: Young People aged from 13 Years to 17 Years: 7 Children

This section provides an overview of the cases of seven children who died of natural causes while in the care of the HSE.

Age at Time of Death

- Six young people were aged between 13 years and 16 years.
- One young person was 17 years of age.

Placement at Time of Death

- Four young people were in foster care at the time of their death.
- Two young people were in residential care at the time of death.
- One young person was in shared foster care and respite residential care because of a health condition.

Length of Time in Care

- One young person had been in care all of his life.
- Six young people had been in care for between 3 months and 15 years.

Length of Time Known to the HSE

- One young person was known to the HSE for 3 months.
- One young person was known to the HSE for 1 year.
- One young person was known to the HSE for 2 years.
- One young person was known to the HSE for 4 years.
- One young person was known to the HSE for 6 years.
- One young person was known to the HSE for 9 years.
- One young person was known to the HSE for 14 years.

HSE Region

- One young person was in the care of HSE Dublin Mid-Leinster Region.
- Two young people were in the care of HSE Dublin North East Region.
- Four young people were in the care of HSE South Region.

Date of Death

- One young person died in 2001.
- One young person died in 2002.
- Two young people died in 2004.
- One young person died in 2006.
- One young person died in 2008.
- One young person died in 2009.

Gender

- 4 children were male.
- 3 children were female.

The graphs below show a breakdown of figures and percentages in relation to the natural deaths of children and young people in care.

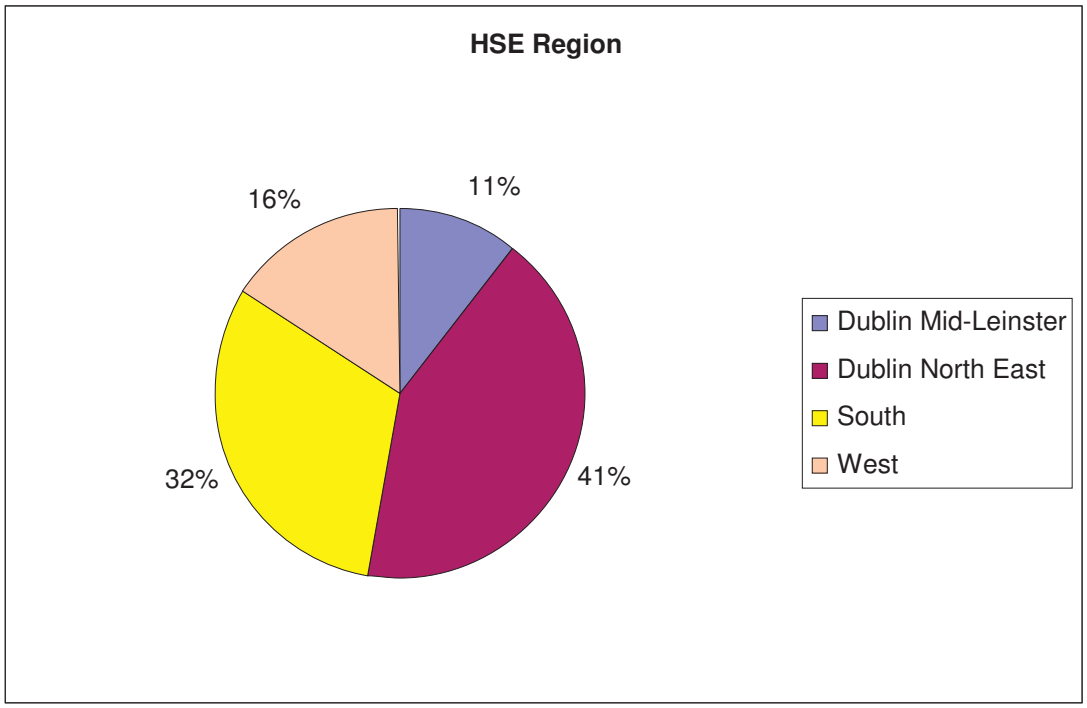

Fig. 1.1.1 – HSE Region (Natural Deaths of Children and Young People in Care)

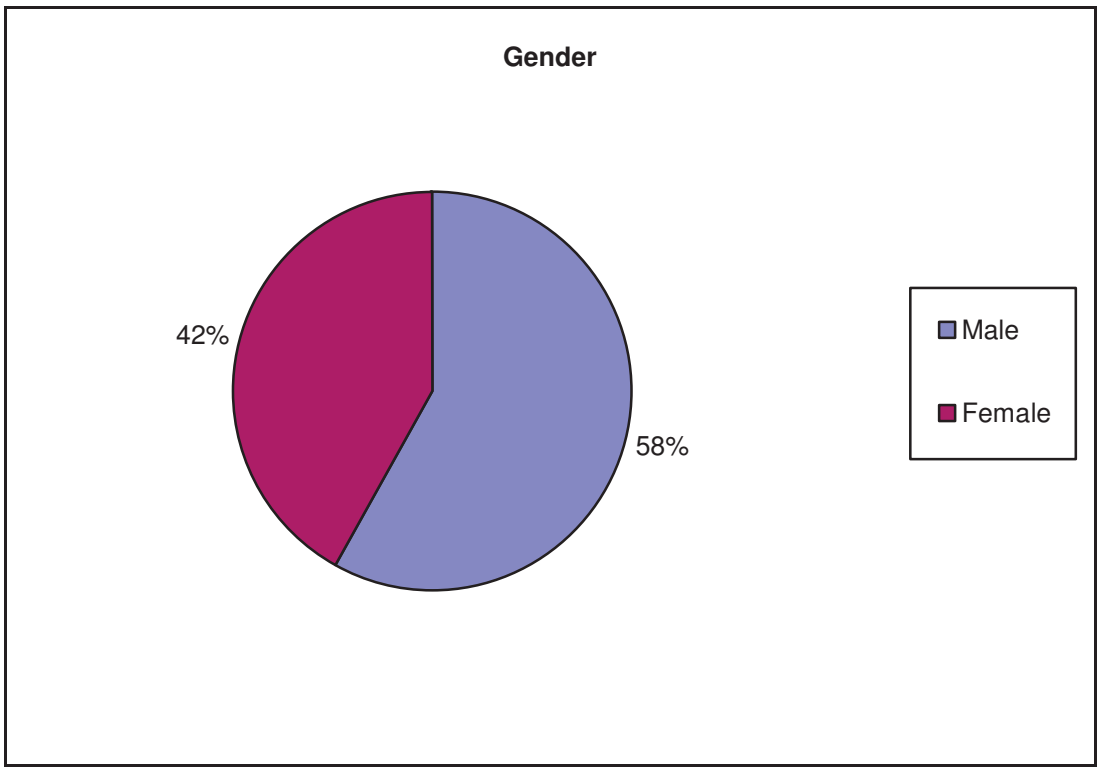

Fig. 1.1.2 – Gender (Natural Deaths of Children and Young People in Care)

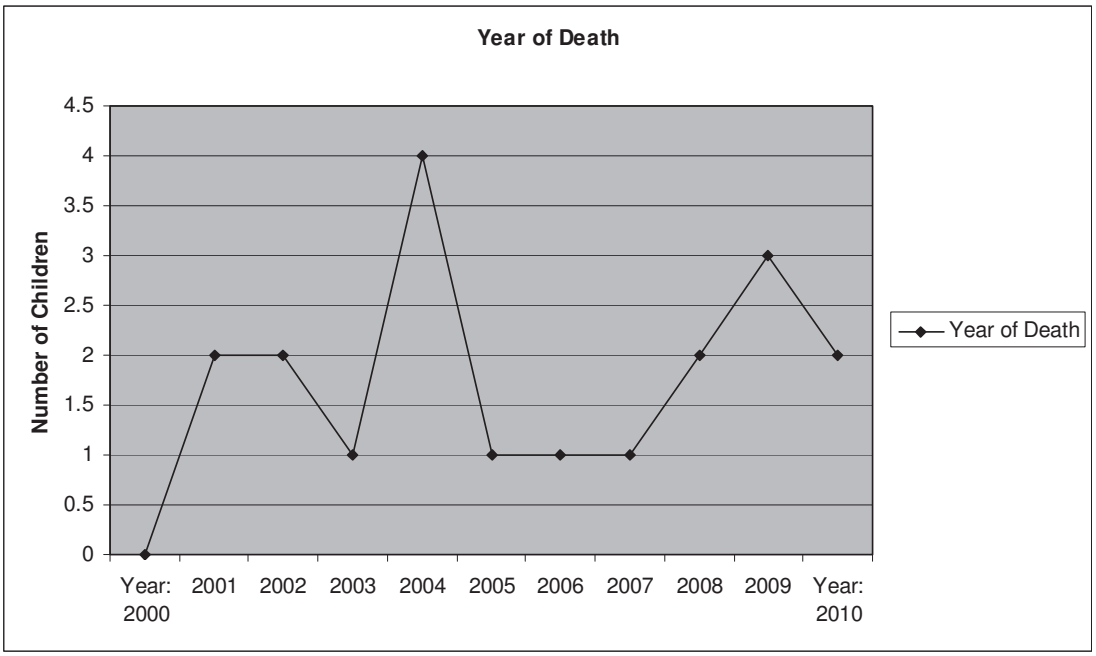

Fig. 1.1.3 – Year of Death (Natural Deaths of Children and Young People in Care)

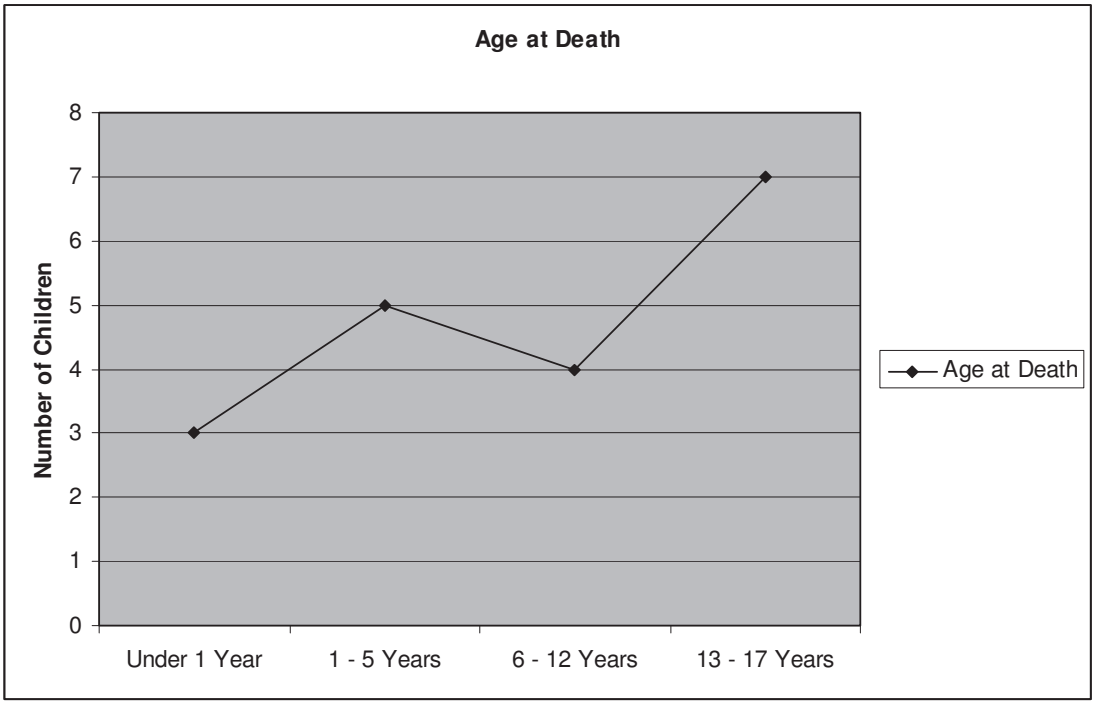

Fig. 1.1.4 – Age at Death (Natural Deaths of Children and Young People in Care)

PART 2: UNNATURAL DEATHS OF CHILDREN AND YOUNG PEOPLE IN CARE

Overview of Analysis

The ICDRG received and reviewed the child and family records for 17 children and young people who died of non-natural causes while in the care of the HSE between 2000 and 2010.[4] Road traffic accidents are included in this section. The overview provided below breaks the category of non-natural deaths into three sections:

Section 1: Children between 4 and 12 years;
Section 2: Young Persons aged between 14 and 16 years; and
Section 3: Young Persons aged 17 years;

At the end of Chapter 2, Part 2, a number of graphs show a breakdown of figures and percentages in relation to the non-natural deaths of children and young people in care.

[4] Initially, the HSE provided the ICDRG with the child and family records for 12 children in this category. However three of the children who had died following road traffic accidents were originally categorised as natural deaths as was one child who had drowned and one child who had died from asphyxia. Those 5 deaths were subsequently correctly categorised as non-natural deaths.

Section 1: Children aged between 4 and 12 years: 3 Children

This section contains the information related to 3 children aged between 4 and 12 years who died of non-natural causes between 2000 and 2010.

Age at Time of Death

- One child was 4 years old.
- One child in was 7 years old.
- One child was 12 years old.

Placement at Time of Death

- All three children were placed in relative foster care at the time of their death.

Length of Time in Care

- One child had been in care for 2 years.
- Two children had been in care for 3 years.

HSE Region

- One child was in the care of HSE West.
- One child was in the care of HSE Dublin North East.
- One child was in the care of HSE Dublin Mid Leinster.

Year of Death

- One child died in 2001.
- One child died in 2003.
- One child died in 2008.

Gender

- One child was male.
- Two children were female.

Individual Case Analysis

2.2.1 Child in Care 1

Child in Care 1 died in 2001, aged 4 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This child was taken into care in circumstances where one parent had passed away and the remaining parent had a considerable alcohol addiction. This addiction had a significant impact on the parent's ability to care for the child and also his older siblings. He was also identified as having significant developmental delays. All of the children were placed with a member of the extended family following repeated referrals from family members, community members and professionals.

Initially, the child was taken into the care of the HSE under section 4 of the Child Care Act, 1991. Subsequently, however a full care order was made under section 18 of the Child Care Act, 1991. Appropriate access was organised for the parent.

The child remained with the extended family member supported by professionals for the child's developmental needs and also professional help regarding the parent's alcohol dependency.

This child died in tragic circumstances. The family were distraught and ongoing support is being provided.

Services Engaged for Child in Care 1

- HSE Social Work Department;
- Homemaker Services;
- Addiction counsellor;
- Bereavement counselling;
- Psychology and sensory assessment;
- Paediatric evaluation; and
- Early Years pre-school.

There is evidence of all the services interacting well together once the child was in care.

Good Practice Observed on File of Child in Care 1

- Care plan completed.

Concerns Arising From File of Child in Care 1

- No review of the child's death was completed.

2.2.2 Child in Care 2

Child in Care 2 died in 2003, aged 7 years old. The cause of death has been verified by the ICDRG from official records.

Summary of Care Circumstances

This child's birth mother passed away in tragic circumstances. The father of the child was unable to care for the children of the family and a relative assumed their care. The HSE initially refused to support this placement. This caused problems as the relative was unable to support the children without the foster carer allowance. The relative was, however, approved as a foster carer when she was able to locate the birth father six months after assuming parental responsibility for this child and her sibling. There was no evidence of a full foster care assessment having been carried out. However, a Garda check and a HSE check were carried out.

This child died in tragic circumstances and the family were understandably very distressed by her death.

Services Engaged for Child in Care 2

- HSE Social Work Department (minimal intervention)

Good Practice Observed on File of Child in Care 2

- Support of fostering link worker after the death of the child.

Concerns Arising From File of Child in Care 2

- Voluntary Care admission form was not signed;
- No Social Worker was allocated (reference in papers to a resources issue);
- No care plan;
- No review of the child's care;
- No medical assessment of the child;
- The child didn't have her own file;
- The files relating to the child were not organised; and
- Complete and total disregard for the Fostering Regulations.

2.2.3 Child in Care 3

Child in Care 3 died in 2008, aged 12 years old. The death was registered on foot of a Coroner's Certificate.

Summary of Care Circumstances

Child in Care 3 was admitted into the care of the HSE when she was 9. She was admitted to care under Section 13(1) of the Child Care Act, 1991[5] following allegations of serious abuse. Subsequently, both she and her two younger siblings were made the subjects of a full Care Order under Section 18 of the Child Care Act 1991.[6]

There was significant family friction regarding the circumstances of this child's reception into care. This friction continued until the child's death and she had expressed very clearly the pressure she was experiencing as a result of this ongoing friction. In the weeks prior to her death, this child had been observed engaging in behaviour which indicated suicidal thoughts. However professionals or caring adults were not made aware of the entire picture. This child had been referred to a psychologist on the local Child and Adolescent Mental Health Services (CAMHS) by the HSE Social Work Team but the referral had not resulted in a case being opened at the CAMHS by the time she died.

[5] Section 13 allows a District Court Judge to make an Emergency Care Order on the application by the HSE where there is reasonable cause to believe that there is an immediate and serious risk to the welfare of the child or there is likely to be such a risk which necessitates the child being placed in care.

[6] Section 18 allows for the making of a care order where, inter alia, the child has been or is being assaulted, ill-treated, neglected or sexually abused.

During this child's three years in the care of the HSE she had two foster care placements and experienced 32 moves to respite foster care. At the time of her death, she was in relative foster care.

This child died in tragic circumstances and those who cared for her were understandably very distressed by her untimely death.

Services Engaged Regarding Child in Care 3

- Specialist Sexual Abuse Unit;
- Play Therapy;
- Education Services;
- Referral of alleged abuse to treatment services (this referral was not taken up); and
- Referral to Gardaí in 2001 regarding an allegation of abuse.

Good Practice Observed on File of Child in Care 3

- Good evidence of supervision;
- Care Plan on file and it was followed;
- Court orders are present on the file;
- Children First reviews completed; and
- Court made aware of the death.

Concerns Arising From File of Child in Care 3

- No birth certificate on the file.
- No individual file for this child. This file is for all three siblings.
- This child had four different Social Workers.
- There were a high number of foster care respite placements in a reasonably short period of time.
- It is suggested in the record that a review of the death of this child was undertaken by the Risk Management Team of the HSE. However this is not on the file provided to the ICDRG.

- The file records a decision not to request the child's GP to have her referred to mental health services "as this might encourage more worrying behaviour giving it attention". This was based on a general (not case specific) discussion with a Psychologist.
- This child should have had an assessment by the CAMHS service at an early point. There must be a protocol between the HSE Social Work Department and CAMHS that provides for an immediate service to children and young people who are displaying high risk behaviours.
- This child was under extreme pressure by the alleged abuser to retract her statement concerning what she had witnessed in relation to the allegation of abuse of her sibling. Others known to the child also added to that pressure. It must be queried whether a placement in the local area was the best option in view of the level of hostility and ongoing pressure the child was experiencing. In every other respect the placement with relative foster carers appears to have met the child's needs.

Section 2: Young People in Care of HSE aged 14 to 16: 8 Young People

This section contains the information related to 8 young people aged between 14 and 16 years who died of non-natural causes between 2000 and 2010.

Age at time of death

- Two young persons were 14 years old;
- Two young persons were 15 years old; and
- Four young persons were 16 years old.

Placement at Time of Death

- One young person had been moved from a secure unit to a step down facility and was due to be returned to the secure care unit at the time of death.
- Two young people had been placed in a foster home; one of them had absconded at the time of death.
- Four young people had been placed in residential care; two had absconded at the time of death.
- One young person had been placed back at home at the time of death.

Length of Time in Care

- Three young people had been in care for less than 9 months at the time of their death.
- Three young people had been in care between 3 years and six years.
- Two young people had been in care between 10 and 11 years.

HSE Region

- Three young people were in the care of HSE Dublin Mid-Leinster Region.
- Two young people were in the care of HSE West Region.
- Three young people were in the care of HSE Dublin North East Region.

Year of Death

- Two young people died in 2000.
- One young person died in 2003.
- Three young people died in 2006.
- One young person died in 2007.
- One young person died in 2009.

Gender

- Six young people were male.
- Two young people were female.

Individual Case Analysis

2.2.4 Young Person in Care 4

Young Person in Care 4, died in 2006, aged 14 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was referred to the Child and Adolescent Mental Health Service (CAMHS) by his family who expressed the view that he was out of their control because of his behaviour. The family were very concerned that he had befriended undesirable individuals who were considerably older than him and was abusing alcohol, staying out at night and not attending school. He was then approximately 13 years old and appears to have enjoyed normal family life until that time. He had attended school and engaged in the usual childhood activities. He was diagnosed as having learning difficulties although from the records it was not entirely clear when that diagnosis was made.

Following the referral, the young person was initially seen by CAMHS who then referred him to the HSE Social Work Department as well as continuing to see him and his family. Concerns were expressed that his behaviour was putting him at extreme risk. The Duty Social Worker organised an activity based placement for the young person and the case was allocated to a Community Care Social Worker. Services were offered to the family and young person including a parenting course and a Strategy Meeting was held to draw together all the services for this young person and his family and to plan the way forward. Shortly afterwards he was received into voluntary care under Section 4 of the Child Care Act, 1991[7]. A foster care placement was organised for him but he left after a few days. He then refused to meet with his psychiatrist at CAMHS and attempted to harm himself. A place was offered to him as an inpatient in hospital but he refused to attend. However, he did attend a meeting with the psychiatrist at the hospital and agreed to reengage with CAMHS. There is an admission to voluntary care form on record at this time but it is not clear that he ever actually came into the care of the HSE.

[7] Section 4 provides for the taking of a child into voluntary care by the HSE where it appears to the HSE that the child requires care or protection and will be unlikely to receive it unless taken into care.

During this period, a number of meetings were held with a view to making progress with his care and efforts were made to outline to him the risks he was facing. A case conference was convened after 6 months and it was recommended that an application should be made to admit the young person into a secure care unit.

The young person was placed in the secure unit for 4 months by order of the High Court and a Guardian ad Litem was appointed for him. It is recorded that he appeared to have settled well in the secure unit and was worried about moving from there. He was subsequently moved to residential accommodation, with a view to his eventually returning to his family home. He absconded from the residential facility after just two nights and was missing, for the most part, until his death. In the months after leaving the residential placement he missed a series of appointments with the CAMHS clinical team. It is not clear from the records provided to the ICDRG as to whether or not information on these missed appointments was notified to his family each time. During this period, the HSE made an unsuccessful application to the admission panel to place this young person back in a secure unit.

This young person continued to move between a local family and homelessness and generally he refused to engage with services. He was effectively out of school from the time he came to the attention of the services and it is not clear if sufficient efforts were made to integrate this young person back into the mainstream education services. His Guardian ad Litem expressed strong concern that the young person was open to serious risk. An allegation of sexual abuse by an older female was made and notified to the Gardaí a few days later by the HSE Social Work Department. This issue does not appear to have been notified to his family until after the young person had himself been interviewed. This appears to be in conflict with the *Children First Guidelines* operational at that time.

Finally, after a period of three months the High Court made an order that the young person should be placed in a secure unit. Following discussion with senior staff the Social Worker informed him of the order of the High Court and noted that he became agitated when advised of this. He was informed by phone as he refused to meet with the Social Worker.

Once he was aware of the plan to return him to secure care the young person was not located by the HSE or the Gardaí. A few days later, on the night of his death, it is recorded that he returned home and left in the family car. The Gardaí were notified of this by his family. His body was found the next day.

At the request of the family, the Ombudsman for Children completed an investigation into some aspects of the care received by this young person. The High Court considered the circumstances surrounding this child's care and the circumstances by which a secure order was made but not acted on immediately.

Services Engaged for Young Person in Care 4

- HSE Social Work Department;
- CAMHS;
- Secure Care Unit;
- Residential Care (number of placements offered but not taken up); and
- Gardaí.

There is evidence of inter-agency working in many areas of this young person's care but the purpose of a number of interagency meetings was not clear and it is not clear if the seriousness of the risk this young person posed to himself was fully understood by everyone involved.

Good Practice Observed on File of Young Person in Care 4

- Numerous meetings held to try and facilitate the path of this young person into care.
- Considerable efforts made to engage with this young person.
- Risks which the young person faced outlined to him personally.

Concerns Arising from File of Young Person in Care 4

- It appears from the records that the *Children First Guidelines* were not followed in relation to the allegation of the sexual abuse of this young person.
- It was not clear when this young person was in the voluntary care of the HSE and when he had been discharged.

Comment: A significant incident systems review was carried out by an external group for the HSE following the death of this young person. This review made a number of recommendations to guide future practice.

Given the issues raised in the review of the files furnished to the ICDRG it is recommended that a holistic review of this case be undertaken. This recommendation is not intended as a criticism of other reviews undertaken in respect of this case.

Young Person in Care 5

Young Person in Care 5 died in 2006. The Coroner's office has confirmed that the inquest in respect of this young person has not been held and her death has not been registered.

Summary of Care Circumstances

This young person and a number of her siblings had been on the Child Protection Register in another jurisdiction and the family had been known to the Social Service in that area for very many years. The HSE was alerted when the family moved to Ireland. Following this alert, the HSE Social Work Department engaged with the family and initial assessment work on the family was completed. A support plan was put in place 5 months later when it emerged that this young person had been a regular non-attendee at school. Subsequently, this young person's situation was converted to a Child Protection Case when other serious issues regarding the young person were outlined in referrals.

The young person was received into care under Section 12 of the Child Care Act, 1991.[8] She was initially placed in a residential care facility. However she absconded from this facility regularly and remained there only a short time. She was then placed in a foster home from where she again absconded almost immediately.

During her short time in the care of the HSE, it appears that she was in constant contact with an adult who supported her running away, while purporting to cooperate and aid the HSE. An order

[8] Section 12 gives the Gardaí the power to remove a child to safety where a member of the Gardaí has reasonable grounds for believing that there is an immediate and serious risk to the health or welfare of the child and it would not be sufficient for the protection of the child from such a risk to await the making of an application for an emergency care order under Section 13. After the removal of the child, the Gardaí must deliver the child to the custody of the HSE as soon as possible.

under Section 47 of the Child Care Act, 1991 forbidding this contact was appropriately granted to the HSE at its request.[9]

She was subsequently found but ran away from the social work office and she was missing from then until her body was found some time later.

Services Engaged for Young Person in Care 5

- Family Support;
- Psychology services (not fully availed of due to the young person absconding);
- Residential Care;
- Foster Care;
- HSE Social Work Department;
- Education and home school liaison service; and
- Gardaí.

Good Practice Observed on File of Young Person in Care 5

- Evidence in the file of consistent work with the young person and her family prior to her reception into care.
- Evidence of significant liaising and positive engagement between the Gardaí and the HSE.
- Plans were put in place when the young person went missing to secure an appropriate placement for her when she was found.
- Files are well organised.
- Evidence of professional supervision and support.
- Very comprehensive summary on file.
- The Court was informed when this young person's body was found.

[9] Under Section 47, where a child is in the care of the HSE, the District Court may, of its own motion or on the application of any person, give such directions and make such order on any question affecting the welfare of the child as it thinks proper and may vary or discharge any such direction or order.

Concerns Arising from File of Young Person in Care 5

- Delay in referring this young person for assessment by CAMHS.

Comment:

A HSE review is underway into the care of this young person.

2.2.6 Young Person in Care 6

Young Person in Care 6 died in 2000, aged 15 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person came to the attention of the HSE as a result of concerns about her behaviour. Her parents were unable to control her and she was out of school as a result of her conduct. She was known to the HSE for 3 years prior to her death and she was in care for most of this time. It is noted on her file that she could pose a real danger to herself and others.

She was initially received into voluntary care under Section 4 of the Child Care Act, 1991[10] and subsequently an interim care order was made under Section 13 of the Child Care Act, 1991 in respect of this young person.[11] This young person had at least 6 different placements during her time in care. She was also missing for some periods and believed to have been living on the streets. She travelled abroad at one point. Her placements included supported lodgings, residential care and eventually a placement in a residential unit that offered high support. She had four different Social Workers and there appears to have been one period of 7 months when no Social Worker was allocated to this case despite the high risk to her wellbeing noted on her files.

This young person was identified as being at severe risk of harming herself or others from an early point in her contact with services and some of the plans made for this young person were

[10] Section 4 provides for the taking of a child into voluntary care by the HSE where it appears to the HSE that the child requires care or protection and will be unlikely to receive it unless taken into care.

[11] Section 13 allows a District Court Judge to make an Emergency Care Order on the application by the HSE where there is reasonable cause to believe that there is an immediate and serious risk to the welfare of the child or there is likely to be such a risk which necessitates the child being placed in care.

not appropriate. She was initially placed in supported lodgings at the age of 13 and then moved to a foster care placement for 4 months. During this placement her behaviour was of serious concern and the placement broke down. She then appears to have spent a month living on the street and using the Out of Hours service to obtain accommodation. Throughout this period, this young person was associating with older youths and sleeping rough occasionally. She attended at local hospitals a number of times with injuries which had been self-inflicted and disclosed numerous attempts to take her own life.

Subsequently, she was placed in another foster home in a rural area. Again, however, this placement broke down after a number of months and in the period that followed she alternated between living rough in the city centre and staying in supported lodgings.

At this time she travelled abroad with a young adult. Finally an application to authorise her detention in a specialist facility, was made to the High Court. The application was based on her need for a stable placement to address her emotional and educational difficulties and to ensure she had access to necessary psychotherapy.

The High Court made an Order detaining this young person in a specialist facility run by the then Eastern Health Board and she remained there for almost two years. During this placement she absconded many times. She appeared at times to make progress in recognising the negative consequences of her aggressive behaviour. Counselling was provided for her.

On each occasion as soon as she was offered more freedom she met up with people who had befriended her when she lived on the streets and she appears to have recommenced abusing both alcohol and drugs.

Finally, this young person absconded from a work placement. She made a number of telephone calls to her Social Worker over the next few weeks, during which time the Gardaí and the HSE were actively looking for her. Her body was discovered 2 weeks after the last telephone contact from her.

Services Engaged for Young Person in Care 6

- Paediatric Hospitals;
- NGO specialist service;
- Child and Adolescent Psychiatric services;
- HSE Social Work Department;
- Foster care;
- Supported Lodgings;
- Residential Care; and
- Gardai.

Concerns Arising from File of Young Person in Care 6

- No information on the file regarding the circumstances of her death.
- The file recording is very poor, confusing and difficult to follow.
- There are multiple copies of reports, many not dated so it is difficult to ascertain the sequence of the documents and the events involved in this young person's care.
- Four different Social Workers in the 3 years this young person was in care.
- Some periods where no Social Worker was assigned to this young person.
- High number of placements for this young person.
- It appears that there may have been a failure to follow up allegations of abuse made by this young person and a failure to follow up a disclosure of her involvement in prostitution.
- Inappropriate care plans were put in place.
- Interagency working was less than optimal.
- There is no record of notification to the High Court of this young person's death.

Note: Case Management Review

A case management review was carried out on behalf of the HSE. It was completed in 2001. It was not within the terms of reference that it would be published. The review considered the social work files, interviewed most of the staff involved with the young person and many other persons who were involved with this young person. In addition the review considered the

policies and procedures that pertained at the time of this young person's period in the care of the HSE.

The review identified many recommendations for the future care of troubled young people. As with other reviews it is not known if the recommendations were implemented.

2.2.7 Young Person in Care 7

Young Person in Care 7 died in 2006, aged 15 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was received into care when he was 5 years old under a Voluntary Care Order pursuant to Section 4 of the Child Care Act, 1991. Subsequently, a Full Care Order was granted in respect of him under Section 18 of the Child Care Act, 1991. The reasons given for his reception into care were that there was concern regarding his welfare at home and domestic abuse which was affecting the care of the children.

During this young person's 10 years in care he had at least ten different placements which included 5 short term placements during his first year in care. Most of these placements do not appear to have met his needs and as noted on the records supplied to the ICDRG it is clear he frequently absconded to be with his family. He had 6 Social Workers during these 10 years and there appears to have been periods when he had no Social Worker.

Two years prior to his death he was placed back with his family. This placement was planned, but there is no evidence available on the file to indicate that it was believed this return home would be beneficial for him. A project worker was allocated to him with a view to engaging him in educational and social activities. Upon his return home, he stopped attending school. This young person travelled around with his mother and this made it difficult to maintain work with him. The Care Order in respect of this young person was still in place.

Prior to his death he had left home to go to Dublin to meet up with family members. He was found dead 4 days later. This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 7

- HSE Shared Parenting Scheme;
- HSE Social Work Department;
- Foster care;
- Residential Unit;
- Child Care Worker; and
- Education services.

Good Practice Observed on File of Young Person in Care 7

- Reviews were carried out during this young person's periods in residential care and the HSE was compliant with the Child Care Act 1991 during these periods.

Concerns Arising from File of Young Person in Care 7

- High number of placements, particularly short term placements.
- Six Social Workers during 10 years in care.
- Periods when no Social Worker was assigned to this young person.
- This young person was placed back with his family but there is no evidence on file to suggest that it was thought this move would be beneficial for him.
- Chaotic files.
- No individual file for this young person. Material included in the family file and there is little emphasis on this young person.
- No thorough assessment or care plan on file for this young person.
- No admission medical on his reception into care.
- This young person was in the care of the HSE but living at home. The family were not constructively engaging with the HSE.

Note: Critical Incident Report

A critical incident report was carried out by the HSE in response to the death of this young person. The undated report was carried out by a HSE Manager. The report was based on a review of written case material, telephone conversation and face to face discussions where necessary. It is a very brief report and does not for example detail who was interviewed or why.

This report was not written with a view to publication. It found that this young person was discharged home while still on a full care order. It is recommended that a child who is the subject of an ongoing full care order should not be discharged home.

2.2.8 Young Person in Care 8

Young Person in Care 8 died in 2009, aged 16 years old. The ICDRG was advised by the Coroner's office as to the cause of death.

Summary of Care Circumstances

This young person was known to the HSE from a very early age after his mother died of a drug overdose. He suffered from severe neglect as a child and toddler. He was found at one stage trying to eat fish fingers from the freezer. When his mother died, he was discovered with her body. At that time, his father was serving a long term prison sentence overseas. Following the death of his mother, he was raised by his extended family. His aunt and uncle cared for him for 9 years. The placement broke down when his father was released from prison. He engaged with and attended the Child and Adolescent Mental Health Services (CAMHS) regarding behaviour management issues for 4 years prior to being received into the care of the HSE.

He was received into voluntary care at the age of 13 under Section 4 of the Child Care Act, 1991. This was precipitated by an escalation in his behavioural issues whereby he assaulted staff and students at his school. This young person was initially placed in a number of short term accommodation facilities. Unfortunately, his poor behaviour continued to escalate and 3 months after being received into care a Special Care Order was granted under Section 23B of the Child Care Act, 1991.[12] This order appears to have been obtained as an emergency following his

[12] Section 23A (as inserted into the Child Care Act, 1991 by Section 16 of the Children Act, 2001) provides

exclusion from a hostel he was placed in, because of criminal damage to the hostel. No family welfare conference was convened prior to this application, as required under Section 23A (2) (a). There is no evidence on the files supplied that the Special Residential Services Board was consulted about this application. Following this successful application, this young person spent 20 months in a special care unit.

While residing in the special care unit, this young person was assessed and diagnosed with a severe form of ADHD. He was prescribed medication for this condition which was regularly reviewed. He absconded from this unit on a number of occasions and during his placement in the unit, he was charged with a number of offences. From the records supplied to the ICDRG it appears that he was also involved in a gambling incident with a staff member in the secure unit whereby he won a significant amount of money.

Following his stay in the secure unit, this young person was discharged to reside with his father. An extensive system of supports was put in place to facilitate this. While this placement was stable for 6 months, it finally broke down and the young person was then dealt with by the Crisis Intervention Service (Out of Hours service). He was 15 years of age at his stage. He was placed in a number of homeless shelters. While he returned to reside with his father for a further period, this did not last and again he resorted to the Crisis Intervention Services.

During this period it is recorded that the young person became more and more involved with crime and was engaging in drug use. He was questioned by the Gardaí regarding offences of handling stolen property, assault, robbery, stealing cars and the possession of illegal drugs. This young person was remanded to a children's detention centre. On admission to the Centre he tested positive for drugs. He was then placed in a long term residential care facility but regularly absconded and broke the conditions of his bail on many occasions. He had been 3 years in the care of the HSE at the time of his death.

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that it is the duty of the HSE to apply to the court for a special care order under Section 23B (or an interim special care order under Section 23C) where it appears to the HSE that a child requires special care or protection which he or she is unlikely to receive unless the court makes such an order. The court can grant the order under Section 23B where it is satisfied that the behaviour of the child is such that it poses a substantial risk to his or her health, safety, development or welfare and that the child requires special care or protection which he or she is unlikely to receive unless the court makes the order.

This young person had one consistent Social Worker throughout his time in care. The Social Worker appeared to have built an extremely good relationship with him and worked very hard to try and help him. There was also very good care given to the young person by his aunt and uncle who cared for him for 9 years. The placement broke down when his father was released from prison. The young person's family continued to visit him in all his placements but they were unable to manage his behaviour.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 8

- HSE Social Work Department;
- Special Care Unit; and
- Gardaí.

Good Practice Observed on File of Young Person in Care 8

- Work of the Social Worker was excellent.
- Clear evidence of good casework.
- Good supervision.
- Good planning for this young person.
- There is evidence of excellent co-operation between the Gardaí and the HSE.

Concerns Arising from File of Young Person in Care 8

- There was a failure to diagnose the young person's ADHD early on, which condition caused him confusion and difficulty in processing information
- Following his diagnosis with ADHD, there was a lack of an appropriate therapeutic placement
- There is a need for joint HSE and Criminal Justice and CAMHS approach to young people who are of such high risk

Note: Critical Incident Report

A critical incident report in respect of this case was completed by the HSE. This report is based on a social work report and on an end of placement report from his last placement. It was completed in March 2010. It found that the social work staff and residential care staff had worked very hard to help this young person and that his family had supported that work. He was well liked in his placements. It noted that his early years had significantly affected him and that there was a need for joint HSE and Criminal Justice approach to young people who are of such high risk. The Report concluded that despite attempts to assist him during his years with his extended family, his ADHD was not diagnosed and this coupled with the tragedy he suffered in his early life resulted in this young person having a very difficult life. The terms of reference did not include publication.

2.2.9 Young Person in Care 9

Young Person in Care 9 died in 2007, aged 16 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person first came to the attention of the HSE when he was 8 years old following allegations of neglect. From the records furnished to the ICDRG it appears that the father of this young person had a significant dependency on alcohol and this may have contributed to the neglect of the children. Neighbours provided care for the young person for some time and after almost two years he was received into the care of the HSE under Section 4 of the Child Care Act, 1991. There is no reception into care form on file provided to the ICDRG. This young person had three foster care placements following his reception into care. His final placement was made when he was 13 years old and he remained there until his death in 2007. This placement appears to have met his needs very well and he was very settled there. He is described as having been a very confident and well adjusted young person who enjoyed sport.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 9

- Education; and
- HSE Social Work Department.

Good Practice Observed on File of Young Person in Care 9

- The two year period when a Social Worker was allocated to the case shows evidence of good social practice and engagement with this young person.

Concerns Arising from File of Young Person in Care 9

- There is no admission to care form for this young person.
- There is no evidence that the young person had a medical examination prior to placement with foster carer.
- This young person had no allocated Social Worker for 5 years prior to his death. The requirements of the Child Care Regulations were not adhered to. The file records that this was highlighted with Senior Management in the area at the time.
- Statutory Reviews were not completed in accordance with the regulations.
- On two occasions, once in 2003 and once in 2006, workers who were not known to the young person visited to complete a care plan for this young person and to carry out care reviews. In total this young person had four care reviews completed during his seven years in care.
- There are very scant records on file for the 5 years prior to his death. During this time his placement changed but there is no record to show any work undertaken at that time.
- A summary completed for the purpose of this review and provided to the Local Health Manager in respect of these files indicates that "during this period of time due to the pressures on staff and managers… recording of all contacts with clients were not routinely undertaken". This is not acceptable practice in respect of children who are in the care of the State.

2.2.10 Young Person in Care 10

Young Person in Care 10 died in 2000, aged 16 years old. This death was registered on foot of Coroner's certificate.

Summary of Care Circumstances

This young person was referred to the HSE by his parents as they were concerned that they could not control him and he was a danger to himself and to others. He was involved with criminal activity at this age and was out of school but it does not appear that there were any referrals from the Gardaí or his school to the HSE. Two relatives had expressed their concern for him.

Following the referral, a child psychologist, a counsellor and a Social Worker engaged and worked with him at home. After a family meeting, it was decided that this young person should be received into care. Initially, he was placed in a short term facility and then subsequently moved to a long term placement.

During this time in care, this young person continued to use drugs and his behaviour became very difficult. He was remanded in detention for a failure to comply with bail conditions. During this period, the HSE was unable to source a foster family for him. He continued, however, to have family therapy sessions and addiction counselling and these supports appeared to be having some success in the short term.

The young person went on a planned home leave from his placement. He was aware that he would likely be returned to custody as a result of further breaching his bail conditions.

It does not appear that a HSE review was carried out into the circumstances surrounding this young person's death. However there is evidence on the file of a debriefing session with staff from the residential centre.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 10

- HSE Social Work Department;
- Family Therapy sessions;
- Addiction counselling services; and
- Gardaí.

Good Practice Observed on File of Young Person in Care 10

- One Social Worker during this young person's time in care.
- Care plan on file.
- Reviews of this young person's care were held.

Concerns Arising from File of Young Person in Care 10

- No birth certificate on file.
- No admission medical on file.
- File contains only very basic information.
- No family history contained in the file so it is difficult to ascertain when problems first began with this young person.
- No documented review into this young person's death was carried out - this could have contributed to learning for the management of other similar cases.

2.2.11 Young Person in Care 11

Young Person in Care 11 died in 2003, aged 16 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person had a difficult early life with concerns being expressed about the parenting he was receiving from a very early age. During the early years of his life it appears that he moved between his parent and a much older relative. He first came into care just prior to his fourth birthday due to allegations of physical abuse. Later he was returned to this older relative.

The allegations of abuse continued and for a period of time, this young person resided between his parent who had moved to live abroad and this relative in Ireland. In addition to allegations of physical abuse, this young person was often left alone by his relative. The relative also abused alcohol, something which the young person witnessed. When he was admitted to care on a Fit Person Order at 5 years old, this young person was demonstrating substantial evidence of poor attachment and lack of any consistent parenting. It was clear that his experiences to date had had a significant impact on him. He was subsequently made the subject of a Full Care Order under Section 18 of the Child Care Act, 1991. Evidence of sexualised behaviour on his admission to care does not appear to have been fully assessed.

During his 11 years in care, this young person had 8 different placements including a period in a place of detention for young males age 16 -21 years. One placement in particular had a positive effect on this young person. He remained with a foster family for 8 years. However this placement ended during his teenage years despite the efforts of all concerned to maintain it. The foster family maintained contact with him and continued to be supportive of him. The young person carried a lot of anger regarding the treatment he suffered in his early years.

Following his move from this foster family, this young person's life was very unsettled and he had multiple placements including a stay in a boarding school. He also had a number of stays in supported lodgings and bed and breakfast accommodation as the HSE was unable to find a suitable residential placement for him. Attempts were made through counselling to get this young person to engage with therapy to help him deal with his past experiences. However these were not successful and the lack of trust he had in adults was noted.

From the records provided to the ICDRG it appears that during this period, this young person had also come to the attention of the Gardaí due to involvement in shop lifting, his excessive drinking and his failure to attend school. He was 15 years old at this time. Following his involvement in a road traffic accident, a residential placement was found for him. This placement was judged to meet his needs as they had experience of working with adolescents with challenging behaviour. Unfortunately, it was very close to the area where he had been

drinking and abusing drugs and close to the peer group with which he was pursuing these activities.

While in this residential placement, a care plan was developed, a full assessment of his needs was carried out and reviews were held. Initially this young person settled in this placement. However he subsequently became increasingly volatile and began engaging in more serious criminal behaviour, while increasing his abuse of alcohol and solvents.

In the last year of his life this young person appeared in the Children's Court under Section 4 of the Criminal Justice Act, 1994[13] and under Section 6 of the Criminal Justice Act, 1994.[14] The charges were for breach of the peace, danger to self and others, theft, substance abuse and criminal damage. Following his refusal to obey the requirements of the Court he was remanded to a children's detention centre for 2 weeks. On his release his non-compliance with Court orders continued and he was further remanded to a children's detention centre. He then settled down and attended at an education and training programme for a short period. Unfortunately, the death of a close friend which he witnessed had a profound effect on him and led to his remand to a place of detention for young males 16 – 21 years, for a week.

He subsequently returned to his residential placement and had another period of compliance with the authorities and he commenced work with an addiction counsellor. However, he resumed his association with a peer group that was involved in criminal activities and in alcohol and substance misuse. He was involved in a serious incident of theft. He was again remanded to a place of detention. On his discharge he had less structure to his day. He appears to have been abusing alcohol and a variety of other substances including solvents and cannabis.

It is recorded that in the last two months of his life he had withdrawn from the adults in his life. He was absenting himself from the placement for most of the day. It appears from the files

[13] Section 4 of the Criminal Justice Act, 1994 provides that where a person has been sentenced or otherwise dealt with by a Court in respect of one or more drug trafficking offences of which he has been convicted on indictment, the DPP may make an application to the court to determine whether the person convicted has benefited from drug trafficking.

[14] Where a confiscation order has been made under section 4 of the Criminal Justice Act ,1994, section 6 allows the Court to assess the amount to be confiscated on the basis of the value of the defendant's proceeds from drug trafficking.

reviewed by the ICDRG that while staff suspected he was still drinking and using drugs, the plan to move him towards independent living continued. The meeting where this plan was confirmed does not appear to have discussed his drug use or long periods of absence from the residential care placement.

On the day he died this young person spent most of the day at the residential unit. He left the unit in the evening to sign on at the local Garda station. Approximately a half hour later a young person ran into the residential care unit to say he had collapsed in an apartment across the road. A staff member attempted to resuscitate him while the emergency services made their way to the scene. He was taken to the local hospital and his family was contacted. He was pronounced dead some short time after his arrival at the hospital.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 11

- Addiction Counselling Services;
- HSE Social Work Department;
- NGO Service (in his younger years);
- Psychology services;
- General Practitioner;
- Gardaí;
- Probation Services;
- Residential Services;
- Education and Training Programme; and
- Courts and Prison Services.

Good Practice Observed on File of Young Person in Care 11

- Files were well organised and presented.

Concerns Arising from File of Young Person in Care 11

- Initial placement with relative who had allegedly physically abused him.
- Failure to investigate sexualised behaviour upon his receipt into care.
- High number of placements.
- Seven different Social Workers during his time in care.
- Plan to place this young person towards independent living despite concerns regarding his addictions.
- Failure to discuss his addictions or absences from the residential unit when considering his move towards independent living.
- Management of this young person through the Criminal Justice System meant that a child welfare perspective was diluted at time of significant concern for his welfare.
- Unclear whether the recommendations which came from the review carried out in 2004 have been implemented.
- While there was a care plan completed for Child in Care 11, it was sparse, unsigned and undated.
- The Court does not appear to have been informed of the death of this young person.

Note: Internal HSE Review

An internal review was held by the HSE on all aspects of his care in 2004. The Review team interviewed key people in his life (some interviews appear to have occurred by telephone), staff in his placement and social work staff. The review team used the format of an "appraisal type review". The review did not have the benefit of any standard format being available to the review team. The review concluded that the decision to manage this young person through the Criminal Justice System meant that a child welfare perspective was diluted. The review team found that in the seven months leading up to his death no case conference or strategy meeting was held on this young person, child protection concerns were not reported, his placement was not reconsidered in light of known and developing risks and no Family Welfare Conference was held to consider other solutions within the extended family. The escalating risks were not referred to the HSE monitoring officer for the area. Another key finding was that this case was discussed at meetings of the Child Care Residential Services Management Committee but that the purpose of those discussions was unclear and crucially there was no record to show that ongoing risk and a placement review was discussed.

Seventeen recommendations in total were made but it is not clear from the file furnished to the ICDRG if the learning from this case has been disseminated or if the recommendations have been implemented in this or other HSE areas. This review was not carried out with a view to publication.

Section 3: Young Persons aged 17 Years: 6 Young People

This section covers the cases of six young people who died of unnatural causes while in the care of the HSE.

Age at time of death

- The six young people were all 17 years old at the time of death.

Placement at Time of Death

- 1 young person was in a residential placement at the time of death;
- 1 young person was placed with foster parents at the time of death;
- 1 young person appeared to be moving between home and the Out of Hours Service at the time of death;
- 1 young person was staying in lodgings with agency staff at the time of death;
- 1 young person was not in placement at the time of his death and died in a house used as a squat by homeless people; and
- 1 young person is thought to have been staying with a parent at the time of death.

Length of Time in Care

- 2 young people had been in care for 1 year or less;
- 1 young person had been in care for 2 years;
- 1 young person had initially been taken into care at the age of four but placed back with the family. This young person was back in care for a number of months prior to his death;
- 1 young person had been in care sporadically over his life; and
- 1 young person had been in care for 7 years.

Length of Time Known to HSE

- 1 young person in care was known to the HSE for 1 year;
- 1 young person in care was known to the HSE for 4 years;
- 2 young people in care were known to the HSE for 3 years; and
- 2 young people in care were known to the HSE for 17 years.

HSE Region

- 1 young person in care was in the care of HSE West Region;
- 1 young person in care was in the care of HSE South Region;
- 2 young people in care were in the care of HSE Dublin Mid-Leinster Region; and
- 2 young people in care were in the care of HSE Dublin North East Region.

Year of Death

- 1 young person in care died in 2002;
- 1 young person in care died in 2005;
- 3 young people in care died in 2009; and
- 1 young person in care died in 2010.

Gender

- 5 young people were male.
- 1 young person was female.

Individual Case Analysis

2.2.12 Young Person in Care 12

Young person in Care 12 died in 2002, aged 17 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was referred to the HSE following absence from school for two years and self-harming behaviour and substance abuse. The Social Work Department engaged with her and

her family. She was eventually received into voluntary care under Section 4 of the Child Care Act, 1991.

Despite only being in the care of the HSE for 2 years prior to her death, she had 16 different placements including foster care, residential accommodation, drug and alcohol treatment placements and a short period in a special care unit. At the time this young person died, she was in a residential placement and had been settled there and showing signs of responding to the services engaged for her. She had been out on an organised visit and was returning to the residential unit when the accident occurred.

It is not clear why this young person was not referred to HSE at a much earlier point. She was 2 years out of school, was self-harming and involved in self destructive behaviour at the point of referral.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person in Care 12

- Addiction Counselling;
- Child and Adolescent Psychiatric Services;
- Juvenile Liaison Officer;
- Probation Service;
- Residential Unit; and
- Special Care Unit.

Good Practice Observed on File of Young Person in Care 12

- Well organised file.
- Good quality reports on file.
- Reviews and care plans were completed and adopted to this young person's needs.
- The services offered were appropriate to this young person's situation.
- The Social Work Department offered exemplary and consistent care.

Concerns Arising from File of Young Person in Care 12

- It is difficult to understand why this young person was not referred to the HSE at an earlier date given the fact that she was out of school for two years at the time of referral and engaged in self-harming and self-destructive behaviour.
- There should have been a referral made to CAMHS at a much earlier point.
- It must be queried why it took the HSE so long to bring the application to have this young person placed in special care.
- It does not appear that the Court was informed of the death of this young person.
- There does not appear to have been a review of the death of this young person.

2.2.13 Young Person in Care 13

Young person in Care 13 died in 2009. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was in the care of the HSE for 13 months. He had arrived in Ireland from the Middle East and was received into voluntary care under Section 4 of the Child Care Act, 1991 as a separated young person. Upon being received into care, he was placed in a hostel which held other separated young people and he stayed there for 7 months and was then placed with a foster family.

From his admission he presented as very distressed, isolated and vulnerable. At his admission, a medical doctor reported the young person was presenting with signs of post traumatic stress disorder. A psychological assessment was carried out on him and it was concluded he would be at risk of further self-harming if he remained in the hostel. It appears from the records that he had made two serious attempts at suicide during his time in the hostel and was seen in an Accident and Emergency Department. He was not admitted and his suicide attempt was described as an impulsive act. It was advised that he be linked with the local psychiatric service. The Social Worker with responsibility for this young person recorded that "it was the opinion of the author that a comprehensive psychiatric assessment was not conducted prior to his discharge (from this hospital)". He was seen by the Community Psychiatric service and was

moved to a fostering placement with experienced foster carers who worked with a private fostering agency where he remained for six months until his death. There were other foster children already in the family as well as the foster family's own children.

When he was initially placed with the foster family he appeared to thrive in this placement, but his foster carers reported that he was in a very low mood, distressed and was not eating or sleeping properly. He left a note saying goodbye on one occasion and left the foster home. The family searched for him and found that he had tried to walk out in front of passing traffic. The next day he attended at hospital for a psychiatric assessment. He was deemed to be at high risk of attempting suicide and he was hospitalised for four days.

At a strategy meeting held prior to his discharge from hospital, it was recognised that his suicide attempts were quite real and community care support was provided. It is not clear from the record if his foster carers attended that meeting or if they were aware of the previous suicide attempts by this young person. The report from the hospital stated that he did not present with a mental illness but that his attempted suicide was quite real. At the meeting the young person agreed not to self-harm.

A few days later this young person was seen by a Social Worker who recorded he was withdrawn and had lost weight. Two weeks later the foster carer left a message for the Social Worker to call them as soon as possible. It is recorded on the file provided to the ICDRG that the Social Worker texted that he would call back the next day when he was on duty. When he turned his phone on the next day a message was left to advise him that the young person was dead.
Cousins of the young person were identified in Ireland and the family were involved in planning for the repatriation of his body for burial.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person in Care 13

- HSE Separated Children's Team;
- Hostel for Separated Children;
- Referred to NGO befriending Service;
- HSE Psychological Services;
- Private Fostering Agency;
- General Hospitals;
- VEC Educational Services; and
- NGO (Family Tracing).

Good Practice Observed on File of Young Person in Care 13

- File is generally well organised although it is sparse and reports are not always signed and dated.
- Good support and service was provided by the Separated Children's Team and by HSE Psychologist.

Concerns Arising from File of Young Person in Care 13

- Seven month stay in a hostel despite recognised distress.
- Lack of a care plan until the young person had already spent many months in care.
- More attention should have been given to suicide attempts prior to his foster placement.
- It is not clear if the implications of placing this very vulnerable young person in a foster family with other children and young people were considered prior to his going to live there.
- Unclear from records if foster family was aware of suicide attempts before placement.
- A full psychiatric assessment may have been completed following his initial suicide attempts. However, there is no record on the files furnished to the ICDRG of such an assessment.
- Failure to ensure that there was professional support available to him and his carers when needed.

Note: Case Management Review

A HSE case management review in accordance with Section 8.25.1 of *Children First Guidelines* was undertaken. The review considered the files of the HSE, interviewed many HSE personnel involved in his care, the foster carers with whom he was placed and a number of other professionals. The review was a detailed one and makes a number of recommendations including the need for an integrated approach to developing criteria and guidance for making more accurate age assessments and that those criteria should be agreed between the Office of the Refugee Applications Commissioner (ORAC) and the HSE. Concern was expressed in the case review that this young person was in fact an adult. The report was not produced with a view to publication. It does contain some key recommendations and the HSE should ensure it informs practice in the care of separated young people.

2.2.14 Young Person in Care 14

Young person in Care 14 died in 2009, aged 17 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person grew up in a large family and the conditions of the family were described in the Social Worker record as chaotic and neglectful. Serious levels of aggression and violence existed in the home combined with alcohol abuse, drug abuse and psychiatric illness. The family were known to the HSE for 15 years prior to the death of this young person.

This young person was initially taken into care at the age of 4 because of neglect and a lack of supervision. However, this initial period of care only lasted 14 months at which time he was returned home. Upon his return home, a number of services began working with the family including a family support worker. This service remains in place offering support to the family. A number of agencies external to the HSE were also involved with the family at various times. There is, however, little recorded evidence of positive change in the family circumstances over the years.

Approximately eight months prior to the death of this young person, after a visit to the house, the Family Centre contacted the HSE to report a serious violent altercation in the home involving him. The case was held on the duty social work system and remained unallocated for six months. This young person was again involved in a violent altercation in his home a few months later and was arrested and sent to a place of detention. Upon his release, he was given access to a residential placement through the Out-of-Hours service. At this point, he had not attended school for over a year. He stayed in this placement for 3 weeks during which time therapeutic work began with him and he was judged to be making good progress. He was described as being a "lovely young person".

During his time in this residential placement this young person was admitted to hospital following a serious drug overdose and on discharge was readmitted to his residential placement. He was then returned home although there is no record of why this decision was taken. It was not recorded in the care plan prepared 3 weeks previously. From his return home until his death 7 weeks later it is not clear precisely where this young person was living. He appeared to be moving between home and accommodation provided by the Out of Hours service.

At the time of his death, this young person was being assessed for a residential care placement. This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death. His family was supported by the HSE and other agencies.

Services Engaged for Young Person in Care 14

- HSE Social Work Department;
- NGO Family Centre;
- City Council;
- Education Welfare Board;
- Probation Services;
- Schools; and
- Hospital.

Good Practice Observed on File of Young Person in Care 14

- Family support worker's work is well recorded.

Concerns Arising from File of Young Person in Care 14

- From the records furnished to the ICDRG it appears that this young person's case was designated as a family support case rather than a child protection case despite clear evidence to the contrary. The reasons for this must be ascertained to ensure lessons can be learned from this young person's death.
- There was a complete lack of planning regarding this young person's care following his release from detention. It does not seem that there was any plan as to where he would go following his release.
- It appears that no review of this young person's death was carried out.
- There is no assessment recorded in the files of the family situation or the risks to this young person and/or the other children in the home despite the ongoing neglect, chaotic home circumstances and the drug and alcohol abuse which was occurring in the home.
- For the 15 years this family were known to the HSE, this case was largely dealt with by the duty system and there was no Social Worker allocated to the family except for a short period when the children were in care.
- At one point, an unqualified Social Worker was allocated to this case and while there is a record of this person informing management of events of concern within the family, there is no record of any follow up.
- No evidence of any professional supervision in this file.
- No birth certificate on file.
- Reviews in Residential Care are referred to in the file but there is no documentation on the reviews in the file.
- This entire case should be reviewed to ensure that lessons are learned both from the manner in which care was provided to this young person during his life and from his death.

2.2.15 Young Person in Care 15

Young person in care 15 died in 2010. The ICDRG has been informed that no inquest has yet been held in respect of the death of this young person.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person and his family were known to the HSE prior to his birth. They were living in very overcrowded conditions. When he was 4 years old his father died from a drug overdose. Despite ongoing concerns in relation to the alcohol abuse by the surviving parent and its effect on her ability to care for the children, the HSE closed this case when this young person was 6 years old. There is no written explanation of why this action was taken. In the 6 years the case was open to the HSE four Social Workers were allocated to this case.

Three years later two school principals and a NGO Social Worker raised serious concerns about the family which resulted in the reopening of the case. The case was referred to a Family Addiction and Support Social Work Team (FAST), although the concerns raised were child protection issues. A strategy meeting was held and it was decided to move the mother and children together to a family care placement. However it was another 8 months before the family placement was available. In those months a sibling of the young person was placed in a foster home due to concerns about her care.

The accommodation to which this young person's family was moved was unusual. Two families shared the accommodation and problems arose between them as detailed on the files furnished by the HSE. It is recorded that the young person's mother continued to experience serious substance addiction issues throughout this placement and eventually the HSE discontinued the family placement. It is further recorded that the HSE believed the young person's mother was being enabled to continue drinking without taking responsibility for her children. At the time, the children were in voluntary care under Section 4 of the Child Care Act 1991. Following the mother's removal from the placement, her drinking and substance abuse rapidly worsened. Around this time a Guardian ad Litem was appointed for the children.

A case conference, held when this child was 10 years old, decided a Full Care Order should be applied for in respect of all the children but more than two years elapsed before the order was finally made under Section 18 of the Child Care Act, 1991. This young person was then almost 13 years of age. A risk assessment was undertaken by a consultancy service shortly afterwards and non-verbal therapy, speech and language therapy and anger management sessions were recommended for this young person.

This young person's mother died when he was 15 and he was present, at his own request, for what is described as a very difficult situation.

This young person had 21 placements between the ages of 10 and 17 years old and 16 of these were in the last year of his life. Some of those placements had to be accessed through the Out of Hours services. One significant placement this young person had was with his extended family, as provided for by Section 36 of the Child Care Act, 1991.[15] It appears he had a strong connection with family members. This placement was supported by outreach support from a high support unit where he had a short placement and from which he absconded regularly. It appears that the support services for this placement were eventually withdrawn which resulted in the inevitable breakdown of the placement. He stopped attending school because no local school would admit him although he was on a waiting list to be admitted. Some home tuition was organised but this young person was effectively out of school.

An application was made by the HSE Social Work Department when he was 16 years old to admit this young person to a special care facility. This application was refused on the grounds that he did not meet the criteria. A Guardian ad Litem was again appointed who recommended that a placement abroad be considered but this was not agreed to. This case seems to have continued in the District Court. The failure to act on the recommendations of the report of the Guardian ad Litem is not explained in the documentation furnished to the ICDRG.

From the records furnished to the ICDRG it appears that the young person was moved by the HSE to a residential service that was not in fact registered by the HSE. After 4 months, the young

[15] Section 36 of the Child Care Act, 1991 provides that where a child is in the care of the HSE, the HSE shall provide care for him by, inter alia; placing the child with a relative if the HSE thinks it is proper to do so and this is in the best interests of the child.

person was moved again as this placement was terminated by the private provider due to his alleged drug taking and alleged involvement in criminal activity. From the available records it appears that the provider did not give any notice to the HSE of their decision to ask the young person to leave. Fifteen days later he went missing from a house where he was then living with agency staff and his body was not found until some months later.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Overview

This young person was presenting with difficult behaviour from his middle childhood years. He had experienced significant bereavement and loss during his childhood. He had severe dyslexia which does not appear to have been diagnosed until he was 15 years old. While he was anxious to read and write, there was the lack of a timely appropriate diagnosis and programme of treatment.

There are care plans on file that sought to address his needs but it is difficult to determine whether or not they were carried through. The failure to access an appropriate placement for him and the decision not to seek admission for him to a secure unit needs to be considered further. While many services were offered to this young person and his family, it is not clear that proper consideration was given to matching services with needs and with his ability to engage with them.

His intermittent placement within the extended family where he had a strong connection was not properly supported and indeed services appear to have been withdrawn, resulting in an inevitable placement breakdown. The ICDRG identifies that this is a significant shortcoming in the care provided to this young person and his family.

The files provided to the ICDRG were multiple family files with some records pertaining to previous generations of the family. Multiple records for each of the family children led to difficulty in reviewing this case.

There are long periods where no case files are recorded; case notes are largely unsigned so it is difficult to identify who wrote them. There is a lack of evidence of professional supervisory input and there is little management involvement recorded, except when the young person went missing and when resources sought by the Social Worker and or Guardian ad Litem were not being agreed to (i.e. placement in special care unit and placement overseas).

There were 12 different Social Workers involved in this case in a 7 year period. On some occasions, there were 2 or 3 Social Workers involved. There were also 2 occasions when no Social Worker was involved. At times, it is not clear which Social Worker was the lead worker with the family. There were 5 changes of Social Work personnel involved in this case in one period of just two years.

The Criminal Justice system was also involved in this case and the allocated Juvenile Liaison Officer was very much involved with him.

From the records furnished to the ICDRG it appears that a number of professionals tried to engage with this young person over his care trajectory. Despite that, there is evidence of the system profoundly failing this young person who was known to be at risk from early in his life and a full inquiry is necessary to learn the lessons and inform future practice.

Services Engaged for Young Person in Care 15

- HSE Social Work Department;
- Family Addiction and Support Services;
- Guardian Ad Litem;
- Gardaí; and
- Juvenile Liaison Officer.

Good Practice Observed on File of Young Person in Care 15

- Good involvement between the Juvenile Liaison Officer and this young person.
- Great concern shown by the Guardian ad Litem who tried to get appropriate services for this young person.

Concerns Arising from File of Young Person in Care 15

- The initial closure of this case when this young person was two without any written explanation provided on file is open to question, especially as it does not seem the circumstances of the family had improved since the HSE had first become involved.
- There was no adequate risk assessment or assessment of this young person's mental health.
- There was a large turnover of Social Workers involved in this case.
- There were some periods when there was no Social Worker at all assigned to this case.
- The initial placement of this young person's family in shared accommodation was unusual and appeared to cause problems.
- This young person had a very large number of placements.
- There was a failure to diagnose his dyslexia at an earlier point which resulted in a lack of treatment for this condition.
- The placement by the HSE of this young person with a private service that was not registered with the HSE must be queried and furthermore, the apparent decision of that private provider to terminate the accommodation without notification to the HSE must be considered.
- There appears to have been a lack of continuity in support services available to this young person, particularly in respect of his placement with his extended family which appears to have broken down due to withdrawal of such support.
- There was a failure to notice or address this young person's non-attendance at school.
- While the file shows care plans, it is unclear if these plans were followed.
- It is unclear whether the services offered to this young person and his family matched their needs.
- There are multiple records in the file for each of the children of this family which made the file difficult to review.
- There are large gaps of time in the records on file.
- The case notes in the file are largely unsigned.
- There is a lack of evidence that professional supervision was present in this case and it does not appear that management were involved to any great extent.
- A full review of this young person's care and his death should be carried out.

2.2.16 Young Person in Care 16

Young person in Care 16 died in 2009, aged 17 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from shortly after his birth. There were eleven referrals concerning domestic violence and the children being out of control. There were also a number of referrals from the Gardaí on neglect, risk to the children and non-school attendance before this young person was finally taken into care. He was then ten years old.

From the records furnished to the ICDRG it appears that by the time this young person was taken into care he had both witnessed and been subject to severe domestic violence. His parents also had psychiatric difficulties and drug and alcohol addictions which meant his basic care and parenting needs were not being met. In addition to this, he had very poor literacy skills.

From his reception into care under Section 4 of the Child Care Act, 1991 until his death, this young person had in excess of 25 placements including placements with foster families, relative care, residential care, a High Support Unit, three periods in special care and two placements abroad. He was also on remand in a place of detention and whilst there he attempted to harm himself.

A Children's Services Manager (UK), who knew this young person, commented that "this young person has experienced the care provision at its most punitive". He was moved through placements as they were judged not to be suitable for him or they found it impossible to cater for his needs. The Voluntary Care Order was converted to a full Care Order under Section 18 of the Child Care Act, 1991. It was not possible to locate these documents on the files supplied.

It is not clear from the files how many Social Workers had responsibility for this young person over his time in the care system. In his latter years in care he had one Social Worker on a continuous basis. Needs assessments were completed frequently and care plans drawn up. This young person had developed a serious addiction to drugs by then and he refused to engage in any care setting.

He began to abscond from placements and was alleged to have engaged in criminal activity over the last two years of his life. He was accommodated in supported lodgings, in private rented accommodation and latterly in a hotel from where he was evicted because of his behaviour. Many attempts were made to offer him addiction assessments and treatment.

This young person had no formal placement at the time of his death. This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person in Care 16

- HSE Social Work Department;
- Foster Care;
- Residential Care;
- High Support Unit;
- Special Care Unit;
- Offer of Addiction services;
- Gardaí; and
- Place of Detention for young males.

Good Practice Observed on File of Young Person in Care 16

- Needs assessments were frequently drawn up and care plans were prepared for this young person.
- One consistent Social Worker in this young person's latter years.

Concerns Arising from File of Young Person in Care 16

- This case was held on duty from 8 years when a long term area worker took up this case. This case needs to be reviewed to look at how and why this did not become a focused child protection case much earlier.
- There is no evidence of an adequate initial risk assessment or of early referral for a mental health assessment being considered.
- This young person had a large amount of placements.
- The file of this young person is incomplete with key documents missing.

Note: Serious Incidents Protocol Guidelines Report

A HSE review group set up after his death under Serious Incidents Protocol Guidelines concluded that serious consideration should be given to the development of a compulsory medically supervised detox programme for young people in life threatening situations. The review concluded that this young person had "received a comprehensive social work service" with assessments regularly carried out.

From 2008 onwards it states his reckless lifestyle thwarted the Social Work Department's responsibility to carry out its statutory responsibility. It highlighted the deficits in the provision of services for adolescents presenting with dual emotional/mental health issues. The Review also advocated an Out of Hours social work service for homeless young people. It is not clear if any of the recommendations were implemented.

2.2.17 Young Person in Care 17

Young person in Care 17 died in 2005, aged 17 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

When this young person was 14 years old the HSE was asked by the Court to prepare a Section 20 report related to a custody application which was before the Courts. There is no reference in that report to any issues of concern. There is reference to an earlier referral but the file covering that period was not made available to the ICDRG.

From information on a review report following this young person's death, it appears that when he was 12 years old a school and a family centre both reported concerns regarding this young person's welfare to the local HSE office. The file was closed because "the family could not be located".

This young person was next referred to the HSE by the Gardaí as he was out of home because of alleged physical violence by his family carer. He was accommodated through the Out of Hours emergency service for the following eight months under Section 5 of the Child Care Act, 1991.

The placements where this young person was accommodated were typically hostels and some residential care placements.

He very quickly became involved in crime and was excluded from some placements because of his behaviour. His case was transferred to a different HSE local office when the family moved there. A pattern of offending, alcohol misuse and emergency placements was established over a six month period. He was admitted to hospital on a number of occasions after using drugs.

Finally, when he was 15 years old a case conference recommended that the then criminal court process be adjourned to allow a risk assessment to be carried out. The young person absconded from the assessment unit shortly afterwards and for the next twelve months he was, for periods, on remand for offending, in an assessment unit, back in family care for short periods, and again on remand. His level of offending increased and he was abusing drugs and drinking heavily. In all he had spent 22 months out of home and accessing services through the Out-of - Hours service.

He was then finally placed in voluntary care under Section 4 of the Child Care Act, 1991. There are no admission medicals or birth certificate on file. On two occasions an outside agency was contracted to complete an assessment for this young person but he did not attend to finalise the assessment on either occasion.

A longer term placement was secured for him a few months later and subsequently a placement in a drug rehabilitation unit was organised. This young person was in the rehabilitation unit for a month and appeared to have been making progress but was discharged prematurely following an argument with another resident. It is recorded in a report on the file that when the Social Worker went to collect the young person from this centre, staff there had not informed him that he was being discharged. He returned to his long-term placement with plans to complete the drug treatment on a different basis but these plans were not followed through by him. At this time this young person and his partner were expecting a child and both were allocated Youth Advocate Workers to assist them in setting and reaching goals.

In the final few months of his life there was a marked deterioration in this young person's behaviour and the risk factors for him greatly increased. He had a number of admissions to hospital following drug overdoses; following one such incident he was seen by a psychiatrist whose opinion was that the overdose was accidental. He was drinking heavily again and was offered a further opportunity to attend a detoxification unit but did not attend the appointment. In the last few weeks of his life his lifestyle was entirely chaotic with incidents of violence, being placed on remand and then released on bail and on to the streets again.

At the time of his death, this young person was again out of his accommodation due to his use of illegal drugs. He was thought to be staying with his father. The evening prior to his death he told the Social Worker he was accompanying his partner to hospital as she was in labour. The Social Worker contacted the hospital and was advised they had not arrived there.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person in Care 17

- HSE Social Work Department;
- Child Care Services;
- Out of Hours Service;
- Gardaí;
- Psychiatric Services;
- Addiction Services; and
- 33 Services Engaged for this Young Person in all.

Good Practice Observed on File of Young Person in Care 17

- There is little evidence of good practice in this file.

Concerns Arising from File of Young Person in Care 17

- This young person's file is very disorganised making review difficult.

- There is no Care Plan drawn up.
- No child in care reviews as provided for under the Child Care Act, 1991 were carried out.
- No comprehensive risk assessment was completed in respect of this young person.
- There is no evidence of planning to meet the needs of this young person.
- Queries must be raised as to why an application to place this young person in secure care was never made.
- Queries must be raised regarding the manner in which the care system and the criminal justice system interact in this young person's case (and indeed, the manner in which these systems interact in general).
- Queries must be raised regarding the danger to this young person of being out of accommodation and on the street and whether this became a way of life to him (and again, the general risk of this happening to vulnerable young people).

Note: Report of Internal HSE review

An internal review was conducted by the HSE and the review team comprised two experienced HSE employees. The terms of reference were broadly:

- to review the care provided to this young person from the time he came into contact with the HSE and its predecessor;
- to review how the case was handled in the different parts of the health system;
- to make recommendations and
- to submit the review to the Local Health Manager.

The young person's files were reviewed and some HSE staff were interviewed. The review concluded that there was a lack of formal integrated case and care planning, a lack of singular assigned responsibility and a confusion of roles in relation to the care of this young person. It also identified inexcusable delays in providing essential services. The review concluded that there were tragic systemic failures in this case.

A number of graphs below show a breakdown of figures and percentages in relation to the unnatural deaths of children and young people in care.

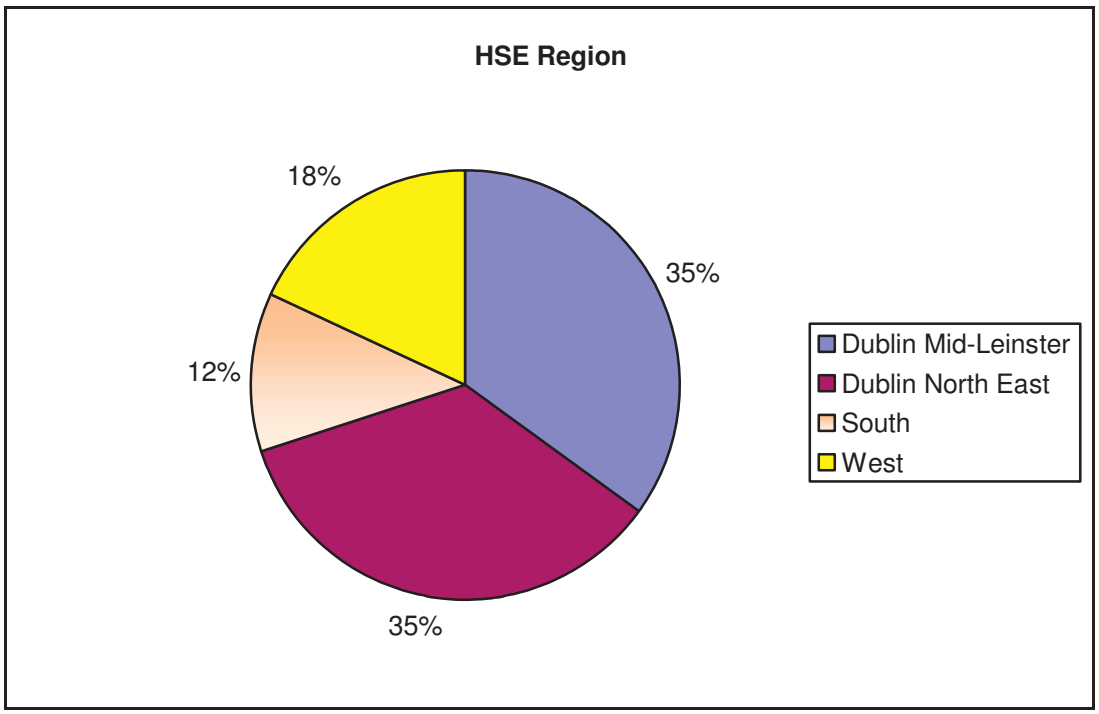


Fig. 1.2.1 – HSE Region (Non-Natural Deaths of Children and Young People in Care)

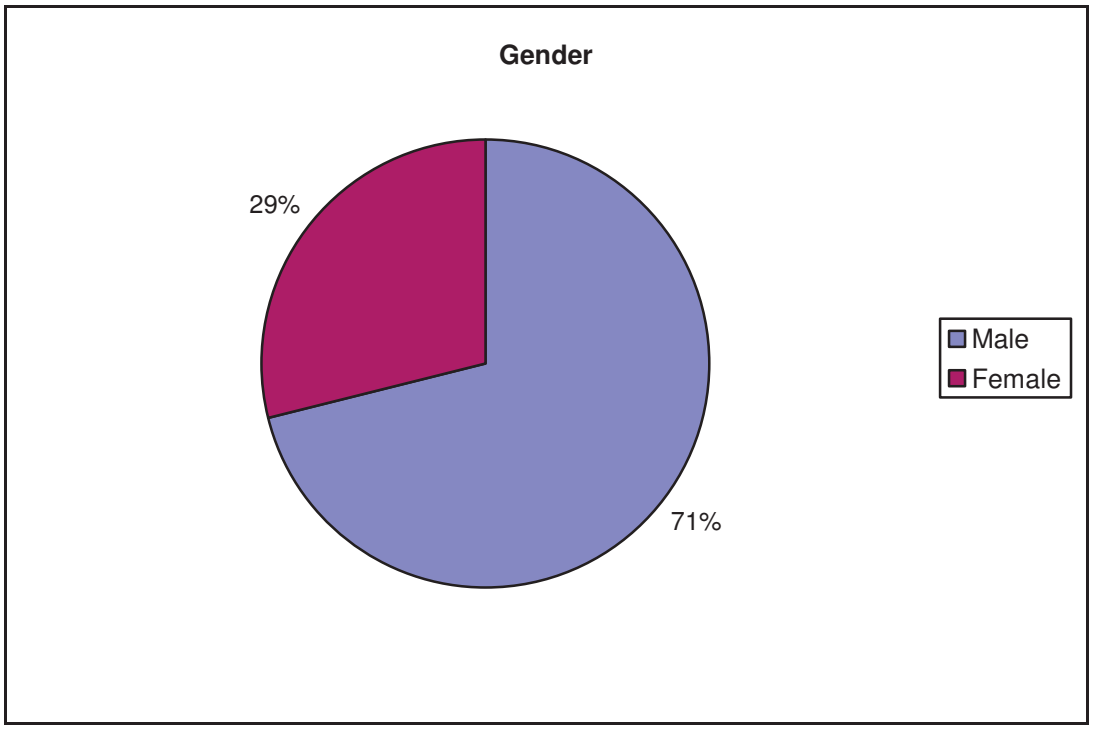


Fig. 1.2.2– Gender (Non-Natural Deaths of Children and Young People in Care)

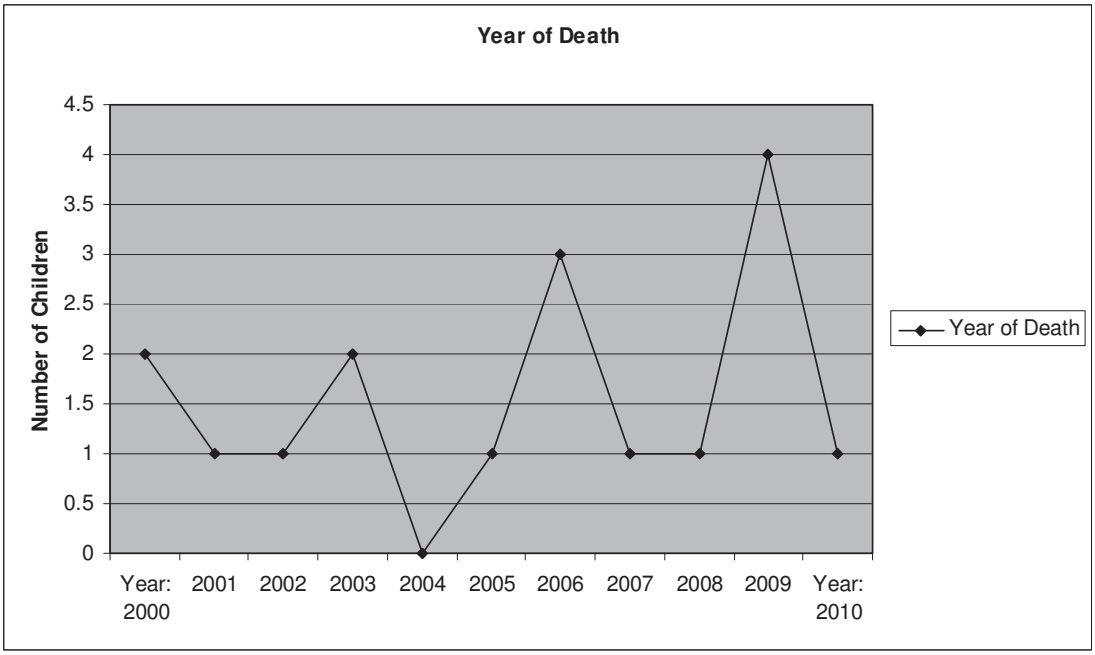


Fig. 1.2.3– Year of Death (Non-Natural Deaths of Children and Young People in Care)

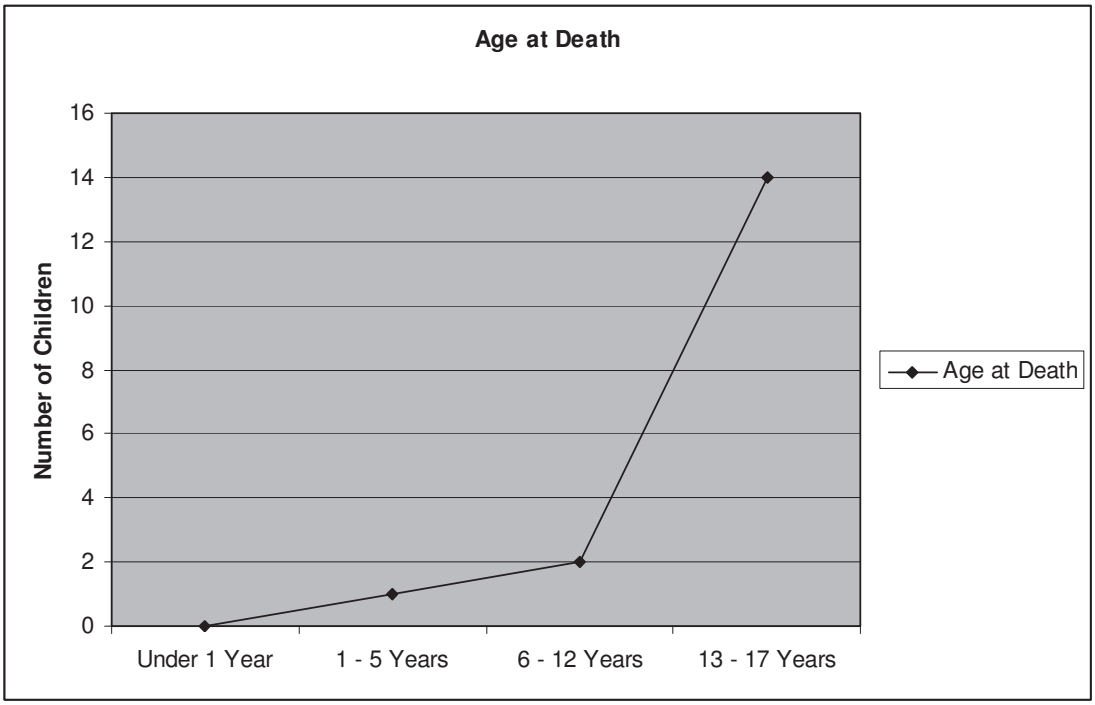


Fig. 1.2.4– Age at Death (Non-Natural Deaths of Children and Young People in Care)

PART 3: DEATHS OF CHILDREN IN CARE - SUMMARY OF GOOD PRACTICE

This section firstly summarises the good practice the ICDRG found in reviewing the files of 36 children and young people who were in the care of the HSE at the time of their death. It includes children and young people who died of natural causes.[16] The section then goes on to outline the concerns the review found in respect of the same files, again in summary fashion. The ICDRG has commented both in respect of good practice and in respect of concerns only where the feature is clearly evident i.e. where the good standard of practice is clearly evidenced and visible or, conversely, where there is a concern about files this can be taken to signify that the file is significantly lacking in information, in record keeping or in presentation. This means that if it is noted that the ICDRG observed, for example, good record keeping on a number of files; it is not implied the remaining files necessarily showed evidence of poor record keeping. Not every aspect of practice is commented on in relation to every file.

2.3.1 Good Assessments, Risk Identification and/or Planning in Place

When a child is referred to or comes into contact with the Social Services, a risk assessment should be carried out to ensure that the needs of the child are identified and that an appropriate care plan can be put in place. Such assessment, risk identification and/or planning was evident in 5 of the files provided to the ICDRG.

2.3.2 Care Plan in Place

In 9 of the files provided to the ICDRG on deaths of children in care, there was a Care Plan on file. The creation of a care plan is a very important marker to have in place when a child is in the care of the State. It is created after the needs of the child have been assessed and shows evidence of forward-planning for the child. The Care Plan is an essential document that must be created for every child in the care of the State.

2.3.3 Care Plan Followed and Reviewed or Planning Completed

Once a care plan is in place, it is appropriate that it should be followed and also reviewed at regular intervals to ensure that it is continuing to meet the needs of the child in care. In 7 of the

[16] These case summaries fall outside the terms of reference of this review.

files received by ICDRG, there was evidence that the care plan was followed and/or reviewed or that planning was completed in respect of the child in care.

2.3.4 Good/Consistent Care Provided by the Social Work Department

In 10 of the files provided to the ICDRG on deaths of children in care, there was evidence of good and/or consistent care provided to the child by the Social Work Department. The provision of good and consistent care to a child under the care of the HSE should be automatic and taken as a given. While it must be acknowledged that lack of resources impacts on this, inconsistency in practices across the various HSE regions and even within each region must be tackled. It is suggested that the placing of the *Children First Guidelines* on a statutory footing will go some way to ensuring a greater level of consistency.

2.3.5 Regulations Followed

Pursuant to the Child Care Act, 1991, regulations have been made to guarantee a consistent approach by the HSE to the care of children. The Regulations are also in place to ensure that the child gets the appropriate level of care. In 3 of the files received by the ICDRG, there was evidence that the Regulations had been followed.

2.3.6 Good Record Keeping

In 15 of the files provided to the ICDRG on deaths of children in care, there was a good standard of record keeping. It is essential that the files kept by the HSE in relation to children in their care are maintained to a high standard with all relevant information being recorded there.

2.3.7 Good Social Work Supervision/Support

It is essential that the provision of care to children by the HSE Social Work Departments be supervised and supported by Team Leaders to ensure that the appropriate level of care and support is being provided. In 8 of the files received by the ICDRG on deaths of children in care, there was evidence of supervision and/or support of social workers being carried out.

2.3.8 Good Foster Care

Where a child has been placed with foster carers, it is imperative that the child receives good care from his or her carers. The fact that the child has been removed from his or her parents

inevitably places the child in a more vulnerable position and the placement of the child with foster carers should be done to meet the child's needs and ensure that he or she feels safe, protected and cared for. In 3 of the files provided to the ICDRG on the deaths of children in care there was evidence of very good foster care provided to the child.

2.3.9 Support for Family/Foster Carers

The provision of support should not stop with the biological family of the deceased child. Where the child had been placed with a foster family or foster families, support should be provided to those carers to ensure that their needs are also addressed. The provision of such support is evident in 4 of the files provided to the ICDRG.

2.3.10 Good Interagency Cooperation

The provision of consistent care of a high standard to children in the care of the HSE requires that the Social Work Department and other bodies (such as the Gardaí, Child and Adolescent Mental Health Services, Public Health Nurses and voluntary agencies) cooperate. In 2 of the files supplied to the ICDRG on the death of children in care, there was evidence of such cooperation.

2.3.11 Appropriate Follow-Up after Child's Death

The HSE should ensure that, following the death of a child in care, an appropriate follow-up is completed including the provision of support to the bereaved family. The Court should also be made aware of the death of a child in care. In 5 of the files provided to the ICDRG, there is evidence of such a follow-up by the Social Work Department.

2.3.12 Review of death of child

In every case where a child in care dies, there should be a review of the child's death and the circumstances surrounding it by the HSE. The ICDRG are aware of 8 reviews of the death of a child in care and provide a comment on each review in this report. Additionally, another review is referred to but if completed it is not on the file, and 1 review is underway.

2.3.13 Miscellaneous

There is evidence of other instances of good practice in the files received by the ICDRG. For instance:

- Community Care staff organised a rota to be available to a child over the weekends as her illness became more severe.
- Timely specialist intervention was organised.
- There was good involvement between the Juvenile Liaison Officer working with the young person

2.2.14 Delays in Placing Child in Care or Full Care

Where a child is in circumstances which would warrant the child being taken into care, it is essential that the HSE move to do this speedily so as to protect the child. In 12 of the files reviewed by the ICDRG, there was a delay on the part of the HSE in taking the child into care or in seeking to place the child on a statutory care order from voluntary care. A number of cases were not pursued early enough or were not properly identified as child welfare and protection cases. There were some cases where there was a failure to follow up on cases after they had initially been assessed.

2.2.15 Failure to Create Care Plan

The creation of a care plan is a very important marker to have in place when a child is in the care of the HSE. It is created after the needs of the child have been assessed and shows evidence of forward-planning for the child. In 15 of the files provided to the ICDRG on deaths of children in care, there was no Care Plan on file. The Care Plan is an essential document that must be created for every child in the care of the HSE.

2.2.16 Consistency of Social Workers

In 11 of the files received by the ICDRG in relation to the deaths of children in care, there was evidence of difficulties relating to the consistency and appointment of Social Workers to the child's case. In some cases, the child had experienced a high turnover of Social Workers during his or her time in care. There were also some cases where no Social Worker had been assigned to the case at all. Both of these scenarios present their own problems. A high turnover of Social Workers means that no relationship is built up between the child and the representative of the body responsible for that child's care (HSE). Furthermore, high turnover can affect the consistency of approach experienced by the child. If no Social Worker is appointed, there is no individual responsible for ensuring the needs of the child in care are met.

2.2.17 Difficulties with Placements

In a high number of files (10) received by the ICDRG in relation to the deaths of children in care, there was evidence of difficulties with the placements for the child. Such difficulties included

poor placement choice, frequent moves and multiple placements. There are a number of reasons for this. Obviously the lack of suitable placements is an issue in some cases. However the failure to properly assess the child's needs and match them to a placement that would fulfil those needs is a matter which needs to be addressed. In some instances a failure to provide adequate support to family foster care placements resulted in a breakdown of that placement.

2.2.18 Lack of Critical Incident Report

When a serious incident occurs during a child's duration in care, it is essential that a critical incident report is carried out. This would obviously include but not be limited to the death of the child. There was no evidence of a critical incident report on 26 of the files received by the ICDRG.

2.3.19 Failure to refer to Appropriate Services

There was evidence in a number of files (5) received by the ICDRG of a failure to follow up on serious issues identified and/or a failure to refer the child to the appropriate services to deal with those issues. It is important that where a child is in need of specialist intervention that such assistance is identified and provided to the child to guarantee that his or her needs are being met.

2.2.20 Poor Record Keeping

It is essential that the files kept by the HSE in relation to children in their care are maintained to a high standard with all relevant information being recorded there. In 15 of the files provided to the ICDRG on children and young people who died while in care, there was evidence of a poor standard of record keeping including incomplete records, failure to record the death of the child on the file and a failure to provide a closing summary. In 2 of the cases reviewed by the ICDRG, there was no individual file for the child and only the family file was received. It is essential that the files kept by the HSE in relation to children in their care are maintained to a high standard with all relevant information being recorded there. In addition, on 7 of the files there was no birth certificate available.

2.2.21 Poor Procedural Practice

It is important that proper procedures be followed when a child is taken into or received into care. On 9 of the files received by the ICDRG in relation to this group, there was no evidence that a medical examination had been carried out on the child. In 7 of the files received by the ICDRG, there was no evidence on the file that the Court had been informed of the death of the child. It is good practice that the Court is informed of the death of any child in care who is subject to a statutory order. In the recent decision of Birmingham J. in Health *Service Executive v. McAnaspie*, whilst the Court ruled that a child who died whilst in the care of the HSE is no longer a child within the meaning of the Child Care Act 1991, it stated at paragraph 11:

> "This does not mean that the HSE should not bring the death of a child who was the subject of a care order back into court. On the contrary, good practice would certainly require that this should happen. There are many reasons why this is so, not least the fact that a child in care is in the ultimate care of the District Court."

2.2.22 Lack of Professional Support and/or Supervision

It is essential that the provision of care to children by the HSE Social Work Departments be supervised and supported by Team Leaders to ensure that the appropriate level of care and support is being provided. In 12 of the files received by the ICDRG on the deaths of children in care, there was no evidence of supervision and/or support of social workers being carried out.

2.2.23 Failure to Review Death

In every case where a child in care dies, there should be a review of the child's death and the circumstances surrounding it. Such a process is essential to ensure that where there are lessons to be learned they are identified and changes are made to the procedures and practices followed by the HSE. In relation to 26 deaths of children in care, there was no evidence of a review of the death of the child or of the care that child received prior to his or her death.

2.2.24 Miscellaneous

In addition to the general concerns above, there were a number of miscellaneous issues which were evident in the files received by the ICDRG in relation to the natural deaths of children in care:

- Social Workers in the hospital or the community did not know that a child from a marital family could not be placed for adoption except in exceptional circumstances.
- Difficulties in recognising and dealing with the impact of cultural issues in relation to child care.
- Issues relating to consent to medical treatment for the child and the receipt of medical treatment by the child.
- Failure to convene a Family Welfare Conference as the waiting list was too long.
- Poor interaction between the Social Workers and the birth family of children where the child has been placed outside of the family.
- Complete and total disregard for the Fostering Regulations.
- Failure to carry out educational checks in relation to the progress of the child at school and failure to follow up on concerns of the monitoring officer in relation to the suitability of a placement for a child.
- Lack of relationship between the child in need and a member of the HSE.
- Lack of communication between agencies.
- Lack of communication and discussion with the child regarding their illness.
- A number of cases were not pursued early enough or were not properly identified as child protection cases. There were some cases where there was a failure to follow up on cases after they had initially been assessed.
- There was evidence in some files of a failure of other services to refer cases on to the HSE, particularly in cases where young people had been absent from school for long periods of time.
- In some cases, there was a failure to investigate or follow up on serious issues emerging for young people i.e. sexualised behaviour, dangers of life in homelessness.

CHAPTER 3: YOUNG PEOPLE IN THE AFTERCARE OF THE HSE

PART 1: YOUNG PEOPLE IN AFTERCARE – NATURAL DEATHS

Overview

The ICDRG received and reviewed the child and family records for 5 young people who were determined to have died of natural causes after being in the care of the HSE between 2000 and 2010. While the Terms of Reference preclude the ICDRG from publishing case summaries in this category it was necessary to review the files to determine the cause of death. This review, however, provided a rich seam of information and this is reflected in the higher level learning in Part 3 of this chapter.

At the end of Chapter 3: Part 1, a number of graphs show a breakdown of figures and percentages in relation to the natural deaths of young people in aftercare.

Age at Time of Death

- Three young people were aged 18 at time of death; and
- Two young people were aged 21 at time of death.

Length of Time in Care

- One young person was in care for 9 years;
- One young person was in care for 14 years;
- One young person was in care for 15 years; and
- Two young people were in care for 18 years.

Length of Time Known to the HSE

- One young person was known to the HSE for 11 years.
- One young person was known to the HSE for 18 years.
- One young person was known to the HSE for 18 years.
- One young person was known to the HSE for 17 years.
- One young person was known to the HSE for 20 years.

HSE Region

- Three young people were in the care of HSE Dublin North East.
- One young person was in the care of HSE West.
- One young person was in the care of HSE South.

Year of Death

- One young person died in 2002.
- One young person died in 2005.
- Two young people died in 2009.
- One young person died in 2010.

Gender

- Three young people were male.
- Two young people were female.

A number of graphs below show a breakdown of figures and percentages in relation to the natural deaths of young people in aftercare.

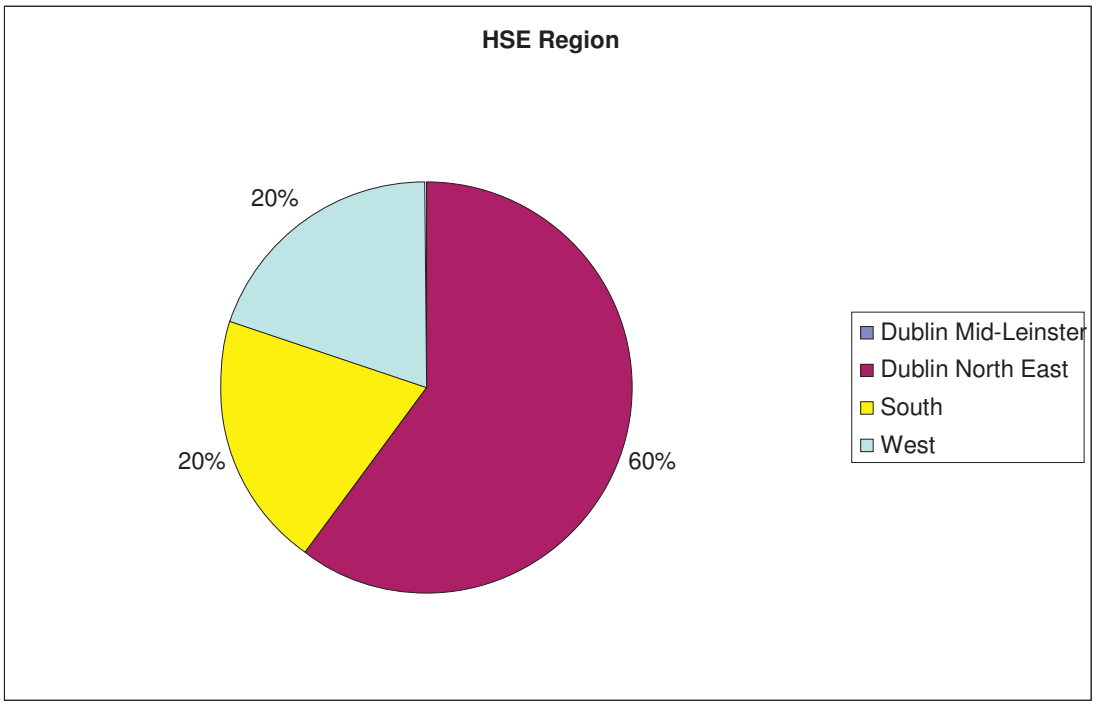


Fig. 2.1.1 – HSE Region (Natural Deaths of Young People in Aftercare)

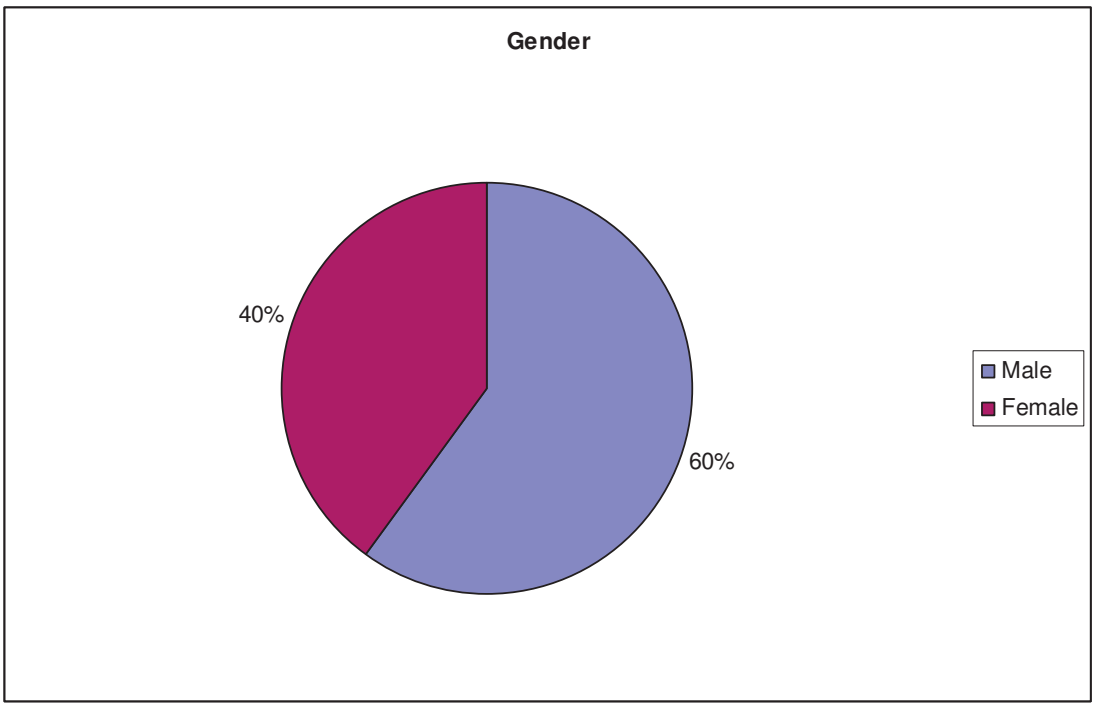


Fig. 2.1.2 – Gender (Natural Deaths of Young People in Aftercare)

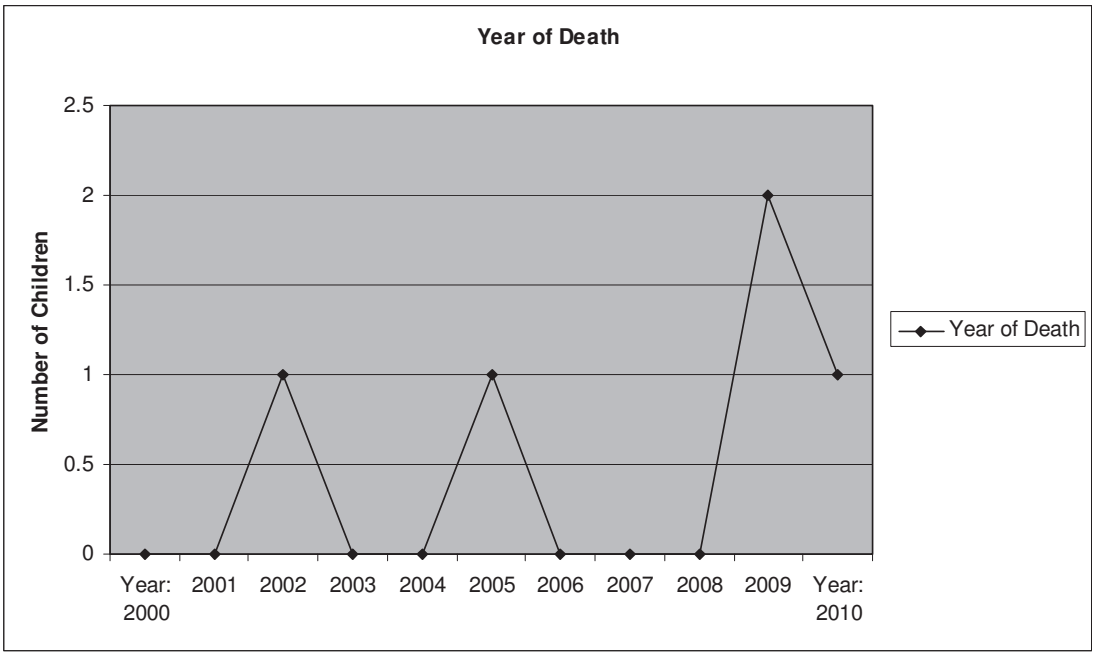


Fig. 2.1.3 – Year of Death (Natural Deaths of Young People in Aftercare)

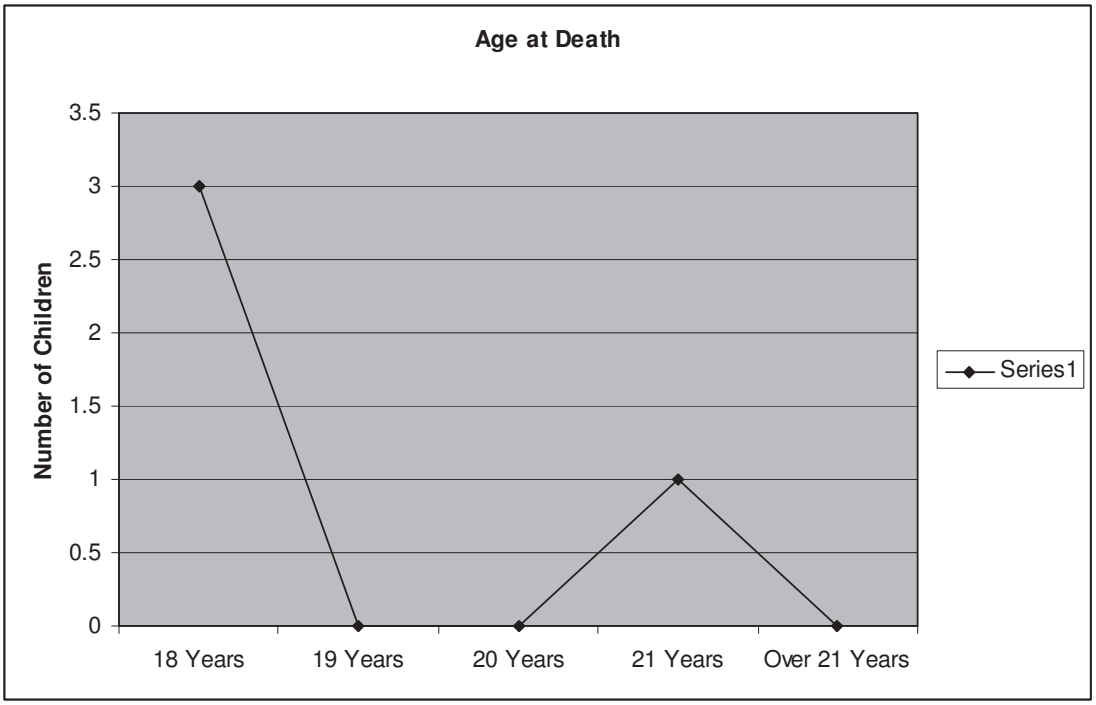


Fig. 2.1.4– Age at Death (Natural Deaths of Young People in Aftercare)

PART 2: YOUNG PEOPLE IN AFTERCARE – UNNATURAL DEATHS

Overview of Analysis

The Independent Child Death Review Group (ICDRG) received and reviewed the child and family records for 27 young people who died of non-natural causes after being in the care of the Health Service Executive (HSE) between 2000 and 2010. The overview provided below breaks the category of non-natural deaths into two sections:

Section 1: Young Persons aged 18 years.
Section 2: Young Persons aged between 19 to 23 years.

At the end of Chapter 3: Part 2, a number of graphs show a breakdown of figures and percentages in relation to the non-natural deaths of young people in aftercare.

Section 1: Young Persons aged 18 years

There are eleven young people in this section aged 18 years old.

Length of Time in Care

- Two young people had spent two years or less in care.
- Six young people had spent between two and six years in care.
- One young person had spent nine years in care.
- One young person had spent 13 years in care.
- One young person had spent 16 years in care.

Length of time known to HSE

- Two young people were known to the HSE for 5 years or less.
- Four young people were known to the HSE for between 7 and 10 years.
- One young person was known to the HSE for 12 years.
- Two young people were known to the HSE for 16 years.
- Two young people were known to the HSE for 18 years.

HSE Region

- Three young people had been in the care of HSE Dublin Mid-Leinster;
- One young person had been in the care of HSE Dublin North East;
- Four young people had been in the care of HSE South; and
- Three young people had been in the care of HSE West.

Year of Death

- One young person died in 2000.
- Two young people died in 2002.
- One young person died in 2004.
- Two young people died in 2005.
- One young person died in 2007.
- Two young people died in 2008.
- One young person died in 2009.
- One young person died in 2010.

Gender

- Seven young people were male.
- Four young people were female.

Placement/Accommodation at the Time of Death

- Young Person (Aftercare) 1 was living with a relative at the time of his death.
- Young Person (Aftercare) 2 was living in private rented accommodation at the time of his death.
- Young Person (Aftercare) 3 was living with a foster family that he had been placed with since the age of 2 at the time of his death.
- It is unclear where Young Person (Aftercare) 4 was living at the time of her death.
- Young Person (Aftercare) 5 was living with foster carers at the time of her death.
- Young Person (Aftercare) 6 was in a single occupancy residential placement at the time of her death.
- Young Person (Aftercare) 7 was on remand in prison at the time of his death.
- It is unclear where Young Person (Aftercare) 8 was living at the time of his death as the files received by the ICDRG do not contain any case files after his 18th birthday but the last recorded residency of this young person was in a sole occupancy flat
- It is unclear where Young Person (Aftercare) 9 was living at the time of his death. He had been discharged from the care of the HSE into the care of his father at the age of 16.
- Young Person (Aftercare) 10 was living in supported accommodation services at the time of her death.
- Young Person (Aftercare) 11 was living independently at the time of his death.

Individual Case Analysis

3.2.1 Young Person (Aftercare) 1

This young person died in 2005, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person became known to the HSE when it is recorded that reports were received from members of the local community alleging the neglect of children of this family. This child was 12 years old. The case was allocated and social work support commenced. It was discovered that this young person's home conditions were poor and hygiene standards were very low. Practical support was provided and a family support worker commenced work with the family. It is recorded that the parents did not cooperate with this service and it was subsequently withdrawn.

Later that year the school raised concerns about the welfare of this young person and his behaviour in school. A psychological assessment was commenced but again there was no parental cooperation with appointments. The HSE was contacted by the Gardaí shortly afterwards expressing concerns that there was chronic neglect in the family and inadequate parental supervision of the children. At this stage, services including family therapy were offered to the parents. However after initial agreement from the parents they failed to follow up with these services.

The records supplied to the ICDRG details an ongoing chaotic household, coupled with physical abuse and neglect of the children. The parents separated around the time of the Garda contact and a Child Protection Case Conference was held shortly afterwards. It was agreed that the children were at serious risk and a decision was taken that unless the parents cooperated with services and assessments, the HSE would initiate legal proceedings under the Child Care Act, 1991. Following the Child Protection Case Conference, the family support worker began working with the family and conditions are noted as improving somewhat but concerns remained high.

When this young person was 14 years old he was out of school for most of the year and spent long periods of time living with a relative. During that year a suspicion arose of a suicidal tendency on his part. He was subsequently assessed at a Child and Family Consultation Service and that service concluded this young person had no suicidal tendencies.

Early in the following year, a Child Protection Case Conference was held where it was decided to seek a Supervision Order[17] with conditions attached including a shared care arrangement with an identified foster carer and the identification of a Child Care Worker to work with this young person. No foster carer could be identified however and the Supervision Order was not applied for as the HSE could not meet the conditions it considered should be attached to such an order. The community child care worker started work some months later. It is recorded that conditions in the home deteriorated again with increased abuse of alcohol taking place. This alcohol abuse appeared to be impacting significantly on the food available to the children.

When this young person was 15 years old there was an altercation in the family home and the Gardaí were called to the house. Following this incident, this young person was admitted to a psychiatric facility for four days. While in this facility he was assessed by the CAMHS service and it was determined he was not suffering from depression. His poor relationships at home were identified as the cause of many of his difficulties. The young person then went to live with a close family relative and the file records that he was received into voluntary care under Section 4 of the Child Care Act, 1991 and placed with this relative. There is no copy of a reception into care form on the file supplied. Likewise there is no copy of the form that would show that the relative was approved as a carer by the HSE.

A further Child Protection Case Conference determined that a Supervision Order be sought with reference to the children of the family because the children were still suffering from neglect despite the intensive support being provided. There was recognition at this conference that the cooperation of the parent was superficial only. Alcohol abuse and other factors were also highlighted.

[17] Section 19 of the Child Care Act, 1991 provides that the Court may grant a Supervision Order on the application of the HSE where the Court has reasonable grounds for believing that the child has been or is being assaulted, ill-treated, neglected or sexually abused or the child's health, development or welfare has been, is being or is likely to be avoidably impaired or neglected. The Supervision Order essentially allows the HSE or someone acting on behalf of the HSE to visit the child periodically.

Supervision Orders under Section 19 of the Child Care Act, 1991 were then made in respect of this young person and two siblings. This young person was assisted to obtain employment locally; however this employment was not successful. A further placement in an education and training programme was not availed of and he became increasingly involved in serious criminal activity. A Child in Care Review was completed and a Care Plan was drawn up in respect of this young person. These documents describe the relative placement as supported lodgings. The Child Care Leader who had worked with this young person expressed her concern that this young person was a risk to himself and others.

The next year the Supervision Orders in respect of this young person and his siblings were renewed. The young person's relative placement was under strain and a placement in a probation hostel was secured but the young person would not accept this.

The Social Worker continued to visit and record the difficulties experienced by the carer and the young person but no action was taken until he appeared in court on criminal charges and was remanded in detention. This young person was then moved to a probation hostel. While at the hostel, he told staff he had tried to harm himself previously and would do it properly next time. He was sentenced to 6 months in custody in respect of the various criminal offences and released after a few months. Following his release, the young person returned to reside with his relative and seemed to settle for a few months. However he again became involved in criminality and was charged with a number of offences. A supervision note recommends that the case be closed as probation was dealing with the young person.

On his 18th birthday a Social Worker visited him at home and advised that as he was now 18 his case would be closed by the HSE but that if he wanted further help it would be available. The young person said he wanted to be left alone and three months later he died.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 1

- Education;
- HSE Social Work Department;
- HSE Childcare Worker;
- HSE Family Support Worker;
- Probation service; and
- CAMHS.

Good Practice Observed on File of Young Person (Aftercare) 1

- Care plan on file

Concerns Arising from the File of Young Person (Aftercare) 1

- It appears from the files reviewed by the ICDRG that there was evidence of chronic neglect of this young person from 12 years onwards. Numerous Child Protection Conferences were held in respect of this young person and his siblings; however there was no evidence of improvement and the situation was allowed to continue.
- It is unclear whether the Supervision Order, when obtained, had any impact on the care of the children.
- Once the Probation Service became involved with this young person his Social Work records show no intensive involvement from the HSE. While concerns regarding this young person were recorded there were no real action plans implemented.
- The care status of this young person was unclear.
- There was a short summary of this young person's case completed after his death. No comprehensive analysis into his care circumstances prior to his death is on record.

3.2.2 Young Person (Aftercare) 2

This young person died in 2008, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person's file indicates that the family was known to the Health Services in another jurisdiction from when this young person was aged 13 years old, when it appeared that drug and alcohol began to be abused in the home. The family moved about quite a lot and this young person came to the attention of the HSE at the age of 16 years when his mother indicated she could no longer cope with what she described as his challenging behaviour.

In addition to ongoing alcohol and substance abuse in the home a poor relationship between this young person and his mother's partner is recorded. The young person moved between various relatives for a lengthy period of time. He was received into the Voluntary Care of HSE under Section 4 of the Child Care Act, 1991 and placed in residential accommodation. This placement did not last long and he was discharged after 6 months for having drugs on the premises. He had a number of other residential placements which also broke down and in each placement concerns were identified relating to his absconding, criminal activity and drug abuse. This young person was also remanded a number of times for criminal offences and was sentenced to four months detention in early 2007. Services were put in place for him at different times including addiction services, youth services, psychological assessment services and an education and training programme. Despite the difficulties he presented with, this young person was viewed as an essentially good young person who was socially inept and walked into trouble when interacting with young people and adults who were more street wise than himself.

Following his release from custody this young person was placed in a private for profit residential placement. He settled reasonably well in this placement for a period of 7 months despite being charged with criminal damage and having a curfew imposed on him by the court. While in this placement, this young person turned 18. An aftercare plan is on file. It was planned that this residential service would support him into his aftercare placement and a key worker was appointed. This key worker had known him in a previous residential placement and from the records appears to have continued to provide a very high level of support to this young person throughout the time he was known to her. In addition an aftercare worker was also allocated to him. An independent living skills programme was put in place.

The transition to independent living accommodation was effected one month after his 18th birthday, at around the time his case file was transferred to another HSE area office. He appears to have been dealt with by the Duty Social work team from then on. This young person's key worker, who was supporting his transition to independent living, indicated in a report that the new HSE area office did not know who had responsibility for him. They were concerned that his behaviour in his accommodation was placing his tenancy there in jeopardy. He had left his education and training programme and the report notes that the aftercare worker was concerned about his drug use, his mental health and his isolation. This young person had not engaged with the aftercare service that was provided for him and the HSE was informed of this. Subsequently he attended an addiction residential service for a short period and he appeared to be more settled.

This young person attended a meeting with his aftercare worker and his Social Worker some six weeks prior to his death. The report of that meeting indicates that he was due to appear before the court in two weeks time on criminal charges. He had not cooperated with the aftercare plan as agreed and this had placed his aftercare funding with the HSE in jeopardy. He had left his education and training programme. Despite this, he had settled in his accommodation and his key Social Worker was still in place. The HSE Social Work Department advised this young person that it was up to him to follow up on access to supports and services. It was further indicated that if he received a custodial sentence he should engage with Probation Services and the Social Worker would continue to try to get him into a local education and training programme.

Following his appearance in court, this young person was not remanded in custody. His key worker advised the HSE that he did not attend court for the subsequent hearing and a warrant was issued for his arrest. The key worker feared he was using drugs again and was due to leave his accommodation as funding for it had run out and the landlord was unhappy with how the accommodation was being cared for. The HSE withdrew funding to the NGO aftercare service for his key worker. One month later the HSE were advised that this young person was in hospital where he died some time later.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 2

- Education services;
- HSE Social Work Department;
- Various Residential placements (some with for profit organisations);
- NGO Aftercare Service;
- Community service; and
- An Education and Training Programme.

Good Practice Observed on File of Young Person (Aftercare) 2

- Statutory reviews and care plans completed for this young person.
- Aftercare plan on the file.
- Good records in general.
- Good support and follow through by the key worker.

Concerns Arising From the File of Young Person (Aftercare) 2

- No adequate risk assessment or mental health assessment.
- This young person was clearly at risk from his admission to care, he proved difficult to engage with.
- His aftercare provision was essentially for 3 months after his 18th birthday. Funding for his aftercare support worker was then withdrawn.
- There was no real engagement with this young person by the HSE once he reached 18 and at best the file evidences an unreal expectation of him to source support in light of his behaviour, life experiences and evidence of growing addictions.

3.2.3 Young Person (Aftercare) 3

This young person died in 2004, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from the age of a year and a half. His mother was very young and was experiencing great difficulty in meeting his needs. He was received into

voluntary care and after an initial placement with a short-term foster family he was placed with long term foster carers where he remained until his untimely death.

This young person remained in voluntary care for 16 years. During that time he had some contact with extended family members and only sporadic contact with his mother, in his adolescent years. There were appropriate reviews held in respect of this young person and his time with his foster family appears to have been happy and fulfilled. He was encouraged to pursue further education following completion of his Leaving Certificate but he decided to go directly into employment. His case was then closed by the HSE. There is no aftercare plan on file however he remained with his foster carers.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 3

- An NGO provided support initially and appears to have provided the Social Workers involved in this young person's early years although the HSE Social Work Department completed the Reviews;
- HSE Social Work Department;
- Foster care services; and
- Education services.

Good Practice Observed on File of Young Person (Aftercare) 3

- Appropriate reviews were held regarding this young person.
- Very good care provided by the foster care family.

Concerns Arising From the File of Young Person (Aftercare) 3

- The files regarding this young person were complete but were not in order.
- This young person was in voluntary care from the age of 2, consistently with same foster carer, while his birth mother lived abroad for many years with no contact with the HSE although his extended family kept in touch sporadically.

- This young person was effectively abandoned in care and consideration should have been given to an application for a full care order to secure his position.

3.2.4 Young Person (Aftercare) 4

This young person died in 2009. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from age 14 following a referral from a hospital. She had been admitted to this hospital following an overdose of prescribed medication. She was also expressing suicidal ideation. The matter was followed up by the CAMHS service and the young person and her father were met by the duty Social Worker.

From the records furnished to the ICDRG it appears that concerns were clearly identified in relation to serious alcohol abuse in the home and subsequent neglect of this young person's welfare and safety. In addition there were a number of recent significant bereavements, including the tragic loss of her mother, for this young person. It was also discovered that she had become involved in some minor criminal matters.

The CAMHS Service followed up with this young person. This service expressed ongoing concerns and wrote requesting a report on home circumstances from the HSE. Some 8 months later this young person again presented in hospital having overdosed on prescribed medication. This was followed some 2 months later by an attempt to drown herself in the river. She was an inpatient in the hospital for 5 days and she made 3 other attempts at self-harm in the following months. She spent two days on an adult psychiatric ward. She was discharged home and 1 week later was back in hospital having tried drowning herself a second time. At that point this case was transferred from the duty team to a long-term social work team.

A report by the HSE describes her as being at ongoing risk of significant harm and stated her parent was unable to cope. This report identified the requirement for a secure placement to address her needs and to keep her safe.

At a meeting of the Admissions Committee of the Special Care Unit it was decided that this young person did fulfil the criteria for admission but the meeting suspended consideration of her admission pending the holding of a Family Welfare Conference as provided for under the Children Act, 2001[18] as amended. This was held shortly afterwards and on foot of an application to the Circuit Court, a wardship order was granted in respect of this young person. The wardship order was extended twice and this young person continued in the special care unit where she is reported to have made good progress.

This young person moved from the Special Care Unit to a High Support Residential Unit. Around that time a report indicates she was made the subject of a Care order for a period of five months (although there is no copy of that Court Order on file) to allow her to be placed in the high support unit.

This young person was discharged home from the high support unit aged 16 years and 10 months. It is recorded that the Court was concerned that nothing had changed at home during her time away. However the Social Worker took the view that the young person had matured, had not displayed any self-harm behaviours and that she had developed more enhanced coping skills. A number of local services agreed to offer her support and the high support residential unit provided ongoing contact for her for 6 weeks post discharge. The Social Worker indicated to the court that the HSE would apply for a Supervision or Care Order if necessary should the situation deteriorate on her return home. The District Court Judge indicated that he would want the HSE to apply for a Supervision Order if the young person or her family failed to engage with the services outlined.

Following this young person's discharge from care there is very little recorded on the files supplied to the ICDRG. It is not clear therefore what, if any, supports were put in place for this vulnerable person. There is also no record of any monitoring of her welfare. She appears to have attended an education and training programme for some time. The first recorded note is five months post her discharge and that records that she was doing well but that nothing had

[18] Section 7 of the Children Act, 2001 as amended provides that a family welfare conference shall be convened by a person appointed by the HSE where there is a direction to do so by the Children's Court or where it appears to the HSE that a child that resides or is found within its area may require special care or protection which the child is unlikely to receive unless the Court makes a special care order.

changed at home. The note records that an option of alternative accommodation had been discussed with her but that she declined it. There are three further such brief reports over the next 6 months with each one stating that there is ongoing monitoring and contact with the young person.

In a period some nine months prior to her death there is a mention of supported lodgings to help move this young person out of a home which continued to be problematic. She moved into supported lodgings and then into a short-term bed in a residential unit. Her stay in the residential unit was problematic in that she found it difficult to follow the rules and she left. At that point, 12 months after she had left care, the HSE Social Work Department organised aftercare support for her. It is not clear from the file if she availed of that service as the record is brief.

One of the last recorded summaries says " …Has made repeated statements of wanting to kill herself, she has been advised to seek medical help, Social Worker has offered to facilitate same, however she refuses this support. …turns 18 in [month noted…2 months away] and the SW Dept will no longer be involved with her…workers have been identified to offer …support towards independent living but it remains to be seen if…will meaningfully use this service."

Two months later, the last record shows the young person had left home to live with a friend. She was on an educational course. Just after her 18th birthday her case file was closed.
There is nothing on the files supplied to the ICDRG to indicate the circumstances of the young person's death. It is not clear from files received precisely where this young person was living at the time of her death. The last entry indicates she had left the family home because she was unable to cope with its chaotic nature.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 4

- Education services;
- An Education and Training Programme;
- Special Care Unit;
- High Support Unit;
- HSE Social Work Department;
- HSE Childcare Workers;
- CAMHS;
- Hospital services;
- Family Welfare conference;
- Residential care for 1 week;
- Supported Lodgings for a few nights; and
- A number of services were approached to provide services for this young person but it is not clear from the file if they were accessed at any point by her.

Good Practice Observed on File of Young Person (Aftercare) 4

- The time this young person spent in the secure unit and the high support unit provided her with stability and she showed good general improvement.
- The Family Welfare conference in respect of this young person was well organised.

Concerns Arising From the File of Young Person (Aftercare) 4

- No adequate risk/mental health assessment recorded.
- The Care Order made in respect of this young person is not on file.
- There is very little evidence of engagement by the HSE Social Work Departments directly with this young person.
- Her early attempts at self-harm were not followed up fully until they became very frequent.
- When the wardship application was made, the Court appointed a solicitor for her. The appointment of a Guardian ad Litem could have provided for greater involvement with this young person.
- Records once the care order was discharged are sparse and do not allow for an assessment of exactly what level of engagement occurred on her return home based on

the information in the file, the level of engagement does not appear to have been in any way adequate to support a young person who was vulnerable and returning home to exactly the same situation from which she had been removed.

- No realistic aftercare plan that was assiduously followed up – it appears to have been left up to the young person herself despite her acknowledged vulnerabilities and family history.

3.2.5 Young Person (Aftercare) 5

This young person died in 2005, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was the youngest child in a large family. From the records furnished to the ICDRG it appears that following the death of her mother when she was 9, she was cared for by members of the extended family. There were allegations made of sexual abuse within the family which were investigated and validated. Following this investigation, a HSE Social Worker was appointed as guardian for this child. A decision was made by the Director of Public Prosecutions not to proceed with a prosecution regarding the sexual abuse and this decision was questioned by the young person at a later date.

This young person was placed in voluntary care under Section 4 of the Child Care Act, 1991. This request for admission to care was signed by the Social Worker appointed as her Guardian with an affidavit.

Counselling was organised for this child on her reception into care. She had four foster placements during her 9 years in care and found it difficult to settle due to her early life experiences. During her time in care, one of her siblings took his own life and this had a significant effect on her. She was involved in self-harm and substance misuse for periods and refused to attend a Child Guidance Clinic for further counselling. The guardianship passed from one HSE Social Worker to another until a nominated Social Worker refused to take on that role.

Finally when this young person was 16 years old a Care Order under Section 18 of the Child Care Act, 1991 was granted. Her care status until then was not clear.

A summary report by a senior HSE employee following her death reported that she was very settled in her final year in care. She had successfully completed her Leaving Certificate and was on a course that she was enjoying. She was continuing to live with her foster family post her 18th birthday on a supported lodgings basis.

Her tragic death came as a complete surprise to all those who cared for her who were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 5

- HSE Social Work Department;
- Clinic run by NGO;
- Child and Adolescent Mental Health Services;
- Education services; and
- Specialist Child Sexual Abuse Unit

Good Practice Observed on File of Young Person (Aftercare) 5

- Evidence of ongoing contact and positive work from HSE Social Work Department.
- Evidence of very positive engagement with this young person and evidence of responsiveness to her distress.
- Good follow up with carers and extended family after death.

Concerns Arising from the File of Young Person (Aftercare) 5

- No early or adequate risk/mental health assessment on record.
- The use of a guardianship order arguably did not meet the needs of the child in this case. The order did not seek to provide the stability which this child required and it did not seek to address the long term needs of the child.

3.2.6 Young Person (Aftercare) 6

This young person died in 2002. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person came to the attention of the State at the early age of 9 months when concerns regarding her welfare were expressed to the HSE. Between her birth and the age of 3, there were 5 confirmed instances of child protection concerns regarding this young person. The records supplied to the ICDRG indicate that the only interventions that occurred as a result of these concerns were home visits. Her parent made an admission of serious physical abuse in relation to this young person when she was aged 7. The 1987 Child Protection Guidelines were not followed in investigating this complaint.

Following this incident, this young person moved to live abroad with her family and she was placed on the At Risk Register in that jurisdiction. The family later returned to Ireland. The Child Protection Services where she had lived notified the HSE of the family's return and asked that a Child Protection Case Conference be held in respect of this young person. On her return, this young person was received into the voluntary care of the HSE under Section 4 of the Child Care Act, 1991. This was just prior to her 15th birthday.

For the 3 years and 8 months that this young person was in the care of the HSE she had to find accommodation through the Out of Hours Service. She was placed in at least 36 different placements including Bed and Breakfast accommodation, apartments, supported lodgings and a number of other placements. None of these placements addressed her needs.

The records provided to the ICDRG outlines that this young person had experienced sexual abuse by older adults who introduced her to alcohol and substance misuse. Despite the abuse this young person was suffering, there does not appear to have been a full assessment of her sexual abuse. For most of her first year in care she did not have regular contact with her Social Worker. She had become very aggressive in her behaviour towards staff and other residents.

There was no coherent plan drawn up for the care of this young person and when psychological and psychiatric assessment reports were provided they do not appear to have been shared with those providing direct care for her. Finally a Guardian ad Litem was appointed for her by the High Court. Following this appointment, a Care Plan was devised for her for the first time. She was now almost 17 years.

During her time in care this young person gave birth to two children. She wished to care for her children and, by order of the court was helped to do this on a trial basis. She was, however, unable to care for them consistently and the children were placed in care. She had regular access to them and never missed a visit. She died in advance of the court hearing an application for Care Orders in respect of the children.

It is the view of the ICDRG that this young person was failed by the care system from early in her life. Initial concerns regarding her welfare were dealt with as single episodes rather than being taken together. Key risk indicators were not fully followed up particularly the serious physical abuse she is recorded as having suffered at a young age. When she was eventually received into voluntary care at 15, she was utterly failed by unsuitable placements. She ended up spending large periods of time on the streets where she was abused and learned not to trust the system to care for her. Her Guardian ad Litem, her Social Workers and the Out of Hours service identified the need for dedicated specific accommodation with appropriate therapeutic services to meet her complex needs. Such a placement was never sourced for this young person. Her final placement was in a sole occupancy unit staffed on 24/7 basis by agency staff. Her use of drugs caused great concern in the latter period of her life but the staff caring for her had no training in addiction and no appropriate referral was made. The standard of this accommodation is described on the record as being very poor. Staff there were often employed on a part-time basis and this meant an absence of a key figure with whom this young person could build and sustain a relationship. Her behaviour towards staff was often extremely threatening and the response appears to have been to closely supervise this young person with rules being introduced in response to the latest crisis and without an overall context or plan. There is no doubt this was extremely difficult for all concerned.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Note: Case Review Report

A Case Review Report was completed following the death of this young person. It was conducted based on documentation provided by the HSE. The review is unsigned and undated. No format or guidance appears to have been provided for the review. The terms of reference included a review of the care of this young person and to make recommendations. Over 40 recommendations were made including many common to other such inquiries; the need for coherent, integrated planning, needs led services, vigilant management through audit, structured case reviews and the maintenance of case files and records for each child. It is not known if any of these recommendations were implemented.

Services Engaged for Young Person (Aftercare) 6

- HSE Social Work Department;
- Guardian ad Litem;
- Out of Hours Service;
- Sole Occupancy Unit; and
- Gardaí.

Good Practice Observed on File of Young Person (Aftercare) 6

- Once this young person had a Guardian ad Litem appointed at age 17, a care plan was finally drawn up.

Concerns Arising From the File of Young Person (Aftercare) 6

- Failure to properly address the concerns about this child's welfare in the first three years of her life i.e. no adequate risk assessment.
- Use of the Out of Hours service for the 3 years and 8 months this young person was in care.
- Failure to address the serious physical and sexual abuse suffered by this young person throughout her life.

- More suitable placements might have reduced the risk of this young person being exposed to abuse.
- Failure to address the needs of this young person through inter-agency cooperation.
- Failure to provide an appropriate placement to address the complex needs of this young person.
- Failure to provide a key worker to represent this young person.

3.2.7 Young Person (Aftercare) 7

This young person died in 2002, aged 18 years old. This death was registered on foot of a Coroner's certificate. This young person was the sibling of another young person discussed in this report.

Summary of Care Circumstances

The family of this young person was known to the HSE for many years as a result of concerns relating to poor parenting practices, neglect of the children in the family, inadequate housing conditions and a failure by parents to engage with the services offered. He remained at home until he was 3 years at which point all the children in the family were made subject to a Place of Safety Order under the provisions of the Children Act, 1908. From the information furnished to the ICDRG it does not appear that any application was made under the Child Care Act, 1991 and this young person was discharged from care at age 16. Under section 131 of the Children Act, 1908, a distinction was made between a child and a young person. A child was someone under the age of 15 years and a young person was aged between 15 and 17 years.

Following the making of the Place of Safety Order, this young person appears to have been placed in foster care and remained there for many years with very few visits or contact with a Social Worker. From the time of his admission to care the lack of a significant attachment caused great difficulty for this young person and this was compounded by very inconsistent access visits. Attention does not appear to have been paid to this significant issue over his years in care. He was placed with the same foster family for many years and as he reached adolescence his behaviour deteriorated and eventually the placement came to an end although sporadic contact was maintained.

From the breakdown of his long-term placement at age 14, this young person had a number of placements, one with a foster sibling and thereafter with the birth family for a short time. His longest placement was in a residential placement run by a security firm from age 15 to 16 approximately and during that time he had some months on a training course. Both the accommodation and work placement came to an end due to his challenging behaviour and substance abuse.

From the records supplied to the ICDRG, there were periods when this young person does not appear to have had a Social Worker allocated to him. It is not clear how often he attended school post the age of 14 and there is no evidence of clear and consistent planning for this troubled young person as his behaviour deteriorated putting his welfare at risk.

Shortly after his 16th birthday this young person presented as homeless and was dealt with by the Out of Hours Service and the Duty Social work system. A Social Worker did engage actively with him at that point and tried to secure a placement with a private security firm for him. However, the necessary meeting did not happen. The files reviewed by the ICDRG included notes of a very poignant interview with this young person at the age of 16 where he cried and stated he was unable to cope with living on the streets. The attachment issues from his early childhood were clearly a source of great distress to him on an ongoing basis.

Shortly afterwards he appears to have moved to live abroad – he was then 17. There is no reference to an application under the Child Care Act, 1991 and this young person appears to have been treated as out of the care of the State from 16 years.[19] Any references to his status after his 16th birthday refer to the original place of safety order only.

When this young person was 17 and a half he returned to Ireland and was involved in criminal offending and it appears from the documentation furnished to the ICDRG that he may have returned to the family home. There is no further recording in relation to this young person until his death was notified to the HSE by his previous foster carer.

[19] Section 48(4) of the Child Care Act, 1991 provides that any child who is being detained in a place of safety under any provision of the Children Act, 1908 shall be deemed to have been received into that place pursuant to an emergency care order.

The HSE Social Work Department undertook all arrangements in conjunction with other key people in his life. There was no internal review into his care period. An inquest was held into the cause of his death.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 7

- HSE Social Work Department;
- Education Services;
- Child Guidance Services;
- Out of Hours Service;
- State Training agency;
- Various hostels;
- Gardaí;
- Prison Services (while on remand); and
- Private security firm.

Good Practice Observed on File of Young Person (Aftercare) 7

- At times of crisis this young person had good active involvement from the HSE Social Work Departments who worked hard to find accommodation for him but their excellent endeavours were without a full and comprehensive care plan that dealt with the totality of this young person's welfare.

Concerns Arising from the File of Young Person (Aftercare) 7

- No adequate risk/mental health assessment recorded.
- This young person had no Social Worker assigned to him at times.
- Key distress at what he perceived as rejection by birth family not addressed when he was younger.

- Inappropriate addressing of accommodation issues from age 14 onwards. He was dealt with via the Out of Hours Service in Dublin which was not this young person's home area and this added to risk factors for him.
- There is no individual file for this young person – it is mixed in with his siblings and family file.
- It took an extensive period of time to try and establish the key facts using this young person's file. It is still not entirely clear. There are handwritten notes on file and it is not clear who the writers of the notes are. They are signed as "Social Worker" but it is not clear if this was a Social Worker allocated to this young person or a Duty Social Worker.
- The most significant issue with this file is that there is no indication that an application was made under the Child Care Act, 1991 to secure his welfare. There is no documentary evidence of a consideration of the 1991 Act or how it integrated with the previous Children Act, 1908.
- This young person was effectively abandoned at age 16 by the system in whose care he had been placed.

3.2.8 Young Person (Aftercare) 8

This young person died in 2008 aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person was known to the HSE from the age of 10 when concern was expressed that his mother who it is recorded had a serious alcohol problem and suffered from depression was unable to care adequately for him. A number of reports were made to the Gardaí regarding this young person, alleging that he was being left at home on his own and that he was in a public house very late at night. Following these reports, social work visits were made to the home. However the young person's mother denied the allegations. It is unclear from the files received by the ICDRG if the risk that this behaviour would pose to this young person was discussed with his mother. There were also concerns expressed over inappropriate sexual behaviour by this young person towards other young people and each of these concerns was appropriately followed up.

Just prior to his 14th birthday, this young person was admitted into the voluntary care of the HSE pursuant to Section 4 of the Child Care Act, 1991. This occurred as his mother was unable to provide care for him due to her ongoing abuse of alcohol. She was also admitted to a psychiatric hospital following an overdose of alcohol and medication.

Following his reception into the care of the HSE, this young person was placed with foster carers where he initially appeared to settle well. He subsequently absconded and refused to return. He was placed with a second set of foster carers and this placement ended when he self-harmed. A family welfare conference was held to develop a safe care plan for this young person as the extent of his vulnerabilities became evident. There is evidence that the Social Work Department made great efforts to organise services for this troubled young person. Initially, he appears to have agreed to engage with each plan, however he would then withdraw. There was ongoing concern that he was engaging with increasingly dangerous behaviour that was putting him at serious risk. These concerns were shared with all the relevant services in an attempt to protect this young person. The issues that came to light related to his confusion over his sexual orientation and his extreme acting out behaviour and self harm.

This young person had five admissions to a psychiatric hospital and was placed in an adult ward. The hospital wrote to the HSE expressing grave concern at this young person's stay in the hospital because he was mixing with patients who were severely ill and his immaturity and risk-taking behaviour was placing him and others at risk. The HSE acknowledged this but does not appear to have made a more appropriate psychiatric placement available when this young person self harmed.

This young person was discharged from the care of the HSE following a Child Protection Case Conference just prior to his 18th birthday. His vulnerability was acknowledged and his refusal to follow through with the many services offered to him was outlined at the Conference. It was decided that he would be discharged to the Adult Mental Health Services of the HSE and that his aftercare services were to be guided by the mental health services. This was to be organised by a Community Child Care Leader who had known this young person and had tried consistently to try and engage him in following up on professional assessments and therapy services. The case

was closed by the Social Work Department and shortly afterwards the case was closed by the Child Care Leader who was unable to make contact with this young person.

The files supplied to the ICDRG show no case records from just after his 18th birthday so it is not possible to say precisely where he was living at the time of his death. The last recorded address for him was a sole occupancy flat.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 8

- Education Services;
- HSE Social Work Department;
- HSE Child Care Leader;
- Gardaí;
- NGO Family Welfare Conference;
- Psychiatric Hospital;
- HSE Psychological Services; and
- Addiction services.

The Services appear to have worked well together but they failed to get this young person's cooperation.

Good Practice Observed on File of Young Person (Aftercare) 8

- Social work visits to the young person's mother following concerns expressed about his welfare.
- Appropriate follow-up to concerns regarding this young person's inappropriate sexual behaviour prior to his being received into care.
- Family Welfare Conference held to try to address the needs and vulnerabilities of this young person.
- Strong efforts were made to try to get this young person to engage with services which would address his needs.

Concerns Arising from the File of Young Person (Aftercare) 8

- No adequate risk/mental health assessment recorded.
- It is unclear whether the early concerns arising from the care of this young person by his mother were ever fully discussed with his mother and the consequences explained to her.
- The HSE did not address the concerns of the Psychiatric Hospital regarding this young person's placement there and his interaction with other, older and severely unwell patients.
- It might have been helpful if the issue of sexual orientation had been acknowledged more fully and if the help of some of the national advocacy groups in this area were engaged to meet with this young person.

3.2.9 Young Person (Aftercare) 9

This young person died in 2007, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

The family of this young person initially lived abroad and moved to Ireland when he was 6. They were known to the statutory Social Services in the other jurisdiction because of concerns regarding the care of the children, their non attendance at school and the presence of a gambling addiction in the family. The statutory services made their concerns known to the HSE when the family decided to return to Ireland. From their return to Ireland until this young person turned 14, this family was intermittently known to the HSE. Concerns raised included domestic violence, alcohol abuse, gambling and also emotional abuse, neglect and physical abuse of the children. There were frequent periods of parental separation and the children regularly changed place of residence and schools.

Four Child Protection Case Conferences were held regarding this young person. The HSE obtained a Supervision Order under Section 19(1) of the Child Care Act, 1991 when this young person was 13. The purpose of the order was to provide for cooperation of the family to ensure that the children attended for assessments as required. The Order was made for 1 year. In respect of this young person, his attendance at school improved and he did cooperate initially

with the activities put in place for him. A psychological report indicated this young person was functioning within the low average to borderline range of ability and recommended extra home tuition to assist him. This was provided for 4 hours per week by the Department of Education and Skills however the Social Worker indicated this was not sufficient to meet his needs. The HSE appealed this decision.

From the records provided to the ICDRG it appears that at the age of 14, this young person became involved in criminal activities including theft and damage. The youth worker engaged with him highlighted that this young person had a great deal of anger which he found very difficult to discuss. A network meeting held at that time agreed to seek a place for this young person in residential care. The purpose of this placement was to meet both his educational and his care needs. He was admitted into the voluntary care of the HSE under Section 4 of the Child Care Act, 1991 to facilitate this placement.

There is very little recording on the file supplied to ICDRG relating to the year this young person spent in residential care. A transfer summary says he engaged well with the programme and a second year was offered but the young person and his father, with whom he was living, declined that offer. At this stage he was 16 years old. He returned home and was linked into a local youth centre and a meeting with him and his father a few months later found he was well settled back in his family. He was making good progress in an education and training programme. The case was then closed.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death

There was no record of any investigation by the services into the death of this young person.

Services Engaged for Young Person (Aftercare) 9

- Education Services;
- HSE and Voluntary Social Workers (It is not clear if the Social Workers from an NGO were working on behalf of HSE) ;
- Psychology Assessment Services;

- Home Tuition;
- Family Therapy service;
- An Education and Training Programme;
- Local Community Youth Service;
- Gardaí; and
- Residential Care.

Good Practice Observed on File of Young Person (Aftercare) 9

- Evidence of good Social Work practice before admission to care.
- Good use of legislation and powers under the legislation.
- All statutory requirements met with regard to this young person.
- There is evidence of good cooperation among services.

Concerns Arising from the File of Young Person (Aftercare) 9

- This young person was discharged from care at the age of 16 and the case closed thereafter.
- This young person's aftercare was left to youth services.
- The file is complete but dividers are not used for relevant sections. Consequently it was difficult to find relevant information.

3.2.10 Young Person (Aftercare) 10

This young person died in 2010, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that at the age of 11, this young person was referred to the HSE due to concerns relating to her mother's severe alcohol dependency and the implications for the welfare of this young person and her siblings. There were also concerns about domestic violence in the family home. Later the same year, this young person was received into the voluntary care of the HSE under Section 4 of the Child Care Act, 1991. She remained in care for fifteen months.

This young person found it very difficult to settle in care as she was worried about her mother and eventually returned home. Concern then emerged regarding her attendance at school and a Child Protection Case Conference recommended that she be received into care again. The young person was very opposed to this proposal and her school attendance and cooperation with other support services improved significantly. Shortly afterwards, her mother died and this caused her great distress.

A Child Protection Case Conference agreed that the young person would remain at home in her stepfather's care and that support would continue to be offered by an NGO Family Support Project and by the HSE who were to monitor her care to ensure the progress evidenced was maintained. Bereavement counselling was also offered but not availed of. A further decision was that her stepfather should apply to be made her guardian under the Guardianship of Infants Act, 1964 as amended. This application was successful. Records show that the young person maintained her progress over the next year and supports were maintained.

This young person became pregnant at age 15. An assessment of her ability to cope with her baby was undertaken and a Child Protection Case Conference decided the young person and her baby should complete a residential parenting assessment. Following the birth of her baby this young person refused to comply with this plan and her baby was taken into the care of the HSE. The young person then agreed to comply with the parenting assessment and did so successfully.

Following the assessment, this young person moved to supported accommodation run by a local social services organisation. Later the young person moved with her child to independent accommodation, with ongoing support from a community mother's scheme, the HSE Social Work Department and outreach services from her supported accommodation. Another child was subsequently born and the young family resided together. The father of the children and his family also provided considerable support, but the relationship between the parents was volatile at times.

The ICDRG was provided with a file record stating that all those involved with this young mother believed her parenting was good, that she was able to meet her children's needs and that she required ongoing support.

Three months after the birth of this young person's child, the HSE decided to close this case 'as it believed there were no longer any concerns or needs which were not being met; family support services from a number of voluntary organisations were to continue`.

One month after the case was closed, this young person died. Her children were safe and cared for within the extended family.

The file records that she that she had been visited by staff from her supported accommodation outreach service the day before she died. This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

A brief report was compiled at the time by the HSE and this report states that "there is no plan to review this case as it does not meet the criteria as set out in HIQA Guidance for the HSE for the review of serious incidents including deaths of children in care". However, the ICDRG understands that the HSE National Review Panel is reviewing this death.

Services Engaged for Young Person (Aftercare) 10

- Education Services;
- HSE Social Work Service for this young person and later for her children;
- HSE Family Support Worker;
- NGO Family Support Service;
- Supported accommodation services;
- Mother and Child units;
- Community Mothers' Scheme; and
- HSE Public Health Nursing Service.

Good Practice Observed on File of Young Person (Aftercare) 10

- Services for this young person were well conducted while she was in care.
- Good planning is evident on the discharge from care and appropriate supports were put in place.
- Appropriate services were put in place for this young person at all times.

Concerns Arising From the File of Young Person (Aftercare) 10

- No adequate risk assessment or mental health assessment on the record.
- Once this young person became a mother, there appears to have been an exclusive concentration on parenting issues perhaps to the determinant of the issues for this young mother's well being.
- It is the view of the ICDRG that this case was closed prematurely.

3.2.11 Young Person (Aftercare) 11

This young person died in 2000, aged 18 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from very early in his life when his mother disappeared from home and could not been located. The young person and his older siblings remained at home supported by their extended family.

When this young person was 10 years old he was taken into the care of the HSE under the provisions of the Children Act, 1908[20] because of concern about physical abuse and neglect within the family home. This was later converted into a Fit Persons Order.[21] The young person was placed in a Children's Residential Service where he remained for six years. During that time he maintained contact with his older siblings. The placement broke down when he was 15 as his behaviour had become difficult to manage within the home and he had a number of short-term

[20] Part II of the Children Act, 1908 made provision for the prevention of cruelty to children and young persons and provided, inter alia, for a place of safety order.

[21] Sections 21 and 24 of the Children Act, 1908 provided for the making of a "Fit Persons Order". A Fit Persons Order expired when the young person attained the age of 16.

placements with foster carers. A pattern emerged where he absconded if there was any discussion around the difficulties he was experiencing and he refused to attend counselling. He moved to a supported lodgings type placement at 16 and it is recorded that this was paid for from the Aftercare Budget.

This young person's legal status was queried as the Fit Person Order had expired and the provision of the Child Care Act, 1991 which would have converted that order to a full care order did not seem to be understood.[22] His Social Worker prepared a report to have him remain in care until he was 18 but it is not clear from the records, supplied to the ICDRG, what happened. In any event, the Social Worker continued to meet with him periodically and helped him to move into a flat where he seemed to have settled. He was troubled about his childhood experiences from time to time but refused to engage with counselling services. The Social Worker closed the case when this young person was 18 as it was proving very difficult to contact him in any consistent manner. The closing summary states that he had been fully advised of aftercare services and made aware that aftercare services were available to him if required. He did not contact the HSE again.

The record shows that, at the time of his death, this young person was working full time and appears to have been settled.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 11

- Education services;
- HSE Social Work Department;
- Children's Residential Care; and
- Psychology Department.

[22] Pursuant to Section 48(1) of the Child Care Act, 1991, where a child was in the care of the Health Board arising out of an order made under Sections 21 or 24 of the Children Act, 1908, that child was, on the commencement of Part IV of the Child Care Act, 1991, deemed to be the subject of a care order committing him to the care of the Health Board.

Good Practice Observed on File of Young Person (Aftercare) 11

- There was consistent engagement by the Social Worker with this young person.
- There was consistent identification of his needs and appropriate services were offered.

Concerns Arising from the File of Young Person (Aftercare) 11

- It does not appear to the ICDRG that the implications for Young Person (Aftercare) 11 of the Child Care Act, 1991 were properly considered. The Fit Persons Order under which this young person was in care expired when he attained the age of 16. However, at that stage, the Child Care Act, 1991 had come into force.[23] Pursuant to the transitional provisions contained in Section 48 of the 1991 Act, this young person was therefore the subject of a care order.[24]
- As a result of the failure to properly consider the provisions of the Child Care Act, 1991, it appears to the ICDRG that this young person was prematurely discharged from the full care of the HSE.

Section 2: Young Persons aged between 19 and 23 years

The sixteen young people in this section were aged between 19 and 23 years old at the time of their death.

Length of Time in the Care of the HSE

- Two young people were in the care of the HSE for 5 years or less.
- Two young people were in the care of the HSE for between 6 and 9 years.
- Seven young people were in the care of the HSE for between 12 and 17 years.
- Two young people were in the care of the HSE for 18 years.
- One young person was in care on and off for 14 years.
- One young person was in care for a short period prior to their 18th birthday.
- It is not known how long one young person was in care.

Length of Time known to the HSE

[23] Part IV of the Child Care Act, 1991 was commenced by S.I. 258/1995 on the 31st October 1995.
[24] As if made under Section 18 of the 1991 Act.

- One young person was known to the HSE for 1 year.
- One young person was known to the HSE for 5 years.
- Two young people were known to the HSE for between 8 and 9 years.
- Six young people were known to the HSE for between 13 to 17 years.
- Five young people were known to the HSE for 18 years.
- It is not known how long one young person was known to the HSE.

HSE Region

- Five young people had been in the care of HSE Dublin Mid-Leinster.
- Four young people had been in the care of HSE Dublin North East.
- Four young people had been in the care of HSE South.
- Three young people had been in the care of HSE West.

Year of Death

- One young person died in 2002.
- One young person died in 2003.
- One young person died in 2004.
- Two young people died in 2005.
- Four young people died in 2006.
- Three young people died in 2007.
- Three young people died in 2009.
- One young person died in 2010.

Gender

- Ten young people were male.
- Six young people were female.

Placement/Accommodation at the Time of Death

- There is no indication on the files received by the ICDRG as to where Young Person (Aftercare) 12 was living at the time of his death.
- Young Person (Aftercare) 13 was moving between the homes of her siblings and her foster family at the time of her death.

- Young Person (Aftercare) 14 was continuing to reside with her foster family at the time of her death.
- Young Person (Aftercare) 15 was living back at home at the time of his death.
- Young Person (Aftercare) 16 appears to have been living independently at the time of his death.
- Young Person (Aftercare) 17 appears to have been living with her foster father at the time of her death.
- Young Person (Aftercare) 18 was last documented as living in transitional housing however it is unclear from the files supplied to the ICDRG where he was living at the time of his death.
- It is unclear where Young Person (Aftercare) 19 was living at the time of his death.
- It appears that Young Person (Aftercare) 20 was living in private rented accommodation at the time of his death.
- It is unclear where Young Person (Aftercare) 21 was living at the time of his death.
- It is unclear where Young Person (Aftercare) 22 was living at the time of his death however he had been staying in bed and breakfast accommodation prior to the closing of his file.
- Young Person (Aftercare) 23 was living in a hostel at the time of his death.
- It is unclear where Young Person (Aftercare) 24 was living at the time of his death.
- It appears that Young Person (Aftercare) 25 was living independently at the time of her death.
- It is unclear where Young Person (Aftercare) 26 was living at the time of her death.
- When the file of Young Person (Aftercare) 27 was closed on her 18th birthday she was living in a bed and breakfast with a plan to move to independent living however it is unclear if she was living independently at the time of her death.

Individual Case Analysis

3.2.12 Young Person (Aftercare) 12

This young person died in 2006, aged 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records supplied to the ICDRG, it is clear that this young person had a traumatic childhood. A pattern of severe domestic violence and alcohol abuse led to the family moving to live abroad early in his life. The family moved frequently to escape from a number of violent and physically and sexually abusive relationships. By age 9 he had experienced nine changes of school and he had fallen significantly behind in his education. This young person was diagnosed as having dyslexia and from an early age was exhibiting behavioural problems. He had been in care while the family lived abroad for a period.

When the family returned to Ireland they very quickly came to the attention of the HSE, as his mother had great difficulty coping with young person's behaviour. In addition, he was excluded from school at the age of 10 because of disruptive and truant behaviour. The local HSE engaged with the family. Very quickly, the allocated Social Worker identified that this child "puts himself at great risk because of his behavioural problems." She expressed her profound concern about his welfare. Her involvement followed an incident where the child, having run away from home, was admitted to hospital and found by the hospital staff to be out of control. No placement was available and he was discharged home. He was then just over 10 years old.

A few months later, this young person was admitted to a group home on a day fostering basis and then for short-term residential care as he had again run away from home. His mother cooperated with the HSE but was unable to control him and was growing increasingly concerned about his behaviour, his alcohol intake and his involvement in petty theft and other criminal behaviour. During this time he was referred for assessment to the CAMHS Services. The need for a placement that could meet his need for safe care and therapeutic treatment was clearly identified.

One year after coming to the attention of the HSE he was admitted to an open residential centre/school. He was placed in voluntary care. Prior to his admission to care he had not attended school for over a year except for a few weeks. He was unable to settle into the school day and his acting out behaviour led to his exclusion.

After an initial settled period in this school, this young person was again absconding and putting himself at risk. This was discussed at meetings and the school notified the HSE that the placement was breaking down. Finally, after 18 months, his placement broke down and he returned home. He was out of school, the family accommodation was overcrowded, he had a new Social Worker and it had proved difficult to get him into a more secure setting. He was now just 13 years old. Home tuition was finally approved for him and suitable personnel were recruited by the HSE. At that point difficulties arose over travel for this young person to and from the tuition, with both the HSE and the Department of Education indicating there was no provision to cover this. After a number of months, the tuition commenced. His family was frequently indicating they were unable to cope with his escalating behavioural issues. A family support worker was engaged to support the family.

After 8 months at home, this young person became involved in more serious criminal behaviour and the HSE requested a placement in a Special Care Unit following an emergency Child Protection Case Conference. A number of months passed with incomplete forms being submitted, queries not answered promptly and finally the request was refused “due to the serious nature of charges outstanding”.

Some ten months after he returned home this young person was again admitted to voluntary care. He appears to have been placed with foster carers and to have established a good rapport with one family that undertook a lot of work with him. However, again he began absconding and getting involved in increasingly serious crime. During the two years when this young person was 13 and 14, there was a constant pattern of his admission to care, initially settling, absconding and offending, returning home, further offending and returning to care. A period in a Crisis Care Placement overseas was undertaken but this too failed after he absconded and offended. He returned to Ireland, was arrested and following a court appearance he returned home when no

placement for his remand could be sourced. Finally he was remanded to a Remand and Assessment Centre for assessment and remained there for six months.

The assessment from that unit, as from previous Social Workers and other assessments, was that this young person required a secure therapeutic residential placement. The other constant was his persistent refusal to contribute to any assessment or to give his views on his future. His pattern of absconding and offending continued and on discharge from the remand centre he was again taken into voluntary care and placed with foster carers who had previously cared for him. They were unable to keep him for a month due to previous family commitments. This young person went home, absconded within a few days and again offended. The Gardaí found him and he was made the subject of a Section 12 Order[25] and placed in a local hospital for a few days.

This family which had cared for him previously was approved to receive a support package to try and sustain him safely in their home and he remained there for a few months. The pattern of absconding and re-offending saw him placed on remand. Later the outstanding charges were struck out. He immediately absconded and re-offended. His foster carers assumed care for him once again until he returned home and did not return. This closed off the option of a return to his foster care placement for him. He was then aged 15 years old.

There is very little further recording on the file about this young person. A letter indicates he had received a custodial sentence at age 16 while a social work letter states that it was then intended to close this case. There is a reference to this young person being 18 then but this is an error that appears to have resulted from confusion over his date of birth. There is a record of a review meeting in a step down facility. It is not recorded who attended this review but the recommendation was that this young person would benefit from therapeutic help, to enable him to address his alcohol and drug abuse and to deal with the loss and bereavement he had in his life. Again it is noted that he refused any intervention. A hand written note indicates this

[25] Section 12 of the Child Care Act, 1991 provides that where a member of the Gardaí has reasonable grounds for believing that there is an immediate and serious risk to the health or welfare of a child and it would not be sufficient for the protection of the child from such immediate and serious risk to await the making of an application for an emergency care order, the Gardaí can enter any house or other place and remove the child to safety.

young person was to be placed in a hostel and that the Probation and Welfare Service was involved.

There is one further note that the Gardaí made a referral to the out-of-hours service the following month for this young person to be accommodated overnight but when the service went to bring him to a placement he refused to go.

There is nothing further on the records supplied to the ICDRG. There is no indication on the file as to where this young person was living at the time of his death.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 12

- HSE Social Work Department;
- HSE Family Support Services;
- Child and Adolescent Mental Health Services (CAMHS) ;
- Gardaí;
- Education Services;
- Home tuition;
- Dyslexia Service;
- Residential Care;
- Crisis Care Service;
- Step down centre; and
- Remand and Assessment Service.

At times the various services worked together to get assistance for this young person but plans made at Child Protection Case Conferences and Strategy Meetings often went unheeded when the HSE was unable to secure a therapeutic placement for him.

Good Practice Observed on File of Young Person (Aftercare) 12

- There was a clear recognition from the beginning that this young person was at risk and quickly became a risk to others. Assessments were completed and all came to the same conclusion but the placement identified never materialised.

Concerns Arising from the File of Young Person (Aftercare) 12

- A number of Social Workers had ownership of this case and at times the Social Worker on record was also acting in a managerial capacity. At one point the Principal Social Worker appears to have been compiling reports for court appearances.
- The file provided to the ICDRG has made the task of completing a summary in respect of this young person very difficult. Some papers are filed upside down and in no particular order.
- There is no closing summary and the file contains papers related to other members of this family and to another young person who does not appear to be a family member.
- It is recommended that peripheral material such as the CVs of potential home tuition teachers not be kept on a HSE main file that relates to a particular child/young person.
- The educational needs of this young person were never met.
- There was a lack of clarity over who should do what. For example, it was unclear whether the HSE should have responsibility for the provision of home tuition.

Comment

The ICDRG believe that this case illustrates a clear inability on the part of the HSE to cope with the demands of disturbed young people in an outcome-focussed manner. Everything was attempted but little achieved. An inter-disciplinary working group should be established to address the needs of these young people.

3.2.13 Young Person (Aftercare) 13

This young person died in 2006. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person was the youngest of a large family who were known to the HSE for many years prior to the birth of this child. The home situation is described as being very chaotic with one parent serving regular periods in prison while the other parent suffered from depression and was frequently hospitalised. There was ongoing neglect and concerns regarding physical abuse in this family.

Despite services such as home help, budgeting, and day-care being put in place the situation did not improve and the year before this child was born all her siblings were removed into voluntary care under the 1908 Act. Sometime after the older siblings were received into care, the records provided to the ICDRG show that concern was expressed regarding sexual abuse of some older members of the family. This concern was accepted as being valid.

This young person was cared for at home for 2 years and then removed into voluntary care where she remained until she was 18 years old. She was with the same foster family for most of her time in care and regular reviews were held. The foster placement seems to have been largely successful, although the behaviour of this young person, who is described as having a very anxious attachment to her mother, was very challenging at times. She attended boarding school for one year when she had dropped out of the local school. On occasions she left her foster home at night and refused to reveal where she had been. The Gardaí were appropriately informed.

Every effort was made to ensure this young person's safe care. In her teenage years she began to drink heavily and to mix with young people involved in the abuse of illegal drugs. This young person was referred to many different specialist services, including play therapy and counselling, but she often refused to attend as she got older.

There was an Aftercare Plan in place with preparations over the last year she was in care. She moved into a flat which she shared with another young person and she was involved in a

training programme. Her progress was mixed on the course and she was not accepted on the second year of her course. She was asked to leave her accommodation because of disagreements with some other residents and was living between her siblings and spending some overnights with her foster family.

Some months prior to her death she was contacted by a member of her extended family who was living abroad. On the files furnished to the ICDRG it is recorded that this person had spent many years in prison for very serious and violent offences. Without the knowledge of her foster family, siblings or Social Worker, she went to visit her relative and on her return some days later she alleged she had been violently raped, and her life had been threatened if she revealed what happened. The records supplied to the ICDRG do not show that she received appropriate counselling after this disclosure. It is recorded that after the disclosure she received a number of death threats from her relative and a text message threatening her that she would be dead within a short period of time. The Gardaí were notified about the allegation of rape and the allegation of violence and it is recorded that they were liaising with the Police force in the other jurisdiction to follow up on these allegations.

This young person died in tragic circumstances some time later and those who cared for her were understandably very distressed by her death

Her foster family organised her funeral and it is recorded that the HSE would not cover the full cost of the funeral because she was in aftercare.

Services Engaged for Young Person (Aftercare) 13

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- HSE Child Care Worker;
- Play Therapy Service;
- Education Services;
- Foster Family; and
- Aftercare worker.

Good Practice Observed on File of Young Person (Aftercare) 13

- The foster family where this young person was placed worked hard at making the placement work. They showed great care and concern for her.
- When this young person spent nights away from her foster family without informing them where she had been, the Gardaí were appropriately informed.
- A large number of specialist services were provided for this young person.
- An appropriate aftercare plan was put in place with timely preparation.

Concerns Arising From the File of Young Person (Aftercare) 13

- No adequate risk assessment or mental health assessment recorded.
- This young person spent a long time in voluntary care despite having been assessed as at risk from a relative. .
- There is a history of severe neglect recorded in respect of older siblings. The ICDRG believe that therefore consideration should have been given to the application for a care order in respect of this young person from her birth.
- It is not recorded that adequate counselling services was provided to this young person following her allegations of rape and violent assault.
- The issue of funeral costs was dealt with in an insensitive manner.

3.2.14 Young Person (Aftercare) 14

This young person died in 2006 aged 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was received into voluntary care under the Children Act, 1908 directly after her birth because of the severe post natal depression suffered by her mother. She was placed in a long-term foster home where she remained until she was 12 when, at her request and in line with her family's wish, she returned home. This was a planned move. The placement back home broke down after 9 months and she returned to her original foster home.

This young person found it increasingly difficult to deal with being in care although she enjoyed a warm and loving relationship with her foster family. She required counselling over a long period to come to terms with her unsuccessful return home and the inability of her birth family to care for her. During her teenage years this young person developed Type 1 diabetes and for some considerable time she did not readily comply with the medical regime and diet required to control this illness.

This young person continued to reside with her foster family post her 18th birthday and continued to have contact with her birth family.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 14

- HSE Social Work Department;
- HSE Child Care Worker;
- Clinical Psychology Counselling Service;
- Education services; and
- Adult Psychiatry Services.

Good Practice Observed on File of Young Person (Aftercare) 14

- Good ongoing Social Work service.
- Other services, as required, were provided to this young person.
- The care plan for this young person was completed.

Concerns Arising from the File of Young Person (Aftercare) 14

- No adequate risk assessment or mental health assessment recorded.
- This young person remained in voluntary care for 18 years.
- No medicals for this young person are on the file.

3.2.15 Young Person (Aftercare) 15

This young person died in 2009, aged 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from the age of 12 months. The record supplied to the ICDRG states that a referral was made to the HSE concerning neglect and physical abuse. A social work visit confirmed the allegation and the report states that necessary action was taken. It has not been possible, however, to ascertain what actually happened from the records supplied.

From the age of four until he was sixteen years old this young person had 26 moves. It appears that he was received into the Voluntary Care of the HSE once aged 4. Again, aged 5 he was admitted on five occasions. Each admission was for a short period and the placements were a mix of foster care and residential care. At the age of 6 he had two further short admissions to care. These admissions appear to have been because his parents were unable to cope with his difficult behaviour. A number of referrals were made to CAMHS services and family support services were also put in place to assist the family.

A number of Child Protection Case Conferences were held during that two year period and finally at the age of 7 and a half this young person came into the ongoing care of the HSE on a more permanent basis. This is recorded as voluntary reception into care under Section 4 of the Child Care Act, 1991 but the appropriate Reception into Care Form was not on the files provided to the ICDRG.

From this reception into care this young person had 17 moves including spending three short periods at home. His behaviour continued to deteriorate and there was concern over his exhibiting sexualised behaviour at a young age. An assessment of this behaviour was inconclusive. The placements offered to him appear generally to have been appropriate but as the years passed it became increasingly difficult to meet his needs in less structured settings and his placements broke down because of the safety risks his behaviour posed. In therapeutic placements he did very well for some periods and had intensive help from a therapist to help

him adjust his behaviour and cope with the challenges he had in everyday life. Special needs assistance was provided to keep this young person in the education system. He was assessed as having a mild learning disability.

When this young person was 12 his placement broke down, the HSE could not source a suitable placement and he returned home with intensive outreach support. His parents could not cope with his behaviour. A placement was found for him outside the region with a 2:1 staff ratio, which was then increased to a 3:1 ratio, to enable the unit to keep the staff and young person safe.

He remained in this unit for 2 years and at age 14 and a half he moved to a specially adapted high support unit. This unit was adapted to provide care for adolescent boys with specific emotional and behavioural difficulties. The programme is of two years duration and includes additional weekly psychological support. He was charged with a number of assaults on staff during his first year there and was placed on probation. He was assessed as being of medium to high risk of engaging in serious offending behaviour.

At the second last care review meeting, it was decided that he needed to go to a follow-on residential placement on completion of his two year therapeutic programme. An application for a further placement was made and a residential placement was offered but not taken up. His final care meeting decided he should return home. It is not clear what the rationale for this decision was. The young person wanted to go home, his parents had kept regular contact with him and were very concerned for his well being. There is disagreement evident on the record regarding the issue of his return home. His parents' view that they could not cope with his behaviour other than for short periods is recorded. In any event he went home at 16 and a half directly from the high secure therapeutic service. He continued to receive psychological support once at home, but it is not clear from the files how frequently this was provided.

His parents appear to have made many requests for support once the young person returned home. He attended a youth project and seemed to be functioning reasonably well there. The HSE funded a taxi to take him there but withdrew the funding prior to his 18th birthday. The

Director of the Service appealed for the funding to be continued as it was felt his progress required that.

Two months after he returned home a project worker was appointed to ease the transition home and she was involved with him for 1 year after he left care. She requested aftercare services for him but a memorandum on the file states that he was not eligible for aftercare as he had not been six months in care post his 16th birthday. The memorandum does not address the nine years he had spent in care and the difficulties in his life of which the HSE was fully aware.

This case was closed when this young person was seventeen years and four months old.

This young person died in tragic circumstances some time later and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 15

- HSE Social Work Department;
- Residential care;
- Foster care;
- Psychological and Psychiatric Support;
- High Support Unit;
- Gardaí;
- Probation service;
- Project worker;
- Family support services;
- Youth service; and
- Private Care Provider.

Good Practice Observed on File of Young Person (Aftercare) 15

- There are clear periods when those involved with this young person worked intensely to meet his needs which were challenging and complex. This includes the staff in residential care units.

- This young person's project worker continued to offer support after the case was closed and tried to get Aftercare support for him.
- The Director of the youth service worked hard to keep him in the service.

Concerns Arising from the File of Young Person (Aftercare) 15

- No adequate risk assessment or mental health assessment until he had spent long periods in care.
- Some of the files supplied are difficult to read and there are long periods when there are no relevant records.
- The decision that this young person was not eligible for aftercare is difficult to understand from the information on the files reviewed by the ICDRG.
- It is difficult to understand why this young person was discharged home directly from a high support unit when there was such ongoing concern for him. While he clearly wished to return home and not to remain in or return to care and his family remained committed to him, from the record it appears that the family did not fully understand or accept he was returning home permanently.

3.2.16 Young Person (Aftercare) 16

This young person died in 2005, aged 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

The family of this young person was known to the HSE for many years prior to his birth and all but one of his siblings were removed into care over the years. A social work report records that when this child was 6 months old he was removed into the care of the HSE under a Fit Persons Order pursuant to the Children Act, 1908 and placed in short term foster care. This was successfully challenged by his parents and he returned home. Some months later the family split up in the wake of allegations of severe domestic violence and substance abuse. This child then moved with his mother and some siblings to a Women's Refuge. Personnel there were concerned about the care of the children and subsequently this young person was admitted to hospital with gastroenteritis. The medical staff noticed a lot of bruising on his body and at that point he was removed, again pursuant to a Fit Persons Order under the 1908 Act. This order was

continued until he was 16 years. This order does not appear to have been converted to an appropriate order when the Child Care Act, 1991 came into force.

It is difficult to identify the exact sequence of his placements as the records provided to the ICDRG are hard to follow. It appears, however that this young person had two short term placements in his first 21 months in the care system, initially with a foster family for 3 months, then in a residential home for 18 months. He then moved back to his foster home where he spent the next 19 months. When he was almost five years old he was moved again to another foster home where he remained until he was almost 13 years old.

The records show that from early childhood this young person presented with challenging behaviour and could be very aggressive when frustrated. At age 13, an assessment by the CAMHS Service found that he had a severe attachment disorder and would require ongoing counselling.

His foster placement broke down when he 13 years old and he returned to live at home and a Community Psychiatric Nurse commenced work with him. It is recorded that the Fit Persons Order was continued at that point, although by then the Child Care Act, 1991 was in force. He remained at home for 7 months and then experienced 3 different residential placements between the ages of 14 and 16. One of these placements was under the management of a private security firm. This young person returned home at that stage without the agreement of the HSE. Within a short period of his returning home his behaviour was again causing concern and some respite care in his last residential placement was organised for him.

A very serious dispute arose between two HSE areas (then two separate Health Boards) concerning who had care responsibility for this young person as his family lived in a different area from the area that had responsibility for him previously and in whose area his long-term foster family lived. This dispute involved legal representation for each of the then two separate Health Boards and ultimately this was resolved following legal action by his family. During the period of 14 months when this dispute was ongoing, there was minimal social work support for this young person and his family. One area closed the case and the other area refused to accept the case.

This young person's behaviour continued to deteriorate. He was frequently in trouble for criminal offences usually in the context of the abuse of alcohol and drugs and eventually he was admitted to an Adult Psychiatric Hospital. Upon his discharge, addiction counselling was offered to him but this was rejected by the young person. The hospital expressed concerns that this young person was not in care under the Child Care Act, 1991 so that his complex needs could be met in an appropriate way.

Finally, it was determined which area of the HSE would take responsibility for him. He remained in the area where his family lived and had periods where life appeared to have become more settled for him. An aftercare plan was put in place for him with an external agency and that appears to have been more successful. Prior to his death he was living in a more independent situation, had regular support from an aftercare worker and practical matters related to employment and finances were resolved.

He advised his family he was moving to live out of the area and then failed to make contact with them. He died some time later.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 16

- HSE Social Work Department;
- Residential care;
- Foster care families;
- Psychological and Psychiatric Support;
- Gardaí;
- Aftercare worker from private agency;
- Family support services;
- Youth services; and
- A number of Private Care Providers.

Concerns Arising from the File of Young Person (Aftercare) 16

- No adequate risk assessment or mental health assessment on record.
- The needs of this young person were challenging and complex from an early age. On admission to the care of the State he was found to be neglected and physically abused.
- His placements broke down because of his attachment difficulties. It would have been appropriate for this central issue, which was recognised, to have received attention at a much earlier point and his long term foster carers who endeavoured to care for him as long as possible could have benefited from support and services from the outset of his placement back with them as a small child.
- His needs were not holistically assessed and he was allowed to return home without any risk assessment or assessment of his family's capacity to care for him.
- The files supplied are not in order, many are difficult to follow and it required much work to get any picture of the life and many moves experienced by this young person.
- The needs of this young person were not properly considered when two HSE areas spent long periods refusing to take responsibility for him. It is the view of the ICDRG that there was a waste of public funds in engaging legal services to reach a conclusion that should have been agreed by HSE management. The time lost and energy expended in engaging in this drawn out dispute may not have influenced the outcome for this young person but it reflects very poorly on the management of the child welfare services.

3.2.17 Young Person (Aftercare) 17

This young person died in 2005, aged 19 years old. The death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was known to the HSE from age 5 years when she was taken into the care of the HSE on a voluntary basis initially and then under a Fit Persons Order under the Children Act, 1908. Her mother was in long-term psychiatric care and her father was unable to provide a satisfactory level of care for her due to alcohol addiction. She was initially placed in residential care and then moved to a foster care placement which did not work out. She returned to residential care from which she was successfully fostered on a long-term basis. Her father died suddenly when she was 11 years old.

The records supplied to the ICDRG are very sparse and do not provide records of this child's early years with her foster carers. However, her placement appears to have progressed satisfactorily until her teenage years when her foster parents separated. This caused the young person some concern as she worried she would have to return to residential care but she remained with her foster father who was reassessed as her carer and this appears to have worked very well. A psychology service was secured to assist her with issues that related to her fears for the future as she understood more about her mother's health and this appears to have been significantly beneficial for her. This young person did very well academically and she was in third level education at the time of her death, insofar as can be determined from the records supplied. Regular care reviews under the Child Care Act were held and some care plans were documented.

Her legal status is recorded as having continued under the Fit Persons Order until she was 16 when her mother signed a request for voluntary care under Section 4 of the Child Care Act, 1991.

An aftercare worker was assigned to this young person when she reached 18 but there is very little recorded as to what if any contact occurred during the aftercare period. From the depositions provided to the Coroner's office it appears that this young person spent an evening socialising with friends, returning home in the early hours of the morning. Her foster father was unable to wake her a few hours later as she had passed away.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 17

- Residential Care;
- Foster care;
- Psychological services;
- HSE Social Work Department; and
- Aftercare worker.

Good Practice Observed on File of Young Person (Aftercare) 17

- Clear attention was paid to concerns of the young person and services were engaged to meet her needs.
- This young person's wishes in relation to her ongoing placement with her foster father were respected and an appropriate assessment was completed.

Concerns Arising from the File of Young Person (Aftercare) 17

- No adequate risk assessment or mental health assessment on record.
- The files supplied to the ICDRG are very sparse, inadequate and do not record the life of this young person in the care of the State.
- Nothing recorded by the aftercare worker on the file.

3.2.18 Young Person (Aftercare) 18

This young person died in 2009, aged 19 years old. The ICDRG has been informed by the Coroner's office that the inquest into the death of this young person has not yet been completed and no death certificate has been issued.

Summary of Care Circumstances

This young person lived with his father until his father passed away when he was 9 years old. From the record provided to the ICDRG it appears that there were allegations that this young person had been neglected and subjected to physical and sexual abuse. Older siblings had been abandoned in hospital and placed in foster care while other siblings were in care in another jurisdiction.

Following the death of his father, he was placed in voluntary care and was placed with friends of the family under Section 36 of the Child Care Act, 1991.[26] This young person also had three aunts who took an interest in him and cared for him whenever they could. His mother had a learning disability and also had mental health problems throughout her life and was regularly

[26] Section 36 of the Child Care Act, 1991 allows for a child in the care of the HSE to be placed with relatives or for the HSE to make other suitable arrangements as it thinks proper.

admitted to a psychiatric hospital. She is also reported to have abused alcohol. His father is said to have had mental health difficulties also.

From the records furnished to the ICDRG it appears that this young person's parents had a very volatile relationship with several break-ups and arguments. The mother was unable to keep appointments to see her children in care and at no time did she care for all of them in a family setting. She died from a subdural haematoma when this young person was 16.

This young person was described as presenting like a 2 year old when he came into care even though he was 9, he could not wash himself, use the toilet or chew his food. He was clearly not used to a routine in his life and seems to have raised himself. It is not clear from the records if the HSE had properly and fully assessed the care of this young person and his siblings during the years they were in their father's care.

This young person was in foster care with the same family for almost 5 years and initially he appeared to settle and function well. From the records it would appear that the child absconded from this family on a number of occasions. Finally the placement broke down and the young person alleged he had been physically abused. This allegation was investigated however it was not substantiated. For the next two years he accessed the out-of-hours service and spent some time in accommodation for homeless children. His behaviour at times was described as being very disruptive and he left the accommodation of his own accord. One of his aunts provided supported lodgings for him at weekends. It is recorded that she requested supports and counselling to address the various serious issues that arose from his life and early childhood. She was constantly told that he was on a waiting list for those services. However, no significant appropriate counselling was put in place. This care arrangement broke down as she was concerned that his drug abuse was creating safety issues for her small children. He returned to the out-of-hours service.

When he was 17, this young person returned to the original foster family. Again however, this placement broke down. Two high support placements were offered to this young person but he refused to attend either.

Efforts were made to provide an aftercare programme for him with a view to placing him in semi-independent living in a supported environment. He engaged with this aftercare programme to a certain extent but he was still not in safe accommodation.

This young person appears to have been drawn into criminal activity and drug abuse while on the streets and there was concern that his behaviour was bringing him into contact with older adults who posed a threat to him. It appears that he spent some time in prison where he had visits from his family, was drug free and looking to get treatment for his drug addiction. Shortly after his discharge from prison he was found dead.

It is not known if this young person was discharged from care – his file appears to have been closed when he reached the age of 18 however this is not explicitly stated on the record. The ICDRG did not receive any details on the circumstances surrounding the death of this young person from the HSE.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 18

- CAMHS;
- HSE Social Work Department;
- Out of Hours Service;
- Residential accommodation;
- An Education and Training Programme;
- NGO services;
- Teen counselling service;
- Aftercare worker NGO service;
- National Education and Welfare Board services;
- Youth Advocacy programme; and
- Youth homeless services.

Good Practice Observed on File of Young Person (Aftercare) 18

- The death of this young person is the subject of an ongoing review by the National Review Panel.

Concerns Arising from the File of Young Person (Aftercare) 18

- No adequate risk assessment or mental health assessment is on record.
- There appears to be some information missing from the files received by the ICDRG – there is no information provided on the death of this young person.
- It is not clear how this young person and his sibling were left in the care of a father where living conditions, personal care and nutritional needs were not being met. The description recorded on file of the two children on their reception into care suggests neglect of their basic needs over a long period of time.
- Early intervention and monitoring of this family might have pre-empted most of the difficulties experienced by this young person.
- Neither the feelings of grief experienced by this young person nor the abuse suffered by him at a young age were addressed.
- There were periods when no Social Worker was assigned to this young person.
- The critical needs of this young person were not addressed.

Comment: This young person's contact with his extended family where he had a strong connection does not appear to have been properly supported and indeed counselling services were not provided when it was known that his early years were characterised by neglect and abuse. The ICDRG is concerned that there appears to have been significant shortcomings in the care provided to this young person.

A number of professionals tried to engage with this young person over his time in care. The aftercare service provided does not appear to have met his needs although his key worker tried very hard to secure services for him. This young person was at risk from early in his life and a full inquiry is necessary to learn the lessons and inform future practice.

The Ombudsman for Children has undertaken an examination of this young person's interaction with the HSE in response to complaints received by that office under Sections 8 and 9 of the

Ombudsman for Children Act, 2002. The ICDRG understands that the National Review Panel is also reviewing this case. It is very important that the lessons are learned from this case and that young children with vulnerable parents are not left in an unsafe environment. It needs also to be understood why the admission of this young person to the care system does not appear to have triggered appropriate counselling services and other supports.

3.2.19 Young Person (Aftercare) 19

This young person died in 2004, at the age of 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person was the youngest of three children. It appears from the records furnished to the ICDRG that there were frequent violent altercations in the home with the mother presenting to a women's refugee with her children. The mother decided to live abroad and she removed this child and his older sister with her. The oldest sister remained with the father.

While living abroad, it is recorded that the mother abandoned both children in a crèche. The children were placed in emergency foster care and after contact was made with the father, the children were returned to Ireland. This young person was received into voluntary care and placed with foster carers and his sisters were placed in residential care. A Fit Person's Order under the Children Act, 1908 was also made in respect of this young person. He continued to have some contact with his father and his younger sister. He had no contact with his mother for many years.

As this young person matured he became unsettled and needed a number of services and management. He was reviewed by a psychologist who assessed that he had difficulty bonding due to his abandonment as a child. When he commenced secondary school, he also moved foster homes.

At this stage, issues of a sexual nature manifested themselves, with this young person displaying inappropriate sexualised behaviour with his peer group and teachers in the school setting. He was also accused of sexualised behaviour with a foster family child and this was investigated and

subsequently validated. It appears that he was assessed by a specialist agency which deals with sexualised behaviour and was given specialist counselling. He appears to have benefited greatly from this.

In his teenage years, this young person became involved in criminal behaviour and he spent time in a criminal detention facility. Placements became difficult to secure as this young person had been labelled as a sexual abuser and this meant that placement managers were reluctant to put the other children/young persons in their facilities at risk.

This young person was placed in a step down facility following his period in the criminal detention facility. He made great progress while in this facility. Great efforts were made to try and find a subsequent placement for him to ensure continued support and assessment and to help him cope with his discharge from care at the age of 18. There were also repeated requests by this young person's Social Workers for a specialist re-assessment in relation to his sexualised behaviour. However it appears that this was refused due to a lack of funding.

He had been placed in a final residential facility after the step down facility but he found the setting too confining and displayed impatience and aggression. He was discharged after 2 months in residence and went to live with his previous foster carers but this too did not work out.

The young person was discharged from care aged 18 years to transitional housing. It appears he gradually became more troubled. His case was closed then, so effectively he was on his own and on the streets. There is no more documented contact with the young person after this time. He was found dead some time later.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 19

- Gardaí;
- Mental Health services;

- Voluntary & Community services;
- HSE Social Work Department;
- Foster Care services;
- Psychology services;
- Specialist Assessment Services;
- Homeless Services;
- Courts Service;
- Specialist Child Sexual Abuse Unit;
- Child Care Worker;
- Remand Centre;
- Psychotherapy services;
- Work Placement; and
- Sporting facilities.

Good Practice Observed on File of Young Person (Aftercare) 19

- Good interagency cooperation.
- Services appear to have been well organised and client focused in the early years.
- Genuine efforts were made by this young person's Social Workers to ensure that he had appropriate support and placements.
- Files are very detailed and well documented.

Concerns Arising from the File of Young Person (Aftercare) 19

- There are no details on the file of the last four months of this young person's life.
- The labelling of this young person as a potential sexual abuser had a significant impact on him, as it significantly affected his ability to obtain homeless accommodation and general accommodation. This continued despite his very positive engagement with and response to treatment.
- It appears that he benefited greatly from the specialised counselling in relation to his sexualised behaviour, however no re-assessment was obtained. The ICDRG believe that had an updated assessment been obtained, his accommodation provision might have been different.

- The aftercare provision for this young person was too short and his file was closed before it was established that he was secure in his independent living accommodation.
- It is recommended that aftercare should be a comprehensive statutory service provided to vulnerable persons such as this young person and reviews should be undertaken to inform decisions as to whether the recipient is able to live safely independently.

3.2.20 Young Person (Aftercare) 20

This young person died in 2010. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

It is detailed on the HSE files that both parents of this young person were alleged to have been heroin users in addition to there being a history of domestic violence in the family. From the files furnished to the ICDRG it appears that that this young person experienced physical violence as a young child. During this time, it is recorded that extensive social work intervention was offered to support the family including a family support worker and day fostering for the children. There is nothing on the file provided to the ICDRG to indicate this work was followed through as full recording appears to have begun only after the children were taken into care.

This young person was initially received into voluntary care aged 5 and there was an indication that this would only be for a period of 5 weeks. He went on to have in excess of 18 placements in the care of the HSE. His mother left Ireland shortly after this young person was received into care. The young person appears to have remained very close to his younger sister and they were placed together for his first three years in care. His contact with her was restricted when he was placed in the High Support Unit although he was constantly asking for greater contact. This young person had no contact with his father until he left care.

During his time in care, he was displaying high risk behaviours akin to a much older child, including the abuse of solvents at the age of just 9 years old. As a result, this young person was placed in residential care. During his four months in residential care, he sometimes went missing for nights at a time and was engaging in criminal activities.

Subsequently, this young person was admitted to a Special Care Unit on foot of a High Court order. He was just over eleven years old. At this point he was displaying extremely risky behaviours including drug and alcohol abuse, living on the street in addition to regularly absconding from his previous placement. He remained in the Special Care Unit for 15 months and was placed in a children's detention centre for 3 weeks following destructive behaviour in the Unit. He then returned to Special Care for a further 8 months. While in Special Care, there were various assessments carried out on this young person including psychological and psychiatric assessments. He was diagnosed as having Attention Deficit Hyperactivity Disorder and Socialised Conduct Disorder. There were protracted hearings in relation to this young person in the High Court.

Over the next 4 months this young person moved between periods of absconding, being placed in High Support Units and children's detention centre until he was convicted and sentenced to 2 years detention for criminal damage.

While there was a plan to gradually move this young person home to live with his mother from his period of detention, when the plan began to show cracks, greater supports were not offered. Originally it was planned that he would return home 6 months before the end of his detention, but this was delayed until the detention actually ended. From the records provided to the ICDRG it is recorded that while living at home he was openly taking drugs and drinking. He was 15 years old. There were a few visits to the young person on his discharge from detention, but it appears from the file that there was a lack of involvement by the Social Work Department at this time.

This time appears to have been extremely chaotic for this young person and his behaviour appears to have truly deteriorated and he became subsumed within a criminal sub-culture. This young person appeared to have moved out from his mother's house and began living with his sister and then, subsequently his father. The last recording of his whereabouts was that he was living with another relative.

This young person died in tragic circumstances some time later and those who cared for him were understandably very distressed by his death

Services Engaged for Young Person (Aftercare) 20

- Gardaí;
- Mental Health services;
- Voluntary & Community services;
- Psychiatric services;
- Psychological services;
- Juvenile liaison programme;
- Family support services;
- HSE Social Work Department;
- Guardian Ad Litem; and
- Community child care worker.

Good Practice Observed on File of Young Person (Aftercare) 20

- Good interagency cooperation regarding the mother's drug abuse.
- Good interagency cooperation when this young person was placed in Special Care and the High Support Unit.
- Numerous care plans were drawn up for this young person.

Concerns Arising from the File of Young Person (Aftercare) 20

- No adequate risk assessment on the record.
- There was a family history of psychiatric illness and this young person was exhibiting very difficult behaviour from 9 years old. No Mental Health assessment was undertaken in respect of this young person until many years after his admission to care.
- It appears that this young person was essentially abandoned once he left the detention centre. There appears to have been little support offered to him from that point. He does not appear to have received any aftercare.
- The lack of interaction between the criminal justice system, the psychiatric services and the welfare and protection systems in respect of very troubled young people is clear in this case.
- The legal status of this young person needs to be clarified. Initially he was placed in care under a Voluntary Care Order. He was admitted to Special Care in September 2001 under a High Court Order. It is not clear whether this Order was discharged upon his

being detained for criminal damage or indeed whether the Voluntary Care Order was still in operation.

- It is recommended that a more in-depth review of this case should take place as the evidence on the file provided to the ICDRG is not sufficient to fully ascertain the level of care given to this young person.

3.2.21 Young Person (Aftercare) 21

This young person died in 2007, aged 19 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person's mother was a known drug user and served many prison terms for drug related offences. Her partner also appears from the files to have been a known drug user who had served various periods of time in prison for armed robbery. This young person was raised by his maternal grandmother from birth. There doesn't appear to have been any appointment of the grandmother as a guardian, there is a case note reference on the file to the fact that the child was being raised by her. When his mother was released from prison, she acquired her own accommodation, but this young person continued to live with his grandmother.

There were four referrals to the HSE from when he was aged between 8 and 11 years old. Two of these referrals were in relation to where this young person and his siblings would live. It appears that his mother was not happy that the children were residing with the grandmother. It was concluded that there were no child protection issues present when the referrals were followed up. There was also a referral by the Gardaí in relation to child welfare and a referral regarding domestic violence. The later referral regarding domestic violence resulted in this young person being placed in the care of the HSE and he continued to reside with his grandmother (it appears to have been voluntary care; however this is not clear from the records provided).

The first Care Plan completed when this young person was 16 indicated work was needed in relation to a "peer he is hanging around with" and that this young person was in need of a youth

support service. There is no evidence of this being followed up. There was no Social Worker appointed to this young person until he was 16 years old. Prior to that point the case was dealt with solely by the duty Social Workers. There were in excess of 12 Social Workers involved with this case and there appears to have been no continuity in the care provided by the HSE Social Work Department to this young person.

This young person attained his Junior Certificate and went on to secure an apprenticeship and appeared to be progressing well. At that point another Care Plan was completed but appears to be a "cut and paste" process from the previous Care Plan. When he was 17 the Social Worker wrote a letter stating that this young person was no longer on the apprenticeship course and therefore his grandmother was no longer entitled to a fostering allowance.

Later that year this young person's grandmother contacted the HSE Social Work Department, told them she was moving out of Dublin and that this young person had sourced private rented accommodation, where another family member was the caretaker. The Social Worker from the Family Addiction Support Team (FAST) wrote supporting rent allowance for the young person. The FAST team appears to have been involved with the mother of this young person; it is not recorded if this young person himself was in receipt of a service from this team.

There is also a record on the file of a phone call from this young person's mother to the duty Social Worker when he was 18 to state that he had harmed himself after consuming a quantity of alcohol. The duty Social Worker gave the mother the name of the allocated Social Worker. However no further contact was recorded on the file in relation to this. The matter appears to have been left at that. There is no information relating to the aftercare of this young person on the file received by the ICDRG.

This young person's grandmother rang the Family Addiction Support Team (FAST) to inform them that he had died. It is recorded on the files furnished to the ICDRG that a Social Worker was requested to link with the family. There is no record that this occurred. Three weeks later the Grandmother again requested help. A home visit two days later revealed that the young person had appeared very happy, had gone to bed and had been found dead by the following morning.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 21

- Gardaí;
- HSE Social Work Department;
- Mental Health Services;
- Voluntary & Community Services; and
- Addiction Services.

Concerns Arising from the File of Young Person (Aftercare) 21

- No adequate risk assessment or mental health assessment on record.
- There is a very poor level of recording on the file with most of the records that are available concentrating on the needs of the mother and other family members. Little is noted concerning the risks to this young person and his sibling. There are 3 different dates of birth for this child on the file.
- There were in excess of 12 Social Workers involved with this young person. However a dedicated Social Worker was not appointed until 5 years after he was received into the care of the HSE.
- It appears that there was no sustained engagement with this family or attempts made to build up a relationship with this young person. This is evidenced by the lack of engagement with this young person, no aftercare support being offered to him and no sense of how life was for this young person who was in the care of the State.
- The support offered to this family appears from the records to have been inadequate. Any social work intervention appears to have occurred as a result of contact from the family at times of crisis, although these calls do not appear to have been followed up in every instance.
- Issues regarding this young person, his care and needs which emerged at reviews do not appear to have been followed up.
- In the file provided to the ICDRG, there appears to have been only one instance where a Social Worker actually spoke to this young person. Other than this one instance, it appears all contact was with the grandmother or mother.

- There appears to have been a lack of follow-on social work involvement once this child was taken into care.
- This young person's case would benefit from looking closely at the types of interventions that were identified as potentially meeting the young person's needs and why they were not offered.
- It is also suggested that identifying the supports that the family feel they needed which they did not receive may serve to identify preventative strategies for young people in a similar situation for the future.

3.2.22 Young Person (Aftercare) 22

This young person died in June 2007, at the age of 20 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that this young person presented to the duty Social Worker with his mother when he was aged 17. He advised that he was sleeping in his car as he had been thrown out of his home. His parents were separated and his mother was living with her partner.

The father was reported to be abusing alcohol and providing inadequate care for this young person and his sibling. This concern does not appear to have been followed up with the father of this young person. This young person had been working and he was providing for himself and his sibling. However he had finished his last job one month previously.

This young person could not live with his mother as he had previously been involved in a serious altercation with her. It was agreed that his mother would sign a voluntary care form and that this young person would be placed in a Bed and Breakfast accommodation until the age of 18. His mother indicated that she would view the accommodation and she would support him there.

A Social Worker continued to monitor and see him for the few weeks and he was reported to be doing well. The case was closed by the HSE just before he was 18. There are no further details

on the file and it does not appear that any follow up was carried out in relation to this young person.

There is no information on the records provided to the ICDRG on how this young person died or on the circumstances surrounding his death.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 22

- Bed and breakfast accommodation.

Concerns Arising from the File of Young Person (Aftercare) 22

- No adequate risk assessment on file.
- This is a very short file with very little information recorded.
- It is worrying that this young person was offered care for a few weeks prior to this 18th birthday and then received no follow up.
- There does not appear to have been any attempt to address the issues that had led to him being rendered homeless in the first instance.

3.2.23 Young Person (Aftercare) 23

This young person died in 2007, at the age of 20 years old. This death was registered on foot of a Coroner's certificate. This young person was a sibling of another young person referred to in this report.

Summary of Care Circumstances

From the records furnished to the ICDRG it appears that the family of this young person was known to the HSE from his birth. There was concern about poor parenting practices, neglect, inadequate housing conditions and a failure to engage with support services.

A Fit Persons Order under the Children Act, 1908 was granted in relation to this young person and his three siblings when he was 9 months old. The young person and his brother were placed in foster care together. The young person remained with this foster family from age 9 months until he was 17. From the records furnished to the ICDRG it appears that the foster family had difficulty in managing his behaviour and his drug habits and the placement broke down as a result. He often went missing, stayed with friends and abused illegal drugs. This was appropriately reported to the Gardaí.

Following the break-down in his foster care placement, this young person returned home initially and then stayed with his sister for some time. This was followed by a period in two Special Care Units and a number of homeless shelters. During this period of time, his Social Worker remained working with him. He was allocated a NGO worker when he was 17 and he found this service very supportive and helpful.

From the records available to the ICDRG it appears that his exclusion from the funeral of his brother who grew up with him and who died when this young person was 16 had a profound effect on the well being of this young person.

Between the ages of 18 and 19 years, this young person spent most of his time in a criminal detention facility as a result of convictions for robbery and petty crime. He was addicted to drugs and alcohol and it appears the crimes were carried out to feed these habits. His case was to be closed as he had attained the age of 18 but when the Social Worker met to discuss this with him she discovered he was sleeping rough and was drinking very heavily and abusing drugs. The Social Worker accessed mental health services for him and visited him daily to provide emotional and practical support by buying him food and clothing.

Some months prior to his death, this young person was admitted to hospital in Dublin for an unintentional drug overdose. The overdose had caused serious damage to his lungs but he refused to follow up on this. At this time, his Social Worker secured a place for him in a drug and alcohol treatment centre but he was discharged within a week. The Social Worker found a place for him in a second treatment centre but again he was discharged, with the Centre stating that his needs were more complex than they could provide for.

A place was then found for him in a hostel and he stayed there and was drug-free. It was required that he leave the hostel during the day so his Social Worker collected him each morning and brought him back each evening. After three months of being free of alcohol and drugs, he began abusing these substances again and was discharged from the hostel. He began attending a psychiatric hospital and moved into a hostel linked with the hospital as part of its out-patient treatment programme. He responded well to this programme and attended the psychiatrist regularly.

Just prior to his death he had asked his Social Worker to get him a pair of black jeans and she had agreed. They were to meet to organise the purchase. However the hostel phoned her to tell her that he had been found dead in his room. He had given her name as his next of kin. He had returned to the hostel early the previous night. He did not appear to have been intoxicated or affected by drugs. He had a cup of tea with staff and then went to bed and was found dead the next morning.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 23

- Gardaí;
- Mental Health Services;
- Voluntary and Community Services;
- HSE Public Health Nurse;
- Community Welfare Officer;
- Family Support Services;
- Child and Adolescent Mental Health Services;
- HSE Social Work Department;
- NGO worker; and
- Risk Assessment and Consultation Services.

Good Practice Observed on File of Young Person (Aftercare) 23

- The Social Worker who was engaged with this young person for the last 5 years of his life provided him with exceptional support and is to be commended for her work.
- This young person received significant help and support from his NGO worker.

Concerns Arising from the File of Young Person (Aftercare) 23

- The files received by the ICDRG were badly organised with poor quality of reporting.
- It appears from the files that this young person had in excess of 7 Social Workers and there was a period of time when no Social Worker was allocated to him.
- There should be a separate file for each of the children of the family.
- There was no early comprehensive assessment carried out of the risks to or needs of the children in this family.
- While a needs assessment was completed, it was only undertaken in his later years in care.
- The coordination of services supplied to this young person could have been improved.
- There was no comprehensive risk assessment/mental health assessment carried out at an early point and the planning in relation to this young person appears to have been reactive rather than proactive.
- As this young person was unlikely to return home, adoption should have been considered at an early point as a childcare option.

3.2.24 Young Person (Aftercare) 24

This young person died in 2009, at the age of 20 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

When this young person was 4, the HSE Social Work Department was alerted that concern had been expressed that the children of the family were not receiving proper care. From the records supplied to the ICDRG it is recorded that two months later, this young person was admitted to hospital with bruising on his leg. The hospital Social Worker referred the matter to the HSE Community Care Team. It is recorded that his mother was reluctant to take him home from hospital and thus began a long period of contact with the HSE. The child was informally placed

with the maternal grandmother pending a psychological assessment. The maternal grandmother was then approved as a relative carer.

This young person's parents separated as their relationship was very abusive and it was alleged that there was much domestic violence in the home which had been witnessed by the children. . It is recorded that there were issues concerning the parents' alcohol abuse and the neglect of the children. There were also concerns about the ongoing problems in the home with managing this young person's behaviour.

Over the next four years the Social Work Department worked with the family. The family moved abroad for some periods during this time. Finally this young person was taken into care under a Full Care Order pursuant to section 18 of the Child Care Act, 1991 when he was 9 years old.

After being taken into care, this young person had numerous placements in foster families and with his maternal grandmother who cared for him as best she could. When it got too much for her, she asked the HSE for respite or to seek alternative care for him. Throughout this period, his behaviour was difficult to manage both at home and in school. He is described as a very bright child but not performing to his ability.

This young person maintained contact with his family while he was in care. He had further hospital admissions to Accident and Emergency with lacerations and cuts alleged to have been inflicted in his home.

Until his 18th birthday, the Social Work Department tried to find suitable placements for him including special care provision, but he refused to settle and had a history of aggression and violence towards staff and his carers. During his time in and out of care, this young person had in excess of 12 placements including foster care placements, relative care and residential accommodation.

This young person left care at the age of 18, but failed to engage with the aftercare services on offer to him. There is no evidence of pre-discharge planning. A Social Worker was named to

support him in the event of his returning to the aftercare services and contacted this young person to inform him of this.

There are no details on the file regarding the circumstances surrounding this young person's death.

This young person died in tragic circumstances and those who cared for him were understandably very distressed by his death.

Services Engaged for Young Person (Aftercare) 24

- HSE Social Work Department;
- Mental Health Services;
- Voluntary and Community Services;
- Gardaí;
- Child Guidance Clinic;
- Hospital Services;
- Child care workers; and
- Psychologist.

Good Practice Observed on File of Young Person (Aftercare) 24

- A genuine attempt was made by his maternal grandmother to care for this young person.

Concerns Arising from the File of Young Person (Aftercare) 24

- The file supplied to the ICDRG is very hard to follow as it is disorganised and there is a poor quality of reporting.
- It appears from the files reviewed by the ICDRG that this young person may have been left with his family when there was evidence that he should have been taken into care.
- The interventions in relation to this young person were fragmented with a short-term focus.
- No comprehensive risk assessment/mental health assessment was carried out.
- Ineffective coordination of the services engaged for this young person.

- While emerging problems with this young person were identified, there was no concerted effort to address his problems and his needs.
- There was a lack of permanency planning for this young person with a number of unsuitable placements being used.

3.2.25 Young Person (Aftercare) 25

This young person died in 2006. The death was registered on foot of a Coroner's Certificate.

Summary of Care Circumstances

This young person was part of a large family. From the records furnished to the ICDRG it appears that there was excessive alcohol consumption in the home and arguments frequently occurred between the parents and the children. Moreover, it is recorded that the children were sometimes left alone without adequate food and care while the parents of the family consumed alcohol. The situation deteriorated with the children experiencing problems in school and getting involved in anti-social behaviour. Eventually the family was evicted from their home for non-payment of rent. At this stage, it appears from the records that this young person was already involved in criminal activity.

A number of referrals were made to the HSE which were not followed up immediately. A Child Protection Case Conference was held when this young person was 6 years old and it was decided that the family would be monitored and a Supervision Order under section 19 of the Child Care Act, 1991 was made. It is noted that serious concern was expressed at this Child Protection Case Conference about the potential risks to the children due to the serious level of dysfunction within the family. The family was well known to a variety of agencies at this stage as a result of the alcohol abuse, violence and neglect of the children. However it appears that no adequate supports were offered to the family.

This young person was taken into care on an Interim Care Order under section 17 of the Child Care Act, 1991 after being found by the Gardaí in an open place in the early hours of the morning. She was then 13 years old. The interim order was subsequently converted into a full

Care Order under section 18 of the 1991 Act. A Guardian ad Litem report was prepared for the Court.

This young person was initially placed in a residential home for a short period and was then moved to a short term foster care placement. She was next placed with a foster family where she remained for the duration of her time in care and where she settled well. Regular reviews were completed while this young person was in foster care. She continued to have contact with her parents while in care. However it is stated on the file supplied to the ICDRG that her parents held this young person responsible for both herself and her young brother being in care.

This young person displayed a lot of insecurities during her time in care and had very low self-esteem. She was also functioning at the lower end of the educational achievement table. She was engaged with an education and training programme and made good progress there. However she expressed concerns about her ability to manage after she left care. Unfortunately, this young person had to leave care earlier than planned as her foster care placement broke down due to a violent, alcohol-fuelled episode against her foster mother. Following this, she was accommodated by her sister on the strict condition that this young person would not consume alcohol.

The placement with this young person's sister was treated as a respite placement as there had been an aftercare plan drawn up for this young person whereby she would seek her own independent shared accommodation with a friend.

When she was 19 this young person gave birth to a child and subsequently secured her own independent accommodation. Initially she was managing well however she soon began drinking again and her lifestyle became chaotic. It would appear from the files provided to the ICDRG (which are lacking in detail) that at this stage, this young person stated that she did not wish to engage further with aftercare support. A Child Protection Case Conference was held with regard to her young child and a Social Worker was appointed for her.

This young person died some time later. This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 25

- HSE Social Work Department;
- Foster Care;
- Psychologist;
- Department of Education services;
- An Education and Training Programme;
- Family Support Worker;
- Money Advice and Budgeting Service; and
- Drugs and alcohol counselling,

Good Practice Observed on File of Young Person (Aftercare) 25

- There appears to have been good contact between relevant agencies.
- Child Protection Case Conferences and case reviews were held.
- An aftercare plan was in place (although this young person had to leave care earlier than planned) with agreed support workers identified.
- Files are organised and methodical up to the point that this young person left her foster home.

Concerns Arising from the File of Young Person (Aftercare) 25

- No adequate risk assessment or mental health assessment recorded.
- There is little information on the file in the year prior to this young person's death.
- There was a failure to follow-up referrals regarding this young person and her family immediately and a lack of support given to the family despite knowledge that the files recorded alcohol abuse, violence and neglect of the children.
- There is no record on the file of staff supervision
- There is no indication that the services provided to this young person while in care were continued after she left her foster home.
- There is a lack of detail in the final reports on the file.

3.2.26 Young Person (Aftercare) 26

This young person died in 2003, aged 21 years old. This death was registered on foot of a Coroner's certificate.

The ICDRG was notified of the death of this young person by her family. It was confirmed she had been in the care of the HSE but despite repeated requests, no file has been made available to the ICDRG. The ICDRG wishes to express its profound concern at the fact that no file was furnished in respect of this young person.

The depositions received from the Coroner's Office indicate that this young person had placed her two children in the care of the HSE prior to her death. She had moved to live abroad for some time and had worked in a variety of casual employments. On the day of her death she spent some time in a city centre. She returned to her flat with a friend and went to bed. Her friend was unable to wake her the next morning. An ambulance attended at the scene but it was not possible to resuscitate her.

From the depositions received from the Coroner's Office it appears that this young person had been very unsettled during her teenage years. After the birth of her children she seemed to have settled down for a period.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

3.2.27 Young Person (Aftercare) 27

This young person died in 2002, at the age of 23 years old. This death was registered on foot of a Coroner's certificate.

Summary of Care Circumstances

This young person had attended the Child and Adolescent Psychiatric Service for a time at age 13. The service was involved with her for a number of years dealing with the clinical issues surrounding her "personality disorder and the behaviour problems resulting from this".

At age 16 she was referred to the HSE Social Work Department for a residential placement. This was due to her "personal and family difficulties". The referral stated that she was a risk to herself and that she could not cope on her own and concerns were expressed about her safety.

From the records furnished to the ICDRG it appears that she made 7 disclosures about sexual abuse by a relative which were investigated. She later withdrew the allegations and said she would commit suicide if her parents were contacted about the allegations. The Director of Public Prosecution directed that no proceedings be issued in respect of each allegation.

The HSE placed her in a bed and breakfast pending a placement in residential accommodation.

The residential placement broke down because of her disruptive behaviour and her allegations against other residents there. She moved back to a bed and breakfast accommodation. A plan was put in place to facilitate this young person to move to independent living.

The case was closed by her Social Worker on her 18th birthday. She was referred back to the adult psychiatric service.

This young person died in tragic circumstances and those who cared for her were understandably very distressed by her death.

Services Engaged for Young Person (Aftercare) 27

- Gardaí;
- Child and Adolescent Psychiatric Service ;
- HSE Social Work Department;
- Residential placement; and
- Hospital.

Concerns Arising from the File of Young Person (Aftercare) 27

- No adequate risk assessment recorded.
- Other than the reference in the file to this young person being in care, there is nothing else to indicate she was in care – no records as to the nature of the care etc.

- There is no account of any interventions being made on her behalf by the HSE except the investigations of alleged sexual abuse.
- This young person had a diagnosis of a personality disorder with resultant behaviour difficulties. However there is no indication of any treatment or how this was handled in the residential unit.
- It appears that the HSE Social Work Department seemed to leave responsibility for this young person to the mental health services.
- When she was 18 the case was closed with no further follow-up.

A number of graphs below show a breakdown of figures and percentages in relation to the non-natural deaths of young people in aftercare.

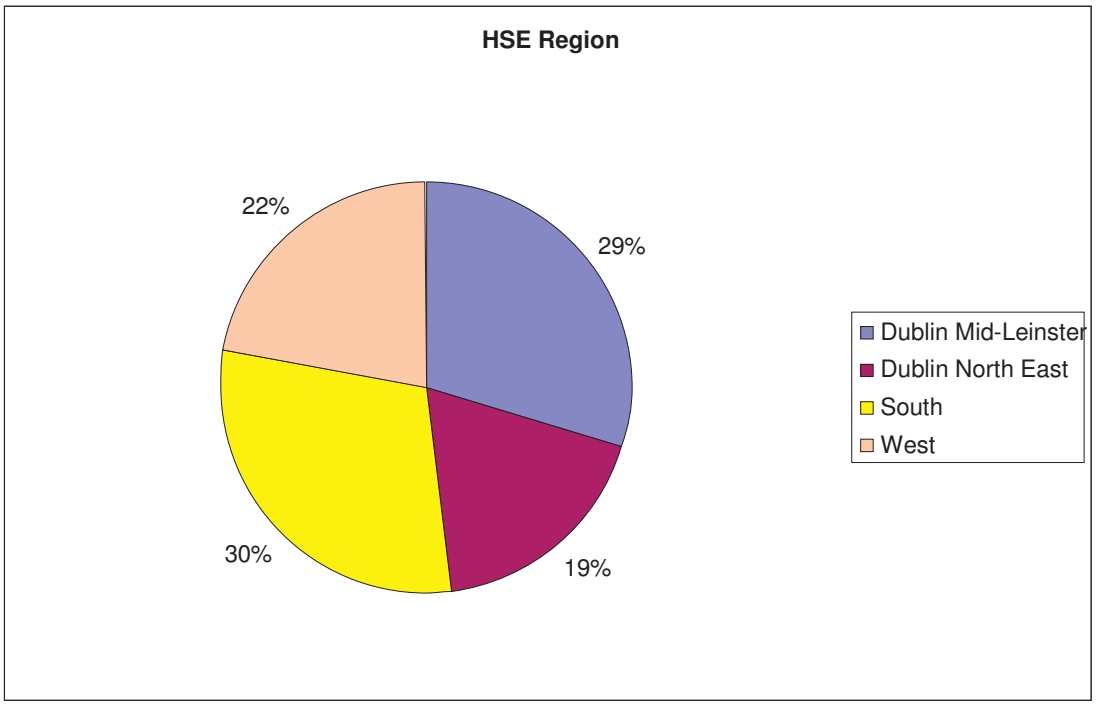


Fig. 2.2.1 – HSE Region (Non-Natural Deaths of Young People in Aftercare)

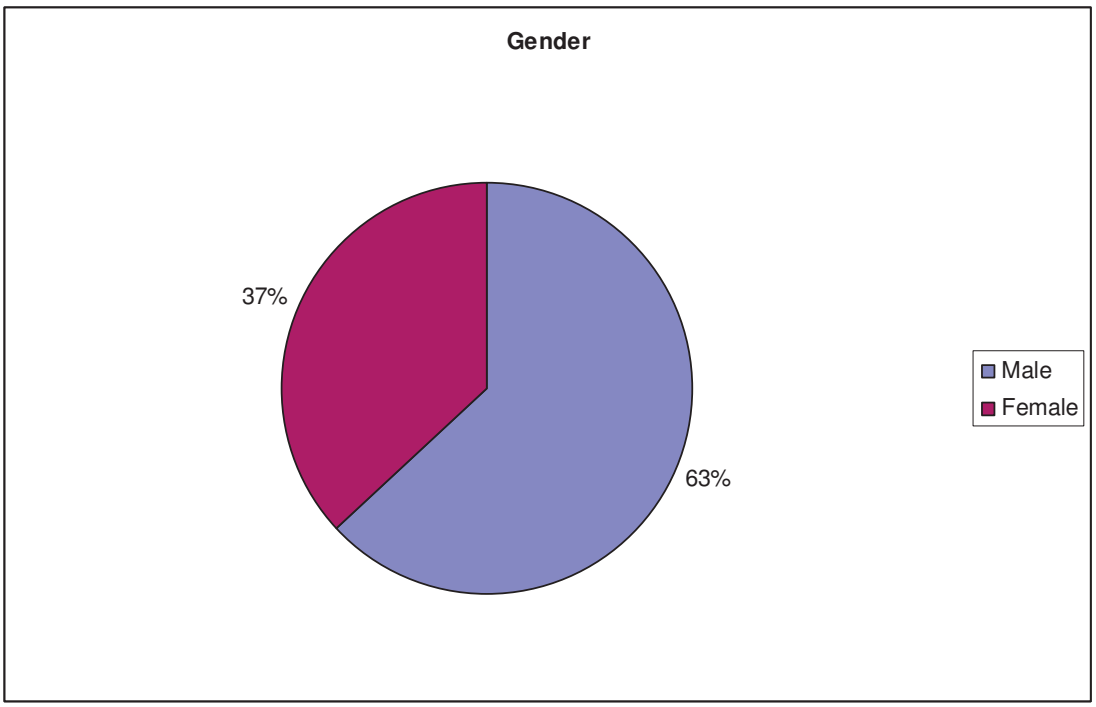


Fig. 2.2.2 – Gender (Non-Natural Deaths of Young People in Aftercare)

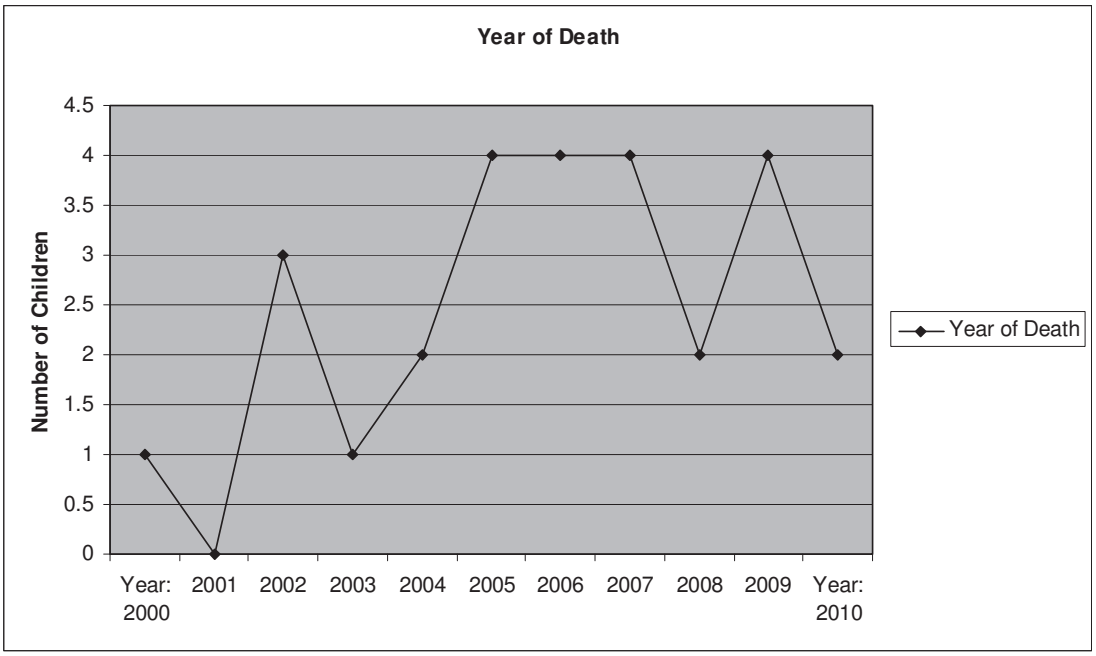


Fig. 2.2.3 – Year of Death (Non-Natural Deaths of Young People in Aftercare)

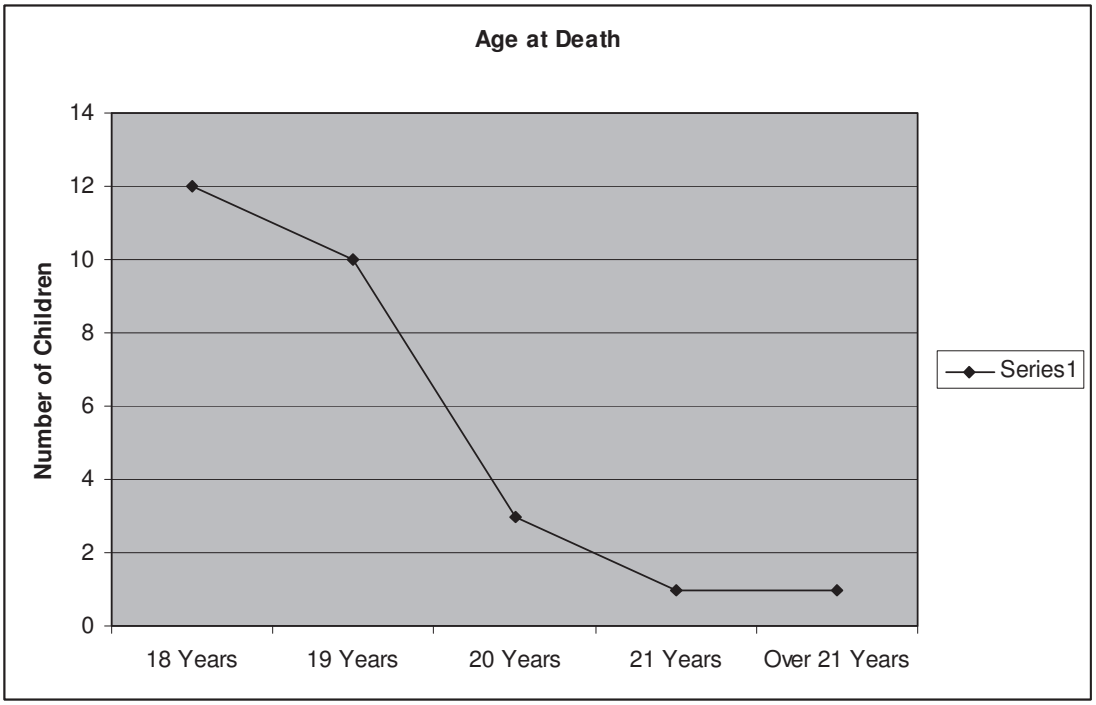


Fig. 2.2.4– Age at Death (Non-Natural Deaths of Young People in Aftercare)

PART 3 : DEATHS OF YOUNG PEOPLE IN AFTERCARE - SUMMARY OF GOOD PRACTICE

This section firstly summarises the good practice the ICDRG found in reviewing the files of 32 young people who had been in the care of the HSE and had left the care of the HSE at the time of their death. It includes children and young people who died of natural causes.[27] The section then goes on to outline the concerns the review found in respect of the same files, again in summary fashion. The ICDRG has commented both in respect of good practice and in respect of concerns only where the feature is clearly evident i.e. where the good standard of practice is clearly evidenced and visible or conversely where there is a concern about files this can be taken to signify that the file is significantly lacking in information, in record keeping or in presentation. This means that if it is noted that the ICDRG observed, for example, good record keeping on a number of files; it is not implied that the remaining files necessarily showed evidence of poor record keeping. Not every aspect is commented on in relation to every file.

The observations made in this part relate to the entire case history of each young person, i.e. their time spent in the care of the HSE, as well as their time in aftercare.

3.3.1 Good Assessments, Risk Identification and Aftercare Plan

When a young person is involved with the HSE aftercare services, an assessment or risk identification should be carried out to ensure that the needs of the young person leaving care are identified. This will allow an aftercare plan to be put in place. Such assessment, risk identification and/or planning was evident in 5 of the aftercare files provided to the ICDRG. There was evidence of an aftercare plan on 4 of the aftercare files received by the ICDRG.

3.3.2 Aftercare Plan Followed and Reviewed or Planning Completed

Once an aftercare plan is in place, it should be followed and also reviewed at regular intervals to ensure that it is continuing to meet the needs of the young person concerned. In 6 of the files received by ICDRG, there was evidence that the aftercare plan was followed and/or reviewed or that planning was completed in respect of the young person concerned.

3.3.3 Good/Consistent Care Provided by the Social Work Department

[27] These case summaries fall outside the terms of reference of this review.

In 10 of the files provided to the ICDRG on deaths of young persons in aftercare, there was evidence of good and/or consistent care provided to the young person by the Social Work Department. When a young person is in the aftercare of the HSE (after attaining the age of majority or for any other reason), they are in a vulnerable position. It is essential that a good and consistent level of aftercare support is provided to them. While it must be acknowledged that lack of resources impacts on this, inconsistency in practices across the various HSE regions and even within each region must be tackled.

3.3.4 Appropriate Placement/Support

As noted above, when a young person is engaging with the aftercare services of the HSE, he or she is in a vulnerable position and it is essential that the appropriate support is put in place and that the young person is in an appropriate placement. In 6 of the aftercare files received by the ICDRG, there was evidence of such appropriate support and placement of the young person.

3.3.5 Good Social Work Supervision/Support

It is essential that the provision of aftercare to young persons by the HSE Social Work Departments be supervised and supported by Team Leaders to ensure that the appropriate level of care and support is being provided. In 1 of the files received by the ICDRG on deaths of young people in aftercare, there was evidence of supervision and/or support of the social work being carried out.

3.3.6 Regulations Followed

Pursuant to the Child Care Act, 1991, regulations have been made to guarantee a consistent approach by the HSE to the care of children and young persons. The Regulations are also in place to ensure that the child/young person gets the appropriate level of care. In 2 of the aftercare files received by the ICDRG, there was evidence that the Regulations had been followed.

3.3.7 Good Interagency Cooperation

The provision of consistent care of a high standard to young persons in the aftercare of the HSE requires that the Social Work Department and other bodies (such as the Gardaí, Child and Adolescent Mental Health Services, Public Health Nurses and voluntary agencies) cooperate. In 7

of the files supplied to the ICDRG on the deaths of young persons in aftercare, there was evidence of such cooperation. Furthermore, there was specific evidence of good interagency working between the Mental Health Services and the Social Work Services in 4 files including timely referral to the Mental Health Services.

3.3.8 Good Foster Care

Where a young person has been placed with foster carers during his or her time in care, it is imperative that the young person receives good care from his or her carers. The fact that the young person has been removed from his or her parents inevitably places him or her in a more vulnerable position and the placement of the young person with foster carers should be done to meet the young person's needs and ensure that he or she feels safe, cared for and protected. In 4 of the aftercare files provided to the ICDRG there was evidence of good foster care provided to the young person.

3.3.9 Support Provided to Family/Carers

As with the category above, the provision of support should not stop with the biological family of the deceased young person. Where the young person had been placed with a foster family or foster families, support should be provided to those carers to ensure that their needs are also addressed. The provision of such support is evident in 1 of the aftercare files provided to the ICDRG.

3.3.10 Good Record Keeping

In 3 of the files provided to the ICDRG on deaths of young persons in aftercare, there was a good standard of record keeping. It is essential that the files kept by the HSE in relation to children in their care are maintained to a high standard with all relevant information being recorded there.

3.3.11 Appropriate Follow-Up after Child's Death

The HSE should ensure that, following the death of a child in aftercare, an appropriate follow-up is completed including the provision of support to the bereaved family. In 2 of the aftercare files provided to the ICDRG, there is evidence of such a follow-up by the Social Services.

3.3.12 Review of Death

In every case where a young person in aftercare dies, there should be a review of the young person's death and the circumstances surrounding it by the HSE. Only one review of the death of a young person in aftercare was evident from the files provided to the ICDRG. The National Review Group is considering 2 other cases.

3.3.13 Miscellaneous

In a number of cases there was evidence of good support from a range of professionals including Guardian ad Litem, mental health professionals and other NGO staff. This good practice is ad hoc but to be commended.

3.3.14 Failure to Provide any or any Appropriate Aftercare

In a number of the files provided to the ICDRG in respect of young people who had been in care and fell into the Aftercare category, there was clear evidence of difficulties with the provision of aftercare or indeed, the lack of provision of aftercare. In one particular file, a young person who had only been in the care of the HSE for a very short time was not provided with any aftercare despite being in a vulnerable position. It seems that the decision not to provide this young person with aftercare was based on his length of time in care. A number of other files show the failure to provide aftercare at all, the provision of aftercare for only a short period of time (3 months for example), the failure to provide a key worker or a failure to engage with the aftercare plan. In one file received by the ICDRG, the young person was not given an aftercare plan but was left the option to contact the Social Services. This was despite his obvious vulnerabilities. Another young person was discharged from care because he was not cooperating. Again, despite this young person's vulnerabilities he was left unmonitored after his discharge from care. In one final concerning case, a young person was discharged from care at the age of 16. The provision of aftercare was left to Youth Services.

3.3.15 Poor Record Keeping

The recording of information and the consistency in recording information on the files of young people in the aftercare of the HSE needs improvement. In 8 of the Aftercare files received by the ICDRG the file was in disarray and there was a poor level of recording. In a further three files, it was impossible to assess what work had been done by those involved in the case due to the poor recording. In addition to these significant difficulties, a number of files show a failure to keep the file in order, failure to record who had made notes on the file, failure to place the Care Order on the file, the lack of a closing summary, the inclusion of peripheral material on the file, failure to record for periods of time or sparse recording once the care order was discharged and a failure to clarify, through recording, the type of care being provided to the child/young person. Two of the aftercare files received by the ICDRG were, in fact only family files and not files relating to the young person in question.

3.3.16 Consistency and Engagement of Social Workers

In 3 of the aftercare files received by the ICDRG, there was evidence that the young person had no Social Worker at times. This lack of a key worker in charge of the care of the young person obviously causes difficulties, indeed in one file it was clear that no Social Worker had a relationship with the young person and 3 different dates of births had been recorded. A further problem which is evident from the files is the short-term nature of the interventions of the Social Workers in some cases or the delay in making an intervention. Furthermore, a number of files showed a high turnover of Social Workers involved in a case. In one particular case, the young person had 12 Social Workers during his time in care and another young person had at least 7 Social Workers assigned to their case. A number of other files showed a lack of engagement with the case including failure to provide support to families except during a crisis or a failure to provide familial support at all, a failure to intervene at an early point and one case where there was only one record of the Social Worker having talked to the child in question.

3.3.17 Failure to Refer to Appropriate Services

It is essential that if the child or young person requires specialised support that a referral is made to the appropriate services. In a number of files received by the ICDRG, there was a failure to utilise and refer young people to such services. The files indicated that certain young people had self-harmed, been sexually and physically abused, been rejected by their birth family, experienced educational difficulties, suffered from grief, experienced attachment issues and experienced confusion regarding sexual orientation. Such difficulties were not addressed by a referral to specialist services and supports.

3.3.18 Failure to Utilise Appropriate Legal Provisions

The files received by the ICDRG show a lack of familiarity with the relevant legal provisions and indeed a failure to utilise these provisions where appropriate. In one particular file, a solicitor was appointed to a child by the Court without consideration as to whether a Guardian ad Litem might have been a more appropriate appointment. The commencement of the Child Care Act, 1991 also appears to have caused some confusion with regard to the continuance of the previous provisions under the Children Act, 1908 and led to a lack of clarification regarding the legal status of a number of young people in the aftercare of the HSE. In another file received by the ICDRG, there was a failure to consider the adoption of a child who had been placed with a

foster family and who was not going to be returned home. Finally, there was one file which evidenced a significant legal dispute between two HSE areas who were engaged in trying to evade responsibility for the young person in question.

3.3.19 Inappropriate Placements

In the aftercare files received by the ICDRG, there was evidence of inappropriate placements being used for young people who had been in the care of the HSE. This included an over-reliance on the Out-of-Hours service and the use of temporary placements frequently.

3.3.20 Lack of Interagency Cooperation

There was evidence of a lack of interagency cooperation on at least 5 aftercare files received by the ICDRG. There seems to be particular difficulties with regard to children/young people with mental health difficulties. In one particular case, the HSE did not address an issue raised by the Psychiatric Hospital regarding a young person who had been placed in an adult ward. In another case where the young person was suffering from mental health difficulties in addition to other clear child protection issues, the case was solely left with the Mental Health Services. Similar difficulties exist where the child/young person becomes involved with the criminal justice system with the HSE pulling out of one case as soon as the young person had been put in detention.

3.3.21 Lack of Proper Procedures

An ongoing problem evident in the files received by the ICDRG is lack of proper procedures. There is no evidence of supervision of staff on most of the aftercare files received by the ICDRG. In 2 of the aftercare files received, there is a requirement for an in depth review. Furthermore, there is no evidence on some files of any processes/procedures carried out following the death of the child/young person.

3.3.22 Review of Death

In every case where a young person in aftercare dies, there should be a review of the young person's death and the circumstances surrounding it by the HSE. No review is recorded or planned in 29 cases.

CHAPTER 4: CHILDREN AND YOUNG PEOPLE KNOWN TO THE HSE

The ICDRG were furnished with the case records of 128 children and young people who were known to the HSE before or at the time of their death. While the Terms of Reference preclude the ICDRG from publishing the 60 case summaries of children and young people who died of natural causes it was necessary to review the files to determine the cause of death. This review, however, provided a rich seam of information and this is reflected in the higher level learning in Part 3 of this chapter.

Three further children were referred to the ICDRG by the HSE in this category and on examining their files it was clear they were not known to the HSE at the time of their death and their cases were not then considered by the ICDRG as they fell outside of its remit.

Part 1: Natural Deaths of Children/Young People Known to the HSE

Overview of Analysis

The Independent Child Death Review Group (ICDRG) received and reviewed the child and family records for 60 children who were known to the HSE when they died of natural causes between 2000 and 2010. Part 1 of this chapter contains an overview of the deaths of these children.

Section 1: Children less than 3 months old
Section 2: Children aged between 3 months and 2 years
Section 3: Children and Young People Aged 2 to 18 years

A number of graphs at the end of Part 1 show a breakdown of figures and percentages in relation to the natural deaths of children and young people known to the HSE.

Section 1: Children less than 3 months old

There are 19 cases in this section. These are children known to the HSE who were less than 3 months old at the time of death and who died between 2000 and 2010.

Year of Death

- One child died in 2000
- Two children died in 2001
- One child died in 2002
- Two children died in 2003
- One child died in 2004
- One child died in 2005
- Two children died in 2006
- Five children died in 2007
- Three children died in 2008
- One child died in 2009

Gender

- Thirteen children were male.
- Six children were female.

HSE Region

- Nine children were known to HSE Dublin North East
- Eight children were known to HSE Dublin Mid Leinster
- Two children were known to HSE South

Age at Time of Death

- Two children died at birth or shortly after birth.
- Eleven children died aged between 4 days and 7 weeks.
- Six children died aged between 8 weeks and 10 weeks.

Section 2: Children aged between 3 months and 2 years

There are 24 cases in this section. These are children who were known to the HSE and who were aged between 3 months and 2 years at the time of their death. They died between 2000 and 2010.

Year of Death

- One child died in 2001
- Two children died in 2002
- Three children died in 2003
- Three children died in 2004
- One child died in 2005
- Three children died in 2006
- Five children died in 2007
- Two children died in 2008
- Two children died in 2009
- Two children died in 2010

Gender:

- Eleven children were male.
- Thirteen children were female.

HSE Region

- Nine children were known to HSE Dublin North East.
- Seven children were known to HSE Dublin Mid Leinster.
- Four children were known to HSE South.
- Four children were known to HSE West.

Age at Time of Death

- Seven children died aged 3 months.
- Seven children died aged between 4 and 5 months.

- Three children died aged between 6 and 7 months.
- Seven children died aged between 10 months and 1 year.

Section 3: Children and Young People Aged 2 to 18 years

There are 17 cases in this section. These are children and young people known to the HSE who were aged between 2 years and 18 years at the time of death and who died between 2000 and 2010.

Year of Death

- One child died in 2000
- Two children died in 2001
- One child died in 2002
- One child died in 2003
- Six children died in 2006
- Three children died in 2009
- Three children died in 2010

Gender:

- Nine children were male.
- Eight children were female.

HSE Region

- Five children were known to HSE Dublin Mid Leinster
- Six children were known to HSE Dublin North East
- Four children were known to HSE South
- Two children were known to HSE West

Age at Time of Death

- Three children died aged between 2 and 4 years.
- Six children died aged between 5 and 7 years.
- Four children died aged between 8 and 13 years.
- Four young people died aged between 14 and 18 years.

A number of graphs below show a breakdown of figures and percentages in relation to the natural deaths of children and young people known to the HSE.

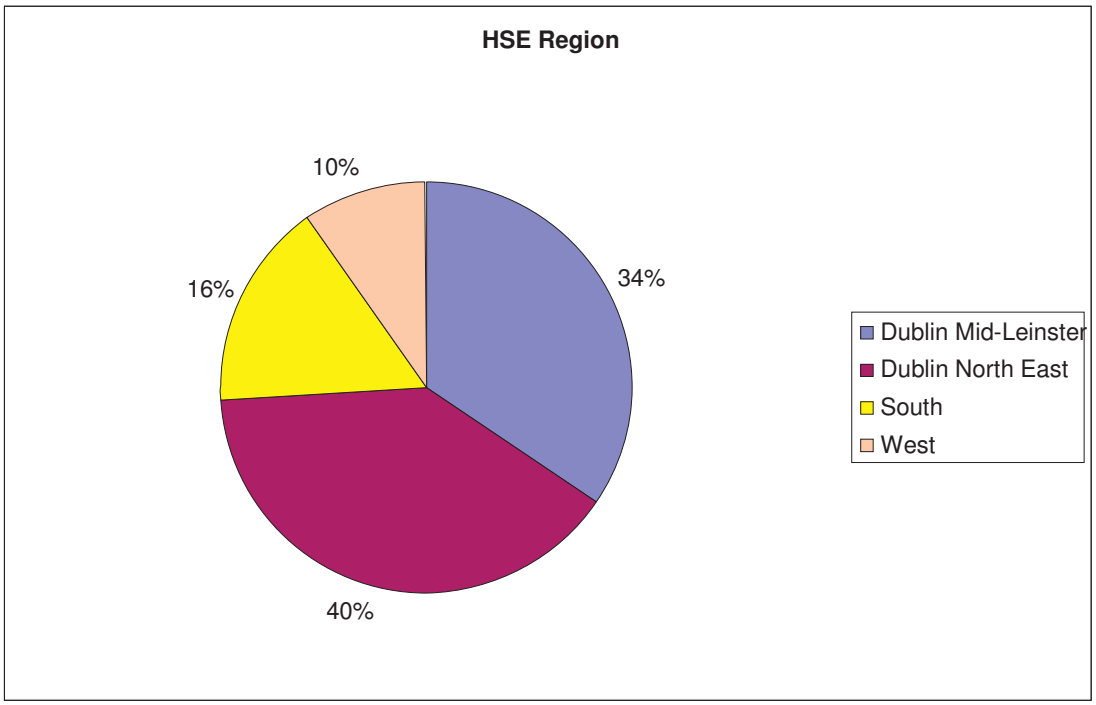


Fig. 3.1.1 - HSE Region (Natural Deaths of Children Known to the HSE)

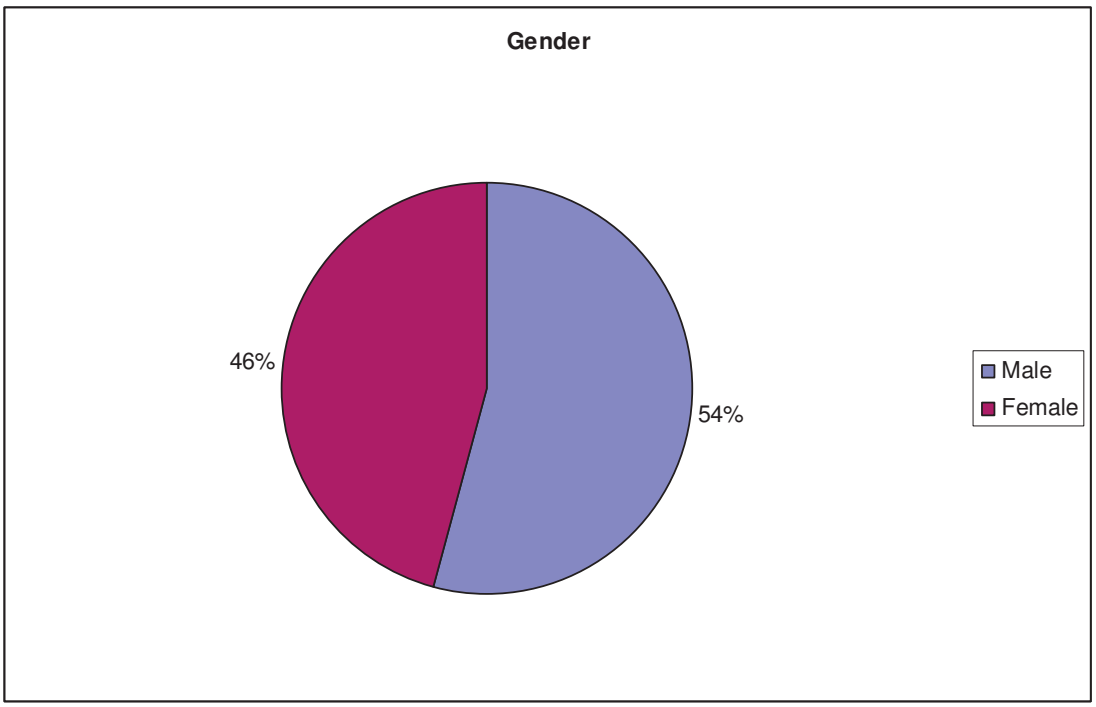


Fig. 3.1.2 - Gender (Natural Deaths of Children Known to the HSE)

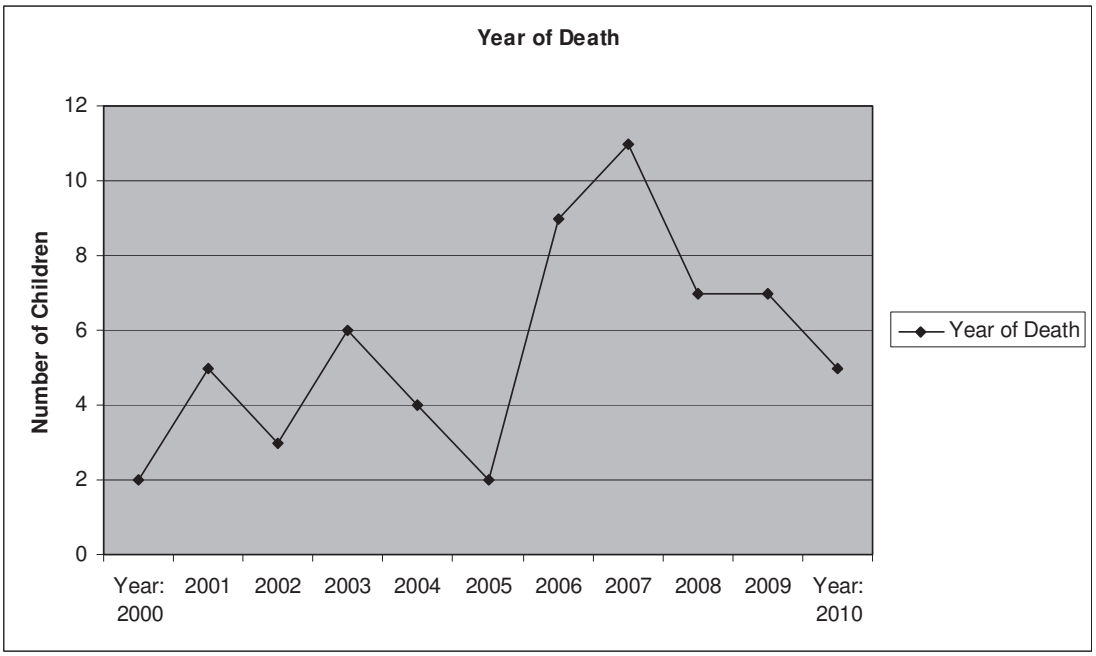


Fig. 3.1.3 – Year of Death (Natural Deaths of Children Known to the HSE)

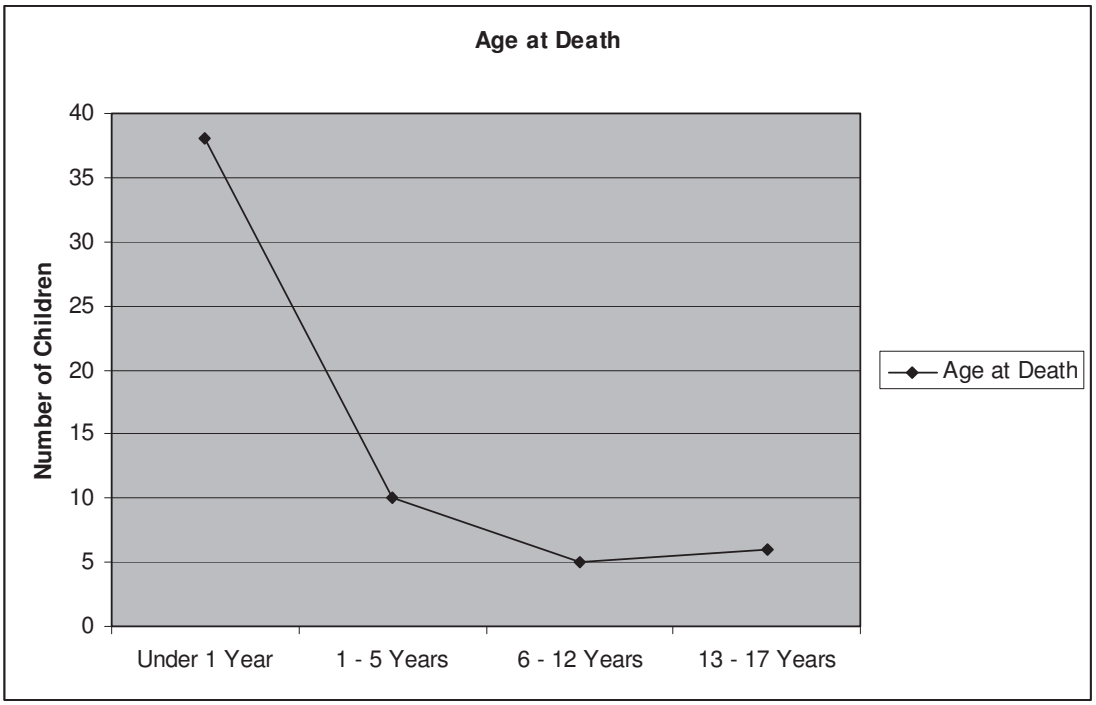


Fig. 3.1.4 - Age at Death (Natural Deaths of Children Known to the HSE)

CHAPTER 4: PART 2: CHILDREN AND YOUNG PEOPLE KNOWN TO THE HSE – UNNATURAL DEATHS

The following is the ICDRG's analysis of the deaths of 68 children and young people known to the HSE and who died between 2000 and 2010. These children and young people died of unnatural causes. The information is presented in three sections:

Section 1: Children known to the HSE who died aged 12 months and under.
Section 2: Children known to the HSE who died between 1 year and 13 years.
Section 3: Young People known to the HSE who died aged between 14 years and 19 years.

A number of graphs at the end of Chapter 4, Part 2 show a breakdown of figures and percentages in relation to the unnatural deaths of children and young people known to the HSE.

Section 1: Children known to the HSE aged 12 months and under

Overview of Analysis

The Independent Child Death Review Group (ICDRG) received and reviewed the child and family records for 6 children who were aged less than one year at the time of their death. Those 6 children were known to the HSE when they died of unnatural causes between 2000 and 2010.

Year of Death

- One child died in 2000
- One child died in 2002
- One child died in 2004
- One child died in 2005
- One child died in 2008
- One child died in 2010

Gender:

- Four children were male.
- Two children were female.

HSE Region

- Three children were known to HSE Dublin Mid Leinster.
- Three children were known to HSE Dublin North East.

Age at Time of Death

- Three children died aged under 6 months old.
- Three children died aged between 6 months and 1 year old.

Individual Case Analysis

4.2.1 Child Known to the HSE 1

This child died in 2010. The death has not been registered.

Case summary

This family was known to the HSE for over a year prior to the birth of this child because of domestic violence and serious alcohol abuse by both parents as outlined in the records furnished to the ICDRG. An older sibling was removed from the family as a small child under Section 13 of the Child Care Act, 1991 and during access, that child was taken abroad by the parents. Subsequently the family returned to Ireland and agreed a safety plan with the HSE and the child was returned home.

A Supervision Order under Section 19 of the Child Care Act, 1991 was put in place. The parents were offered and availed of alcohol counselling, family support work and had regular social work visits over the next few months. The HSE agreed that the Supervision Order could lapse as there were no further notified incidents of domestic violence or drinking. A few days later the Gardaí removed the child under Section 12 of the Child Care Act, 1991 when she was found in the care of her mother who was very intoxicated. The mother was then six months pregnant. An Emergency Care Order under Section 13 of the Child Care Act was granted .The HSE decided to return the child home as the father was not drinking. Three months later the case was closed one week before this new child was born. The family support worker visited after the birth of the child and recorded there were no child protection concerns and that both child and older sibling were well. Later that night this child was taken to hospital where he was pronounced dead on arrival.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 1

- HSE Social Work Department;
- HSE Public Health Nursing Service;

- Family Support Worker;
- Gardaí;
- Fire Services;
- Regional Hospital; and
- Addiction Services.

Concerns Arising from the File of Child Known to the HSE 1

- The closure of this case shortly after legal strictures had elapsed and in view of the then known history of these parents in terms of addiction should be looked at in terms of learning particularly as another child was due to be born to the family. It would perhaps have been better to see how this family were coping with that added stress on family life. It is not suggested that this would have changed the tragic outcome for this child. This case should be comprehensively reviewed to examine learning for future practice.

4.2.2 Child Known to the HSE 2

This child died in 2005. The death was registered on foot of a Coroner's certificate.

Case Summary

From the files furnished to the ICDRG it appears that this case was referred to the HSE Social Work Department by a children's hospital after the child's admission to hospital with injuries. The child died a week later.

The Gardaí investigated the matter and concluded at that time that the child had received his injuries accidentally. A meeting of professionals involved concluded that no further action was required. Subsequently both parents returned to live in their country of origin.

At a later date, results from the autopsy raised a concern over the cause of death. The records show that efforts were made to locate the family who refused to attend for further interviews with the Gardaí. It is recorded that there is no extradition treaty with the country in question.
This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 2

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Children's Hospital;
- Gardaí; and
- International Social Services.

Good Practice Observed on File of Child Known to the HSE 2

- There was a very quick response and involvement of all professional services when the child was admitted to hospital.
- Professional Strategy Meeting took place.
- There was an immediate home visit to ensure there were no other children in the care of the family.

Concerns Arising from the File of Child Known to the HSE 2

- The Gardaí were not able to access the parents of this child to interview them in relation to the circumstances of their child's death. This is, however, a matter of the domestic law of the State where the child's parents are from and are currently residing and the Irish Gardaí and/or Social Services have no control over the implementation of the domestic law of foreign countries. The commencement of implementing legislation for the 1996 Hague Convention may improve cooperation in cases such as this in the future.

4.2.3 Child Known to the HSE 3

This child died in 2000. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the mother of this child was referred to the HSE by her parents who were concerned for both her safety and that of this child. They alleged her partner had been violent towards this teenage mother and that he had a number of convictions for serious crimes. It is recorded that he had a serious alcohol addiction. It appears

from the records furnished to the Review Group that the father of the child was known to the HSE as a result of allegations that had been made against him.

The Probation Service was involved with the father of this child. The Social Worker together with the probation officer met with both partners and discussed their concerns with them. The young expectant mother informed them that she was aware of the allegations and openly discussed his violence to her but said it had happened only once and she was happy with the relationship. The Social Worker recorded "It is difficult to know what is happening here". It was agreed the probation office would continue to work with the partner to address the issues of violence and alcohol abuse.

Prior to the birth of this child, it is recorded that the father had reduced his alcohol intake. The Social Worker visited the expectant mother on her own some months later, advised her of the need to keep the child safe and the mother was keen to state that she believed that her partner was reformed as he was not drinking. This case was then closed.

It is recorded that the hospital staff had no concerns about the care of the child in hospital. Three and a half months later this child died as a result of injuries and her mother also suffered grievous injuries at that time. The perpetrator received a custodial sentence.

Services Engaged for Child Known to the HSE 3

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Probation Officer; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 3

- This file is mostly comprised of hand written notes. In regard to the well being of this child there appears to have been no follow up involvement by the Social Work Department following the birth of this child. Indeed the case was closed prior to her birth.

- From the scant record supplied to the ICDRG the HSE appears to have accepted the wishes of this young mother who had previously been seriously hurt by this man. In view of the known history of this man, a more comprehensive risk assessment for this young mother and her child should have been undertaken. There is no record for example that the Gardaí were contacted at that time.

- No review or investigation to consider the learning from this case has occurred.

4.2.4 Child Known to the HSE 4

This child died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for four years prior to the birth of this child. This child was the youngest of a large family. This child was born prematurely and remained in hospital for some time before being discharged home. There were many concerns expressed regarding serious neglect of the children and the mother's abuse of alcohol. Additionally there were reports that the mother often left the younger children in the care of their 8 year old sister while she went out at night. A family support worker was allocated to the case, she visited twice weekly and some progress was made. A Child Protection Case Conference was held two months prior to the death of this child. It was decided to place the children on the Child Protection Notification System and family support services were offered. The mother was agreeable to these measures but the recording on the file over the next two months shows ongoing resistance to change and inconsistent care of the children.

On the night this child died, the mother had left the children alone at home in the care of an 8 year old child. The next morning the child was pronounced dead at the local hospital.

The other children in the family were taken into care after the death of this child. The Gardaí were involved and the mother pleaded guilty to neglect of the six children.
This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 4

- HSE Duty Social Work Department;
- HSE Public Health Nursing Service; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 4

- The ongoing neglect of the six children in this family was reported to the HSE on a number of occasions. The case continued to be dealt with on the duty system which appears to have led to each report being dealt with in an episodic manner and the mother's explanation being accepted on each occasion.
- The case is recorded on the file as still being held on duty for the year following the death of this child and the record states "there was limited supervision over the year; reviews of the children's care did not take place". This refers to the siblings of this child who were in the care of the State.
- Clearly children who are in the care of the state should be allocated a Social Worker who is part of a team that does not have to deal with duty cases.
- There appears to be a lack of co-ordination from the services regarding the many referrals of neglect.
- An application for a Supervision Order should have occurred at a much earlier point in this case as concerns over the neglect of the children were brought to the attention of the HSE regularly.

Note: Case Review

The HSE commissioned a review of this case one year after her death. The terms of reference of the Review Group was to examine the entire management of the case, to identify any impediments to the care management process and to report on findings and learning arriving from the investigation. The Review Group examined the files held by all the relevant parties, interviewed relevant personnel and considered submissions.

The Review Report identifies 8 points of key learning arising from this case. It makes a number of recommendations including many that have been made by previous inquiries and that pertain to the need for robust management and accountability in departments delivering services to

children and families to ensure compliance with statutory requirements including *Children First Guidelines* and HSE policies.

The ICDRG understands that a decision has not yet been taken by the HSE in relation to the publication of the review report.

4.2.5 Child Known to the HSE 5

This child died in 2002. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was not known to the HSE until after he died. At 7 weeks of age he had been admitted to a children's hospital with a fractured femur. He was investigated for ontogenesis imperfecta (brittle bones). When he was 11 months old he was brought to hospital with a serious head injury and died following surgery. A post mortem was carried out and the state pathology department sent samples to the UK for further analysis.

The mother of the child was pregnant at this time and agreed to the newly born child being placed with a close relative until the results of the inquest was known. A series of parenting assessments were also undertaken.

The inquest returned a verdict of accidental death and the couple's child was returned to his family. A month later the HSE closed the case as the family was coping very well with their child.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 5

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Maternity Hospital;
- Children's Hospital; and
- Gardaí.

Good Practice Observed on File of Child Known to the HSE 5

- All concerns regarding the death of this child were investigated. The relevant agencies interacted well with each other in relation to the welfare of the new child.

Concerns Arising from the File of Child Known to the HSE 5

- The family of this child expressed their unhappiness with the hospital and with the HSE over the long time that elapsed before the matter was resolved and their child returned home.

4.2.6 Child Known to the HSE 6

This child died in 2004. This death was registered on foot of a Coroner's certificate.

Case Summary

The mother of this child was referred to the HSE because of concern regarding the care of her eldest child and he was subsequently placed into the care of a family member. When this child was 8 months old a referral was made to the HSE as the child was being left in the care of a young teenager at night. A Child Protection Case Conference was held and a plan was agreed with the mother. She agreed to attend all appointments necessary for the child and to attend a mother and toddler group.

When this child was 11 months old he choked on a piece of food. He died despite the extensive efforts made to save his life. No underlying pathology was identified at the inquest.

Services Engaged for Child Known to the HSE 6

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Child Care Worker; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 6

- The file provided to the ICDRG is not in any order and is very difficult to follow.

Section 2: Children known to the HSE who died between 1 year and 13 years

The Independent Child Death Review Group (ICDRG) received and reviewed the child and family records for 26 children who were aged between 1 year and 13 years at the time of their death. Those 26 children were known to the HSE when they died of unnatural causes between 2000 and 2010.

Year of Death

- Two children died in 2000
- Five children died in 2001
- One child died in 2002
- Two children died in 2003
- Four children died in 2005
- Four children died in 2006
- Four children died in 2007
- Two children died in 2008
- Two children died in 2009

Gender:

- Twelve children were male.
- Fourteen children were female.

HSE Region

- Four children were known to HSE Dublin North East.
- Five children were known to HSE Dublin Mid Leinster (One child Known to HSE West also).
- Thirteen children were known to HSE South.
- Four children were known to HSE West (One child Known to HSE Dublin Mid Leinster also).

Age at Time of Death

- Eleven children died aged between 1 and 3 years
- Ten children died aged between 4 and 6 years
- Five children died aged between 8 and 13 years

Individual Case Analysis

4.2.7 Child Known to the HSE 7

This child died in 2001. The death was registered on foot of a Coroner's certificate.

Case Summary

This family was referred to the HSE when this child was 12 months old. The referral expressed concern that the children were wandering the road, not adequately fed or clothed and left with inappropriate babysitters. There was also concern that attendance of the older children at school was very erratic. The mother and children were living in a small apartment. There were reports that the mother was drinking to excess. The family was referred to the local family centre and there was intensive daily engagement from that service. Services with budgeting, child care and alternative housing were offered. Despite the progress there were on-going Child Protection concerns and a Child Protection Case conference was scheduled for two days after the death of this child.

This child died in a tragic accident before the family moved to more suitable accommodation. The family centre continued to support the family. Her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 7

- HSE Duty Social Work Department;
- HSE Public Health Nursing Service;
- Gardaí; and
- Regional Hospital.

Good Practice Observed on File of Child Known to the HSE 7

- The family centre services worked well to support this family.

Concerns Arising from the File of Child Known to the HSE 7

- There were significant risk factors in terms of the neglect of the basic needs of the children in this family that suggests that a Child Protection Case Conference should have been held at an earlier point.
- Consideration could have been given to making an application for a Supervision Order.
- There were periods when there was no Social Worker allocated to this family.

4.2.8 Child Known to the HSE 8

This child died in 2003. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for 2 years prior to the birth of this child. From the records furnished to the ICDRG it appears that there were serious concerns that the mother was at risk due to severe domestic violence. In addition the mother had on-going serious mental health problems and had a number of admissions to the Psychiatric Hospital in the months leading up to a tragic incident (when this child was 11 months old). This child suffered severe brain damage as a result of a tragic incident involving his mother. He was admitted to hospital where he remained until his death. Care of the remaining children was then undertaken by the extended family.

The mother was admitted to a psychiatric hospital. A strategy meeting involving the Gardaí and the HSE Social Work Department was held shortly afterwards and it was agreed that while the Garda investigation was ongoing the social work department would consider holding a Child Protection Case Conference. It is recorded that a few weeks later an employee of the social work department was refused admission to attend what is described as an "urgent meeting involving the Gardaí and the Psychiatric Services" on the basis that it "did not involve the department". It is recorded that the case was discussed at a Child Protection Management System meeting a few days later and that this meeting recommended that a Child Protection Case Conference be held when the mother was due for discharge from hospital. A Child Protection Case Conference was finally held 5 months later. The children in the family were placed on the Child Protection Record. This child died in hospital aged 17 months.

There was a Garda investigation and a file was sent to the D.P.P. The mother was found guilty but insane in relation to the incident that led to the death of this child.

Services Engaged for Child Known to the HSE 8

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Gardaí;
- Adult Mental Health Services; and
- Psychiatric Hospital.

Good Practice Observed on File of Child Known to the HSE 8

- There was a very good working relationship with the social work department and the Gardaí. After the incident the other children in the family were protected.

Concerns Arising from the File of Child Known to the HSE 8

- No adequate risk assessment.
- This family was known to the HSE for two years prior to the death of this child. The social work department concentrated their work on trying to help the mother access housing. The Public Health Nursing Service described her as an excellent mother. It later emerged that she had a history of depression but on the records provided to the ICDRG, it is not clear who held that information and the effects it could have on a mother reported to be coping with domestic violence and without adequate accommodation.
- It is the view of the ICDRG that given the very serious incident outlined above a Child Protection Conference should have been held immediately. It is also a concern that there was no place for the child protection worker in the discussions on this mother's mental health assessment. It is crucial that when serious child protection issues arise, there is a full sharing of information between professionals within agreed protocols.
- It is not clear from the information provided to the ICDRG if the HSE considered an application for a Supervision Order to protect the other children in this family.

4.2.9 Child Known to the HSE 9

This child died in 2006. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

This family was known to the HSE from the time this child was 5 months old. From the records furnished to the ICDRG it appears that there was a history of domestic violence and other ongoing concerns regarding accommodation and behavioural difficulties of the two older children who had witnessed the domestic violence. Psychological services were organised for the older siblings. Eventually a Barring Order was obtained by the Mother and she was assisted to obtain alternative housing. When this child was 21 months old, she died in a tragic road traffic accident in which her mother and brother were also killed. There is no other information on the file provided to the ICDRG.

This child died in tragic circumstances and her death and those of family members understandably caused much distress to all those who cared for them.

Services Engaged for Child Known to the HSE 9

- HSE Social Work Department;
- Psychology Service;
- Family Support Services;
- Gardaí; and
- Addiction Services.

Good Practice Observed on File of Child Known to the HSE 9

- The relevant services interacted with this family offering them practical support in securing accommodation. They also addressed the children's behavioural difficulties and the abuse of alcohol in the home.

Concerns Arising from the File of Child Known to the HSE 9

- There is no follow up on this file regarding the welfare of the surviving child.

4.2.10 Child Known to the HSE 10

This child died in 2003. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was referred to the HSE when she was 3 months old. From the records furnished to the ICDRG it appears that there were concerns for the child's welfare as it was alleged that her mother was leaving her at night with unsuitable babysitters. There was also concern expressed that the mother had an alcohol addiction. Following visits by the Public Health Nurse and a Social Worker, who both stated that the child appeared to be well cared for, the case was closed.

The next HSE involvement occurred when the child was 14 months old following the separation of the parents. There were further concerns for the care of the child and the level of the mother's drinking. There was concern expressed that the mother had suicidal ideation and had cut her wrists. A referral was organised for addiction counselling and it was arranged for the mother and child to live within the extended family.

This arrangement changed when the mother and child moved to another HSE area. The case was transferred to the new area, but the records provided to the ICDRG do not show any follow up by the area in which mother and child were then living. Approximately nine months later this child died. There is no further information on the record supplied.

This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 10

- HSE Social Work Department;
- HSE Public Health Nursing Service; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 10

- From the information recorded on the file it appears that this was a vulnerable mother and as such it is the view of the ICDRG that there should have been follow up when she moved to a new HSE area.
- There is a closing summary completed days after the death of this child which suggests the case was open in the new area but if so, there is no record of any work having been completed.

4.2.11 Child Known to the HSE 11

This child died in 2005. The death was registered on foot of a Coroner's certificate.

Case summary

This child was referred to the HSE Community Care Services following his admission to hospital. Both this child and his mother had been involved in a house fire and his mother was in a coma. The hospital queried who had the power to offer consent for medical treatment or make a decision around resuscitation, as there were no known legal guardians in Ireland. The HSE and the hospital sought legal advice but the child died 3 days later before the matter was resolved. His mother also died later that month of her considerable injuries.

Services Engaged for Child Known to the HSE 11

- HSE Social Work Department;
- Hospital;
- Gardaí; and
- Legal advice sought.

Good Practice Observed on File of Child Known to the HSE 11

- The agencies involved acted immediately to resolve the legal issues and ensure this child would receive appropriate treatment.

Concerns Arising from the File of Child Known to the HSE 11

- No concerns have been identified as arising from this case.

4.2.12 Child Known to the HSE 12

This child died in 2002. His death took place in the country of origin of his birth family. The files provided to the ICGRD state that this child and both parents were found dead of poisoning from a gas leak. There is a death certificate from the country where he died on the record supplied to the ICGRD.

Case Summary

From the records furnished to the ICDRG it appears that the family of this child was known to the HSE for many years. The child's mother had a history of alcohol and drug addiction and the half siblings of this child were in voluntary care under section 4 of the Child Care Act, 1991. They had been abandoned by their mother. The father of this child also had other children who were cared for by their mother and the HSE was providing services to support that family.

When he was eight months old this child was brought to a HSE office by a friend of his mother. It was alleged that he had been abandoned and there was concern about physical neglect. The Social Worker recorded that there was significant domestic violence in this family. An Emergency Care Order under Section 13 of the Child Care Act, 1991 was granted in respect of this child and this was followed by an Interim Care Order. Custody of the child was given to his father and a Supervision Order under Section 19 of the Child Care Act was put in place. A specific condition was attached to the Supervision Order stipulating that the child's mother should not attend the father's accommodation at any time and should only have access to the child when supervised by HSE personnel.

Prior to his death, both parents took this child abroad without the knowledge of the HSE and in contravention of the conditions of the Supervision Order. During the holiday the family died from carbon monoxide poisoning as a result of a gas leak.

This child died in tragic circumstances and his death and those of his family members understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 12

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Gardaí;
- Probation Services; and
- Hospital.

Good Practice Observed on File of Child Known to the HSE 12

- The Social Workers were very involved with this family and their respective children and sought to protect this child.

Concerns Arising from the File of Child Known to the HSE 12

- No adequate risk assessment on record.

4.2.13 Child Known to the HSE 13

This child died in 2009. The death was registered on foot of a Coroner's certificate.

Case Summary

This child was 9 months old when he was referred to the HSE after he presented in hospital with a fractured skull. The medical view was that the fracture could have been caused either accidentally or non-accidentally. The child was released from the hospital into the care of his grandmother. A Child Protection Case Conference was held shortly afterwards and the child was then returned home with frequent monitoring by the Public Health Nursing service. Following a comprehensive risk assessment it was concluded that these were committed and loving parents, that there was no child protection concerns and the case was closed. When this child was 2 years old he was knocked down as he played outside his home. He died as a result of the injuries sustained in the accident.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 13

- HSE Duty Social Work Department;
- HSE Public Health Nursing Service;
- Gardaí; and
- Hospital Services.

Good Practice Observed on File of Child Known to the HSE 13

- This case was dealt with in a systematic manner by all the services involved. The hospital personnel, Social Workers and Gardaí were proactive in ensuring the safety of this child. A full social work assessment plus monitoring by the Public Health Nurse was put in place. However, there was some understandable concern about the stress placed on the family.

Concerns Arising from the File of Child Known to the HSE 13

- There is evidence on the case record that despite the work of all the agencies to protect this child until the completion of the risk assessment, there were some communication difficulties and misunderstanding of roles. Some professionals working closely with the family expressed concern about the undue stress the family was placed under during the period of the investigation. It would be important that such misunderstandings be clarified at the earliest possible time.

4.2.14 Child Known to the HSE 14

This child died in 2005. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

The family of this child was known to the HSE for just over one month prior to the death of this child insofar as can be gleaned from the very sparse records provided to ICDRG. The child's parents were separated and there were disagreements over maintenance and access. Both parents had contacted the HSE social work office in relation to those issues. The mother stated that otherwise there were no difficulties at home. On a week-end evening, the mother presented at her local hospital together with her two children and asked to see the Social

Worker. She was informed that there was no one available and she left the hospital. The following day this child was found dead along with her sister and mother.

This child died in tragic circumstances and her death and the death of other family members understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 14

- HSE Social Work Duty Team; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 14

- There is very little information on the record provided to the ICGRD. The file consists of two death certificates and a few short case notes. The issue here is that there was no out-of-hours Social Work service available to this mother and her children and six years on that remains the situation.
- There was no inquiry by the HSE as to the circumstances that pertained when this young mother could not access support and the ICDRG has not been informed of any changes in practice that would ensure that in these circumstances the same response (i.e. no service out-of-hours) would not prevail today.

4.2.15 Child Known to the HSE 15

This child died in 2001. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for four months prior to the death of this child. The referral to the HSE Duty Social Worker was concerned with very poor accommodation and mother's ill health. The mother requested support. The Duty Social Worker visited the accommodation and provided practical support and help with obtaining new accommodation. The duty Social Worker observed a close bond between the mother and her children. This child died by accidental drowning near the family accommodation. The family received enormous support from the local community and the social work service. The HSE continued to support the family and referred the older children for appropriate help.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 15

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Local County Council; and
- General Practitioner.

Good Practice Observed on File of Child Known to the HSE 15

- This family was positively supported by the Social Worker and the relevant local services. There was excellent cooperation between the local services in support of the family.

Concerns Arising from the File of Child Known to the HSE 15

- No concerns have been identified as arising from this case.

4.2.16 Child Known to the HSE 16

This child died in 2007. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

The family of this child were known to the HSE for 5 years prior to the birth of this child. There were concerns regarding the development of her older sibling and a referral was made to the Early Intervention Team. Both the father and sibling had an inherited physical disability. When the family moved areas, it was recorded that the sibling was doing well and the parents were very good at stimulating her. The case file was transferred to the services in the new area. This child also inherited the physical disability. Over the short life of this child, the family moved constantly and services were unable, or failed, to keep in touch with them. Both parents expressed difficulties with their extended families and appeared isolated. The Public Health Nurse stated that the parents were very co-operative. This child was 3 years and 5 months old when she died.

This child died in tragic circumstances and her death and the death of other family members understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 16

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- NGO Service;
- Paediatric Services;
- Early Intervention Teams; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 16

- This file has almost no direct information on this child. There is very little interaction with the family by the services recorded on this file. There is no information at all on the outcome of any Child Protection Conferences. The file consists of numerous copies of the same form. There are no records of any communications with this family during the years from 2005 to 2007 when the deaths occurred.

Note: Report of Inquiry

An inquiry was held into the circumstances surrounding the death of this child and her sibling. The Inquiry Team examined relevant records from a number of agencies and interviewed key personnel. Among other findings the inquiry noted that the deaths were planned and that the father of the family was the dominant person in the family and in the deaths of the other family members, further that the services failed to recognise that this family required extra support and that the system of communication within the HSE appeared to be disjointed. Crucially the Inquiry Team could not identify any one person/key worker who had access to all the information in relation to this family.

4.2.17 Child Known to the HSE 17

This child died in 2005. The death was registered on foot of a Coroner's certificate. The mother in this family received a custodial sentence for the unlawful killing of this child.

Case Summary

The family of this child was known to the HSE from 2001, when the children were referred to the Duty Social Work Team by the Gardaí, as they had been left alone in the hostel where the family was accommodated. The Duty Social Worker visited, cautioned the parents and the advised this was not to reoccur. There were a number of other social work visits while the family were helped to obtain more appropriate accommodation.

This child was born prematurely during this time and was discharged from hospital against medical advice. The records furnished to the ICDRG show that the concerns over this period included domestic violence, alcohol abuse, failure to take this child to attend various medical appointments and an aggressive attitude to HSE visits when the HSE personnel were concentrating on issues related to the care of the children. The documentation closing the case when this child was nine months old, records that there were no major child protection concerns but notes that parents are reluctant to engage with services and recommends that "the situation should continue to be monitored until this child is of an age that would reasonably deem her to be safe i.e. up to 15 months." The closing summary further recommended that the children be monitored by the Public Health Nurse and that a multi-agency professionals meeting be held if the situation deteriorated.

There was an additional referral three months later by the Public Health Nurse when the children were again left unattended in the home. A Social Worker visited and finding two children alone in the house removed the children with the Gardaí to the local social work office. Sometime later that day the mother, responding to the note left, attended at the office where she was interviewed by the Gardaí and Social Work Team Leader. She was verbally abusive, insisting that the children were only left for 5 minutes and that it was not a problem in her culture. It is not recorded that she was informed that this was the second time the HSE and Gardaí had found the children unattended. The children were returned to her care. There is no record that a multi agency professionals meeting was called. Over the following months the

family of this child were visited periodically by Social Workers and the Public Health Nurse also visited. The focus of the work continued to be on encouraging the parents to take this child to medical appointments. The Public Health Nurse is recorded as being happy with the developmental progress of this child. The case was again closed by the social work department when this child was 21 months old.

There is no further record of concerns about this child until the Gardaí contacted the Principal Social Worker to advise that the child had been admitted to hospital following an incident in the home. Her condition was critical. The child died two days later. The child on admission to hospital was discovered to have multiple bruising and a serious brain injury. The other children in the family were admitted to the care of the HSE and eventually Care Orders under Section 18 of the Child Care Act, 1991 were granted in respect of them.

This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 17

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Adult Psychiatric Services;
- CAMHS;
- Women's Refuge;
- Gardaí; and
- Hospital.

Concerns Arising from the File of Child Known to the HSE 17

- There is no evidence on the records provided to the ICGRD of a comprehensive risk assessment being carried out in relation to the child welfare and protection issues in this family. The children were found without adult supervision on two occasions, there were general concerns around attention to medical issues, immunisations and missed hospital appointments in respect of this vulnerable child. Additionally alcohol abuse, domestic violence and aggressive behaviour towards social work visits were of concern.

When declared cultural issues within a community clash with ensuring the safe care of children, acceptable norms of parenting and the relevant legal issues must be made clear to the parents and family alike.

- The relevant services responded quickly to the various crises presented but it appears that each incident was treated in isolation rather than the full picture being considered. There are references to the need for a strategy meeting in the early stages of the HSE involvement with this family but this meeting appears to have never occurred. It is not suggested that the death of this child was necessarily preventable but the child protection concerns were not fully addressed.

4.2.18 Child Known to the HSE 18

This child died in 2005. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

The family of this child was known to the HSE for just over one month prior to the death of this child, in so far as can be gleaned from the very sparse records provided to ICDRG. The child's parents were separated and there were disagreements over maintenance and access. Both parents had contacted the HSE social work office in relation to those issues. The mother stated that otherwise there were no difficulties at home. On a week-end evening the mother presented at her local hospital together with her two children and asked to see the Social Worker. She was informed that there was no one available and she left the hospital. The following day this child was found dead along with her sister and mother.

This child died in tragic circumstances and her death and the death of other family members understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 18

- HSE Social Work Department; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 18

- There is very little information on the record provided to the ICGRD. The file consists of two death certificates and a few short case notes. The issue in this case was the lack of an out-of-hours service available for crisis interventions and this remains the case 6 years on.
- There was no inquiry by the HSE as to the circumstances that pertained when this young mother could not access support and the ICDRG has not been informed of any changes in practice that would ensure that in these circumstances the same response (i.e. no service out-of-hours) would not prevail today.

4.2.19 Child Known to the HSE 19

This child died in 2001. This death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

The family of this child was known to the HSE for seven years prior to her birth. From the records furnished to the ICDRG it appears that concerns focussed on the care of the children. The case was closed after an initial investigation. There were two further referrals four years later involving older siblings who were described as presenting with behavioural problems. It is recorded on the file provided to the ICDRG that this child presented with no problems. She had received all immunisations and her development appeared normal. When this child was 4 years old, the family home caught fire and she died of severe burns. An older sibling was subsequently received into the care of the HSE.

Services Engaged for Child Known to the HSE 19

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Family Support Services;
- Gardaí; and
- CAMHS.

Good Practice Observed on File of Child Known to the HSE 19

- The relevant services offered sustained support to this family both prior to and after the death of this child.

Concerns Arising from the File of Child Known to the HSE 19

- No concerns have been identified as arising from this case.

4.2.20 Child Known to the HSE 20

This child died in 2006. The death was registered on foot of a Coroner's certificate.

Case Summary

This child was referred to the HSE the year he died when a family member was involved in an incident and abandoned the child in a motor vehicle. From the records furnished to the ICDRG it appears that the family of this child had a history of alcohol addiction and involvement in crime. The father was subsequently jailed for outstanding offences.

The mother interacted well with the Social Workers in regard to her accommodation and financial support. When the father was on weekend leave, he was involved in a car accident in which this child died. The father was convicted of dangerous driving causing death and was sentenced to 3 years imprisonment.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 20

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Gardaí; and
- Regional Hospital.

Concerns Arising from the File of Child Known to the HSE 20

- No concerns have been identified as arising from this case.

4.2.21 Child Known to the HSE 21

This child died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the family of this child was known to the HSE from when he was aged two and a half. There were concerns regarding the family's chaotic living conditions and this child's developmental progress. The Social Worker supported this child's mother in relation to accommodation and childcare issues. Speech and language assessment was accessed for him. The family was re-housed and the child began attending pre-school. The case was subsequently closed. The child subsequently died together with his mother.

This child died in tragic circumstances and his death and the death of his mother understandably caused much distress to all those who cared for them.

Services Engaged for Child Known to the HSE 21

- HSE Public Health Nursing Service;
- HSE Social Work Department;
- Local Council Housing Department; and
- Speech and Language Therapy Department.

Good Practice Observed on File of Child Known to the HSE 21

- The Social Worker was very supportive of this family in a practical way assisting the mother in securing accommodation and referring the child to the relevant services.

Concerns Arising from the File of Child Known to the HSE 21

- It is not clear from the records furnished to the ICDRG if there was any involvement with the mental health services.

4.2.22 Child Known to the HSE 22

This child died in 2006. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

This family was known to the HSE since this child was 3 years old. From the records furnished to the ICDRG it appears that there was a history of domestic violence and other ongoing concerns regarding accommodation and behavioural difficulties of two children who had witnessed the domestic violence. Psychological services were organised for this child and another sibling. Eventually a Barring Order was obtained by the mother and she was assisted to obtain alternative housing. This child died in a road traffic accident in which the mother of the family and a sibling were also killed.

This child died in tragic circumstances and her death and the deaths of other family members understandably caused much distress to all those who cared for them.

Services Engaged for Child Known to the HSE 22

- HSE Social Work Department;
- Psychology Service;
- Family Support Services;
- Gardaí; and
- Addiction Services.

Good Practice Observed on File of Child Known to the HSE 22

- The relevant services interacted with this family offering them practical support in securing accommodation. They also addressed the children's behavioural difficulties and the father's abuse of alcohol.

Concerns Arising from the File of Child Known to the HSE 22

- There is no adequate risk assessment recorded.

4.2.23 Child Known to the HSE 23

This child died in 2007. The death was registered on foot of a Coroner's certificate. This child was a sibling of another child discussed in this report.

Case Summary

The family of this child was known to the HSE from shortly after the birth of this child. There were concerns regarding her development and a referral was made to the Early Intervention Team. Both the father and this child had an inherited physical disability. When the family moved areas it was recorded that this child was doing well and the parents were very good at stimulating her. The case file was transferred to the services in the new area. Over the short life of this child the family moved constantly and services were unable or failed to keep in touch with them.

Both parents expressed difficulties with their extended families and appeared isolated. The Public Health Nurse stated that the parents were very co-operative. The child was just over 4 years old when she died.

This child died in tragic circumstances and her death and the death of other family members understandably caused much distress to all those who cared for them.

Services Engaged for Child Known to the HSE 23

- HSE Social Work Department;
- HSE Public Health Nursing Services;
- NGO Service;
- Paediatric Services;
- Early Intervention Teams; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 23

- This file has almost no direct information on this child. There is very little interaction with the family by the services recorded on this file. There is no information at all on the

outcome of any Child Protection Conferences. The file consists of numerous copies of the same form. There are no records of any communications with this family during the years from 2005 to 2007 when the deaths occurred

Note: Report of Inquiry

An inquiry was held into the circumstances surrounding the death of this child and her sibling. The Inquiry Team examined relevant records from a number of agencies and interviewed key personnel. Among other findings the inquiry noted that the deaths were planned and that the father of the family was the dominant person in the family and in the deaths of other family members, further that the services failed to recognise that this family required extra support and that the system of communication within the HSE appeared to be disjointed. Crucially the Inquiry Team could not identify any one person/key worker who had access to all the information in relation to this family.

4.2.24 Child Known to the HSE 24

This child died in 2000. The death was registered on foot of a Coroner's certificate.

Case Summary

This child was brought to the attention of the HSE around the time of her death. On the record provided to the ICDRG it is recorded that the father of the family was suffering from anxiety and had suicidal ideation. The father stood trial for the manslaughter of this child and was found not guilty by reason of insanity. He was detained in the Central Mental Hospital.

The HSE and the staff in the hospital carried out a comprehensive risk assessment before he was released back into the community with conditions attached.
The case was closed some time later by the HSE.

This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 24

- HSE Social Work Department;
- Gardaí; and
- Central Mental Hospital.

Good Practice Observed on File of Child Known to the HSE 24

- The relevant services interacted well with each other in completing a risk assessment prior to the release of the father back into the community.

Concerns Arising from the File of Child Known to the HSE 24

- No concerns have been identified as arising from this case.

4.2.25 Child Known to the HSE 25

This child died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for six years prior to the birth of this child. The children of the family were the subject of an open child protection case for the period of 8 years until this child was 3 years old. The record provided to the ICDRG is primarily concerned with the care of a sibling who was born with a chronic illness. The records show that there were concerns regarding domestic violence and consequent emotional abuse and neglect. There was evidence of the mother sustaining multiple injuries and assaults and spending lengthy periods in domestic violence refuges, which resulted in the children missing a substantial amount of school. The death of the child was accidental and understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 25

- HSE Social Work Department; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 25

- No adequate risk assessment completed.
- The record provided to the ICDRG has little information on this child. The file is not in good order.

4.2.26 Child Known to the HSE 26

This child died in 2001. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE from when this child was five years old. The father reported an allegation of sexual abuse by a non family member. This was fully investigated, found to be unsubstantiated and the case was closed. The parents of this child were separated and the child was in the sole custody of the mother. The care of the child was said to be excellent. The father had agreed access to the child.

Two months later the mother contacted the Social Worker to report that the father had abducted the child. Subsequently, it is recorded that this abduction was planned and designed to suggest that the child had been removed from the jurisdiction. The Gardaí were contacted and initiated a search for this child. The child was missing for 21 months in total. During that time the mother continuously searched for her child and had put a plan in place, with the help of a clinical psychologist, in anticipation of the child's counselling needs on her return. When the child was missing for 5 months, both the Clinical Psychologist and the HSE informed the mother that they were closing the case. An offer of further support was made, if needed, in the future. When the child was 6 years old, she was unlawfully killed in the house where she had been kept in hiding. Her father shot himself in the same incident.

This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 26

- HSE Social Work Department;
- Clinical Psychology Department; and
- Gardaí.

Good Practice Observed on File of Child Known to the HSE 26

- The social work department reacted quickly to the allegation of sexual abuse. The allegation was not substantiated
- There was a plan in place to assist this child and her mother when the child was located and back home/

Concerns Arising from the File of Child Known to the HSE 26

- This record provided to the ICDRG consists of 4 copies of the same few documents.
- The HSE did not carry out a review into the death of this child.

4.2.27 Child Known to the HSE 27

This child died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the family of this child was known to the HSE from when this child was one year old on foot of a referral from the Gardaí in respect of the neglect of the older children. Other referrals around that time detailed the abuse of alcohol in the home, concerns that the children were left with unsuitable babysitters and that adequate food was not always available. The referrals were followed up by the local HSE office. It was discovered that the family had moved and the area they were understood to have moved to was notified about the concerns. From the records furnished to the ICDRG it appears that another referral was made to the HSE regarding concerns that a sibling of this child had been sexually abused. A process of investigation was initiated by the HSE and a referral was made to a specialised child sexual abuse unit. The assessment process was never completed as the family did not follow through on appointments over an extended period.

It is recorded that during the assessment process concerns emerged again in relation to the ability of the mother in the family to consistently parent the children due to her alcohol dependency, drug misuse and gambling. This family was moving constantly and a total of eighteen moves are recorded on the file. It appears that no comprehensive assessment of the child welfare and protection issues in this family was undertaken prior to the death of this child.

This child died in hospital following a single car collision. The mother of this child received a term of imprisonment on two counts of dangerous driving causing death and two counts of dangerous driving causing serious bodily harm in respect of this collision.

Child Protection Notifications were sent to the HSE from the Gardaí attending the scene in relation to the remaining children in the family. A Child Protection Case Conference was held some months later and a plan to deal with outstanding matters was put in place.

This child died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Child Known to the HSE 27

- HSE Social Work Departments in a number of areas;
- Consultant Psychiatrist;
- Clinical Psychologist;
- Addiction Counsellor;
- Specialised Child Sexual Abuse Unit; and
- Gardaí.

Concerns Arising from the File of Child Known to the HSE 27

- It is the view of the ICDRG that the serious child protection issues that arose in this family were not adequately addressed in a timely manner. There was communication to the HSE from a specialised child sexual abuse unit that the family was not attending for meetings and requesting a meeting to discuss how to best address this. That did not happen. It is not evident whether or not the Gardaí were informed of the child sexual abuse allegation. The first Child Protection Case Conference occurred after this child had

died. This family moved area very regularly and that may have contributed to a lack of coordination of the services to address the child welfare issues in this family

4.2.28 Child Known to the HSE 28

This child died in 2001. This death was registered on foot of a Coroner's certificate.
This child was a sibling of another child referred to in this report.

Case Summary

From the records furnished to the HSE it appears that this child's family was referred to the HSE, when she was 1 year old. Concerns focussed on the care of the children. It is recorded that there were two further referrals four years later involving poor parenting issues and behavioural problems relating to this child and an older sibling. This child was displaying serious dysfunctional behaviour and her mother is described as being unable to relate to her. When this child was 8 years old, the family home caught fire and she died of severe burns. Her sibling died in the same accident. An older sibling was subsequently received into the care of the HSE.

This child died in tragic circumstances and her death and the death of her sibling understandably caused much distress to all those who cared for them.

Services Engaged for Child Known to the HSE 28

- HSE Social Work Department;
- HSE Public Health Nursing Service;
- Family Support Services;
- Gardaí; and
- CAMHS.

Good Practice Observed on File of Child Known to the HSE 28

- The relevant services offered sustained support to this family both prior to and after the death of this child.

Concerns Arising from the File of Child Known to the HSE 28

- No adequate risk assessment was recorded.

4.2.29 Child Known to the HSE 29

This child died in 2000. This death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for six weeks prior to the death of this child. The initial referral to the community social work department was made by a medical Social Worker following the admission of one of the younger siblings to hospital with a severe asthma attack. The mother had indicated that the asthma attack was brought on by the stress in the home due to ongoing disharmony between the parents, with frequent physical and emotional abuse. She said she was seeking a barring order against the father.

The children's father was seen and he indicated that the mother had mental health difficulties and abused alcohol and medication. He denied any physical or emotional abuse and said he would leave the home if it helped the situation. Subsequent events vindicated the position of the father. The mother and children spent a number of days in a women's aid hostel prior to moving into rented accommodation. The father was advised to seek access to his children through the courts.

The father visited the social work department a month later, again expressing concern about his children's welfare. He was concerned as there was no cooker in the new accommodation and said that medication was lying within easy reach of the children. He expressed his concern that his children were not safe due to their mother's mental state. Two Social Workers visited the home unannounced and discussed the concerns with the mother. They observed a warm relationship between the mother and children, there was food in the cupboards and the cooker was due to be connected that evening. They did not find anything that indicated that the children were at risk.

The next day the maternal grandmother contacted the Social Worker to indicate that the Gardaí had called to the home as the mother had walked up the road to "clear her head" leaving the children alone. The Social Worker spoke to the mother on the phone and advised her not to leave the children alone. The mother accepted this.

On the morning of the death of this child, the father visited the home and accompanied the mother to the Psychiatric hospital. She left the hospital without warning. Later that day a neighbour visited the family home and found this child lying on the floor. She could not find a pulse. The two younger children were taken into care by the Gardaí under Section 12 of the 1991 Child Care Act. Subsequently, the children resided with their father.

The mother was taken into custody and charged with the murder of this child. She was found guilty but insane and detained in the Central Mental Hospital.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 29

- HSE Social Work Department;
- Adult Psychiatry;
- Emergency Housing; and
- Regional Hospital.

Concerns Arising from the File of Child Known to the HSE 29

- No adequate mental health or risk assessment completed.
- The extent of the mental health difficulties being experienced by the mother of this child was not fully understood.
- A serious incident review should have been completed following this child's death to assist learning in relation to the mental health issues in this case and the interaction of Adult Psychiatric Service with Child Protection Services.

4.2.30 Child Known to the HSE 30

This child died in 2009. This death was registered on foot of a Coroner's certificate.

Case Summary

The family of this child was known to the HSE for four years at the time of his death. Initial contact with the family was in relation to marital problems. From the records furnished to the ICDRG it appears that there were allegations of domestic violence and the mother sought the protection of the court. The father was convicted of an offence and was made subject to the Probation Act. He applied for access to his children and following an assessment by the social work department, unsupervised access was granted under the Guardianship of Infants Act 1964, as amended.

Family support was offered and availed of on an ongoing basis. There were no child protection issues as the mother was deemed to be a protective parent who communicated and supported her children well. It appears from the records that maintenance payments were sporadic and the mother struggled financially.

It appears from the records that this child was close to his father and presented as stressed following the marital separation. He was assessed following the separation but was judged to be coping well. As time moved on this child was the only one of the siblings who continued the access arrangements with his father who had a new family.

On the week he died, the young person had been with his father for access and had enjoyed a fun outing. On the day of his death, he attended hurling training with his mother and brothers and was treated to a special night in with a meal and videos.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 30

- HSE Social Work Department; and
- Family Support Services.

Good Practice Observed on File of Child Known to the HSE 30

- The HSE has continued to provide support to the family and has organised counselling for all family members.

Concerns Arising from the File of Child Known to the HSE 30

- No concerns have been identified as arising from this case.

4.2.31 Child Known to the HSE 31

This child died in 2006. This death was registered on foot of a Coroner's certificate.

Case Summary

This child's mother initially made contact with the Social Work Department a year prior to the death of this child with regard to support and information on accommodation and services for this child. He had been diagnosed with autism two years previously and they had just moved to the area. This child's mother was separated from his father and the father was living some distance from them. The Social Work Department contacted the Department in the area where this child had been living to ascertain their knowledge of the family. No child protection concerns were identified. Advice was given in relation to services and the case was closed.

Some months later, the Gardaí made a referral to the HSE as the children of the family, then aged 10 and 12, had been left at home alone while the mother was out drinking. This referral was followed up by a Social Worker and the mother was referred to addiction services. This referral was closely followed by another referral from the Gardaí, which involved a domestic incident in the family home between this child's mother and her partner. On attending, the Gardaí found the mother intoxicated. Pursuant to section 12 of the Child Care Act 1991, the children were removed by the Gardaí from the family home and placed in an emergency residential centre for the night. This child's father collected them the next day.

Subsequent to this incident, the record details a call to the Social Work Department in the area where the family had previously lived in which it was claimed that alcohol abuse had been a problem and that there was a fire in the family home which was stated to have been started accidentally. The children remained in the care of the father for some time. However he expressed that he was having difficulty balancing work and caring for the children. The mother began and completed 10 weeks of a 12 week programme for alcohol addiction. She requested that the children be returned to her but she was informed by the Social Work Department that checks would have to be carried out before the children could be returned to her care.

The children were returned by the father to their mother when she had only been abstaining from alcohol for a short period of time and this appears to have been done without the knowledge of the Social Work Department. It appears from the records that a visit by a social worker after the children were returned to their mother indicated nothing of concern in the family home, despite this child's sister saying they had been left alone for a number of hours the previous day and that there had been alcohol in the fridge at the weekend.

Some few days later, a fire broke out in the family home. This child's mother and his sister were rescued. He was found unconscious in a back bedroom and subsequently died.

This child died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Child Known to the HSE 31

- Addiction Counselling Services;
- HSE Social Work Department;
- Emergency Residential Care; and
- Gardaí.

Good Practice Observed on File of Child Known to the HSE 31

- The files received by the ICDRG are organised and display evidence of professional supervision and support.
- There is evidence on the file of forward planning for this child, his sibling and his family.

- The Social Work Department carried out thorough inquires of other services connected to the family to ascertain if any child protection concerns existed.
- The Social Work Department was quite systematic in their interventions with this family and displayed decisiveness and speed in relation to measures that needed to be put in place in relation to the protection of the children, involving section 12 of the Child Care Act, 1991 and the subsequent placement of the children with their father.

Concerns Arising from the File of Child Known to the HSE 31

- No sufficient risk assessment was completed.
- The case was never allocated; it was held by the Duty Social Work Team while it was open.
- It appears from the files reviewed by the ICDRG that there was a failure by the HSE in the area where the family lived (when contacted initially) to disclose all pertinent details of the family history. This information should have been communicated earlier as it may have aided the Social Work Department in the family's new area to carry out a more comprehensive risk assessment of the potential dangers for the children.
- When this child's mother asked that the children be returned to her following the placement with their father, she was advised that checks would need to be carried out. No checks appear to have been carried out. It would have been helpful had the treatment centre been contacted to ascertain the reason why she left after 10 weeks completion of a 12 week programme.
- It is the view of the ICDRG that following the return of the children to the care of their mother an overly optimistic assessment of her ability to care and protect her children was formed.
- It is not clear if the concerns of the HSE were fully communicated to the father of these children.

4.2.32 Child Known to the HSE 32

This child died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the Gardaí made a referral to the HSE after a Garda witnessed the father of this child kick and hit his older sister. This child was then 3 years old. The referral was followed up by the Social Work Department and the case was subsequently closed.

When this child was aged 9 the Social Work Department received 5 referrals in just over a twelve month period regarding physical abuse of this child's older sister. The abuse was said to have been perpetrated by family members. This child's older sister was received into the Interim Care of the HSE following this abuse. She was returned home approximately one month later and the case was closed.

From the records furnished to the ICDRG it appears that a short time later, another sister of this child made an allegation of physical abuse against the same family members. She was medically examined and there was no evidence of physical abuse. The allegation was subsequently withdrawn.

This child's sister was noted to be attending a counselling psychologist and was diagnosed with Post Traumatic Stress Disorder, having witnessed the death of her sister in a road traffic accident. This is the only mention on the record furnished to the ICDRG of the child who died in the Road Traffic Accident and who is the subject of this review.

This child died in tragic circumstances and her death will have caused much distress to all those who cared for her.

Section 3: Young people aged between 13 and 19 years

Overview of Analysis

The Independent Child Death Review Group (ICDRG) received and reviewed the child and family records for 36 young persons who were aged between 13 years and 19 years at the time of their death. Those 36 young people were known to the HSE when they died of unnatural causes between 2000 and 2010.

Year of Death

- One young person died in 2001
- Three young people died in 2002
- Two young people died in 2003
- Two young people died in 2004
- Three young people died in 2005
- Two young people died in 2006
- Eight young people died in 2007
- Seven young people died in 2008
- Two young people died in 2009
- Six young people died in 2010

Gender

- Twenty Four young people were male.
- Twelve young people were female.

HSE Region

- Five young people were known to HSE Dublin North East.
- Fifteen young people were known to HSE Dublin Mid Leinster.
- Eight young people were known to HSE South.
- Eight young people were known to HSE West.

Age at Time of Death

- Fourteen young people known to the HSE died aged between 13 and 14 years.
- Nine young people known to the HSE died aged between 15 and 16 years.
- Nine young people known to the HSE died aged 17 years.
- Four young people known to the HSE died aged between 18 and 19 years.

Individual Case Analysis

4.2.33 Young Person Known to the HSE 33

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was the eldest child of a large family. His parents are described as having learning disabilities. The records furnished to the ICDRG show that this family was first referred to the Social Work Department when he was 2 years old. This referral detailed domestic violence which was unconfirmed and the case was closed.

Another referral was made 7 years later following an allegation of physical abuse of this young person's sister by a family member. On investigation of this, the children of the family were found to be neglected. They were described as being "starving, poor diet, filthy". The allegation of physical abuse was also confirmed. There was concern about the parenting capacity within the family. The older children were left to mind the younger children frequently. It appears that following the investigation this young person's sister went to live with a member of her extended family where she remains.

Each of the children had presented with difficulties around behaviour management and Attention Deficit Disorder. There had consistently been poor school attendance, poor speech and language development and developmental delay. All of the children attended an afternoon homework facility. This young person's younger brother was diagnosed with Attention Deficit Disorder and Asperger's Syndrome. He was referred to the Child and Adolescent Mental Health Service. The HSE financed special needs respite care for this young person for one weekend per month. The family is receiving ongoing family support.

Approximately one year prior to his death, the school expressed concerns that this young person might be feeling isolated at home following an unusual essay he wrote in school. His behaviour began deteriorating in school and again the parents were informed of this by the

school. It is noted in the file that his mother was finding it hard to manage, that the family home was chaotic and the mother was ill with stress.

Prior to his death this young person was "grounded" because he was smoking. When prevented from meeting up with a friend he became agitated.

He later died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

This family's case was never allocated to a Social Worker and was dealt with by the Duty Social Work Team.

Services Engaged for Young Person Known to the HSE 33

- HSE Public Health Nursing Service;
- HSE Duty Social Work Team;
- Family Support Service;
- Child and Adolescent Mental Health Service;
- Special Needs School;
- General School Services; and
- Bereavement Group.

Good Practice Observed on File of Young Person Known to the HSE 33

- Respite services and a family support worker were engaged for the family.
- After school help was provided to the children for homework and school activities.

Concerns Arising from the File of Young Person Known to the HSE 33

- No adequate risk or mental health assessment is recorded.
- The file received by the ICDRG is a family file with little mention of this young person.
- There is no evidence of forward planning in relation to this young person or his family.
- The case was never allocated to a Social Worker despite the ongoing concerns.

Comment

This family must receive a comprehensive assessment of their needs to have an overall plan of intervention for the family.

4.2.34 Young Person Known to the HSE 34

This young person died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that contact was made with the HSE in relation to this young person following his admission to hospital with a virus. The hospital noticed that he enjoyed the level of care provided and was happy to remain in hospital.

It is recorded that his mother was unable to accompany him to the hospital on the night he was admitted as she was intoxicated. The record also states that two visitors to the hospital made reference to his mother's over indulgence in alcohol.

The mother was subsequently interviewed by a duty social worker who recorded that she denied that there was any problem. She was provided with support details, should she wish to avail of them.

Following this, a student Social Worker contacted the child's school. The School advised that the young person was a serious challenge in the school setting. There was a history of absence, and generally difficult behaviour. He had been suspended on a regular basis due to breaking school rules and was described as being "a serious distraction to the teaching and learning in the classroom".

Despite this information, the case was closed as it was decided that there were no child protection concerns. That completed the social work involvement in the case.

The final documentation on the file is a note stating that a phone call had been received from the hospital to state that this young person had died following a road traffic accident. Support was being offered to the family by the hospital Social Work Department.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 34

- General Hospital;
- HSE Social Work Department; and
- Education.

Concerns Arising from the File of Young Person to the HSE 34

- No adequate risk assessment completed.
- Despite the contention that this young person's mother was abusing alcohol and the statement from the school that the young person was extremely disruptive in class, was frequently absent and was regularly suspended, this file appears to have been closed without a full assessment.

4.2.35 Young Person Known to the HSE 35

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that this family was originally brought to the attention of the HSE when this young person's oldest brother left home following an argument and was homeless for a short period of time. Following this, the records show that there were ongoing referrals from the Gardaí, the school and a General Practitioner relating to excessive drinking by this young person's mother and the poor level of care received by the children. It appears from the records that the children were frequently left unsupervised, with this young person often left to baby sit and care for his younger siblings.

There is evidence on file that all of the children, including this young person were poorly dressed, without supervision and around town late at night. From the records furnished to the ICDRG it appears that the Gardaí and Social Workers were aware of these issues. There is no record of significant casework or planning meetings until after this young person's death, despite 4 referrals in the previous year outlining concerns regarding the welfare of all the children and a particular reference to this young person reported to be eating dog food.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 35

- There were no services engaged for this young person except one Child Welfare Meeting held immediately prior to his death.

Concerns Arising from File of Young Person Known to the HSE 35

- From the records examined it appears that the clear signals that all was not well in the home i.e. the children missing school, not having clothes or food appropriate to their needs were not acted upon.
- It is the view of the ICDRG that the needs of this young person and his family were not addressed and dealt with. There was no assessment of the family situation and no attempt to put in place a system to protect and care for the children.
- It appears from the records that no consideration was given to providing alcohol counselling to this young person's mother despite clear evidence that she was abusing alcohol constantly.
- It is the view of the ICDRG that this young person was failed by a system designed to protect children in his situation.

4.2.36 Young Person Known to the HSE 36

This young person died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

The file received by the ICDRG contains very little information relating specifically to this young person. It is recorded that his father had been in prison for a serious offence.

From the records furnished to the ICDRG it appears that this young person was very unsettled in school following the imprisonment of his father. There were several incidents of aggressive and sexualised behaviour in the school setting but the needs of this young person were never fully assessed. He had been suspended from school for three days as the Special Needs Assistant who was employed to assist him in the school setting, was not able to cope with him. The record of several discussions with his mother states that she was in denial about his behaviour and that she had indicated that she had no problem managing him in the home setting.

Two years following the closure of this case this young person died. At the time of his death, this young person had been referred for psychological assessment and was on a waiting list.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

From the records furnished to the ICDRG it appears that at no point was a case conference or review held despite the serious nature of the referrals from the school about this young person's behaviour. No risk assessment was completed.

Services Engaged for Young Person Known to the HSE 36

- Awaiting psychological assessment at the time of his death;
- HSE Social Work Department;
- Special Needs Assistant; and
- Education.

Concerns Arising from the File of Young Person Known to the HSE 36

- No adequate risk or mental health assessment.
- There was a failure to address the serious behavioural traits this young person was displaying despite a number of referrals from the school.
- No case conferences or reviews were held in respect of this young person or his family.

4.2.37 Young Person Known to the HSE 37

This young person died in 2010. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was referred to the HSE at age 8 as his mother, who had separated from his father, found his behaviour very challenging. Following the separation, the father moved to live abroad.

A Garda Notification of emotional abuse was also made to the HSE at that time. The case was on a waiting list system and there was no progression for 1 year when an inter agency meeting was held on the case. The CAMHS service reported that the young person was reacting to inconsistent parenting.

About this time, the decision was made for this young person to join his father. This decision was felt to have been arrived at out of desperation, as his mother had threatened to place him in care because she could no longer cope. During his time abroad he was linked into a school and had the services of an Educational Psychologist who provided a full assessment. He stayed with his birth father for a period of 2 years.

There is a reference on the file received by the ICDRG to the young person's imminent return to his mother's care as his father was also having a problem coping with his disruptive behaviour. It appears from the records that the main reason for his return home however was immigration related. There was no set social work plan agreed for the young person when he returned home. His mother was aware of the Child Guidance Service if she needed support after the 'honeymoon 'period had expired. This young person's case was closed one year prior to his death.

There was no further contact with this young person or his family until the HSE was informed of his death. The HSE provided bereavement support to the family.

There is a reference on the file received by the ICDRG to the National Educational Psychological Service implementing a critical incident procedure. There is also a reference to the HSE formulating an interagency response to the young person's death. Neither of the reports is filed on the records furnished to the ICDRG.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 37

- Gardaí;
- HSE Social Work Department;
- CAMHS; and
- Educational Psychologist.

Concerns Arising from the File of Young Person Known to the HSE 37

- No adequate risk or mental health assessment completed.
- There is very little detail on the file received by the ICDRG which has made it difficult to analyse the response this young person received from the HSE. It does not appear, however, that there was any forward planning for his return to live at home. Moreover, no support appears to have been provided for him or his mother to deal with the problems he was experiencing.

4.2.38 Young Person Known to the HSE 38

This young person died in 2003. The death was registered on foot of a Coroner's certificate.

Case Summary

The family of this young person was attempting to deal with the death of the father following a drug related incident. The records furnished to the ICDRG detail that the mother of the family also had a number of suicide attempts involving drug overdoses.

One year before her death this young person was admitted to hospital having self harmed. At that point a referral had been made to the CAMHS for this young person. She intimated to the referring Social Worker that she was petrified of her mother having a death similar to her father. This young person's mother was also HIV positive and had Hepatitis C, so it was natural in view of her experience that the young person's anxiety was raised.

The family was provided with supports to help them cope with their grief over the death of their father. Following a disclosure to her mother by the young person that she had been sexually assaulted a few months prior to her death a detailed interview was conducted and details of the abuse documented. One of the persons alleged to have sexually assaulted this young person was part of the extended family and information about the episode spread throughout the family. The young person was questioned about the incident by family members and became quite fearful and stressed as a result.

A Child Protection referral was made to the Gardaí with follow-up statements organised. The young person initially refused referral to a Specialist Validation and Support Unit but eventually agreed to attend with her mother's support. Unfortunately, before the referral was activated this young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 38

- Bereavement counselling;
- HSE Social Work Department;
- Music therapy;

- Aids Care and Education Training; and
- Health Board Residential Unit (Respite care when mother was hospitalised).

Good Practice Observed on File of Young Person Known to the HSE 38

- Upon the initial referral, supports were put in place to help this young person cope with her grief and other problems.
- There is evidence of good communication between support services.
- Support and emergency accommodation was provided when this young person's mother was hospitalised.

Concerns Arising from the File of Young Person Known to the HSE 38

- A comprehensive risk assessment might have provided useful information of likely stressors for the young person. Having her abuse details common knowledge among the extended family cannot have been a comfortable situation for her at such a vulnerable age.

4.2.39 Young Person Known to the HSE 39

This young person died in 2001. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the initial referral regarding this young person was made six months prior to her death. She was suspended from school for three weeks for violent behaviour and it is recorded that the school was not willing to readmit her until a psychological assessment was completed. The psychologist had written to the Child Care Manager about the appropriateness of this request. This young person's case was referred to the Child Protection Meeting, with a check completed for any earlier files.

There is a reference on the file received from the HSE by the ICDRG that a worker from a children's NGO service had met with this young person and her mother a number of times at the time of this referral but there is no detail as to the content of those meetings.

Two months later there was a further referral from the NGO as this young person had been suspended from school indefinitely due to her behaviour. She had assaulted her mother in the company of the School Principal and the school had stated that she would not be allowed back until she was seen by the HSE Psychologist.

The young person's mother had expressed to the NGO at this point that she was afraid of her daughter and there were few extended family supports to assist in the difficult situation. She had at that point been awaiting an appointment for an assessment with Psychology for one year.

There is reference on the file to the case being allocated to a Social Worker who was on leave and an appointment with a duty Social Worker was offered in the meantime. One month later the young person and her mother met with the duty Social Worker. This young person became extremely irate during the meeting and "stormed out of the building", immediately followed by her mother. There is no evidence on the records reviewed by the ICDRG of any follow up by the allocated Social Worker in the 2 months between that event and the death of this young person. There is no evidence of any further work having been undertaken with this young person.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 39

- Psychological assessment (awaiting appointment) ;
- Children's NGO; and
- HSE Duty Social Work Department.

Concerns Arising from File of Young Person Known to the HSE 39

- No adequate risk or mental health assessment was completed.
- There is very little detail on the file received by the ICDRG.
- This young person was waiting over a year for an appointment with a psychologist, with no evidence of any other assessments being carried out in the meantime to identify this young person's needs or address the problems she was experiencing.

It would appear from the records furnished to the ICDRG that while the case was allocated to a Social Worker, there is no evidence that there was any contact between the Social Worker and this young person.

4.2.40 Young Person Known to the HSE 40

This young person died in 2002. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person's mother phoned the Social Work Department asking for her daughter to be taken into care as she could no longer manage her. Her parents were separated although contact between this young person and her father had been re-established prior to her death.

Difficulties with this young person had commenced in National School as she was involved in bullying, however this matter had been resolved. After starting Secondary School she began to present with problems and she was friendly with older children. She started drinking and saying that she wanted to work and to give up school.

The records furnished to the ICDRG show that approximately one year before her death her mother found this young person very intoxicated in a nearby town. The Gardaí were called to assist in bringing her home. She was often out of home until near midnight, at the age of 13. Her mother was also caring for her grandmother. As a result of this, this young person's mother had to give up work, which caused financial difficulty.

This young person refused to return to school and this decision was accepted by the mother. Following this, she was linked in to a number of youth services. She seemed to enjoy this and appeared to settle down. Arrangements were also put in place for a residential placement with a private organisation.

On the day of this young person's death, the Social Worker called to the family home to discuss a youth service placement for her younger brother. This was to ensure that she did not have to mind her brother during the summer holidays and could continue to attend the programme run by a private organisation. During the conversation the Social Worker commented on how tired

the mother looked. She then confided that this young person and her friend had left home the previous evening at 10.45pm and had not returned home. Her brother was out looking for them. The Social Worker advised that the matter be reported to the Gardaí immediately. This young person's brother returned at that point and reported that he had found his sister and her friend in a nearby field and that she was not moving. The Social Worker ran to the field. She was able to revive the friend but could not revive this young person.

The Social Worker remained with the body of this young person until the ambulance and the Gardaí arrived. The Social Worker returned to the family to offer her condolences. The family are still being visited on a regular basis to monitor well being and offer supports.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 40

- HSE Social Work Department;
- Youth programme provided by NGO ; and
- Gardaí.

Good Practice Observed on File of Young Person Known to the HSE 40

- Efforts were being made to help this young person and she appeared to be responding.
- This Social Worker is to be commended for her efforts when she found this young person and her friend in the field.

Concerns Arising from the File of Young Person Known to the HSE 40

- No concerns have been identified as arising from this case.

4.2.41 Young Person Known to the HSE 41

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

It is not clear from the file received by the ICDRG how the first referral of this young person came to the HSE. However she was referred when she first entered the school setting. It was clearly evident that she was falling behind in junior infants. There were also referrals from doctors in relation to this young person and her siblings. The records furnished to the ICDRG state that she was frequently sent to school in a neglected state with dirty clothes, head lice and at one point had very sore feet that had to be treated by the school. There are documented instances of her not being taken to the doctor when she was ill with a sore throat and swollen glands. There is also reference made on the file to her mother's depression, alcohol abuse, and an overdose and subsequent hospitalisation. One of this young person's older brothers was in prison and there was concern around his influence on the home and the young person, on his discharge, given her difficult behavioural pattern.

Two teachers' reports refer to this young person having problems with literacy and numeracy and it was noted that she was very creative and only really concentrated when dealing with arts and crafts. It was flagged at that time that she had problems dealing with conventional class work but her mother did not appear to understand her educational needs.

A psychology report was completed on this young person when aged 7 which recommended that she be placed in a special school where her needs would be better met educationally. It is alleged that her mother did not cooperate with this plan and wished her daughter to stay in the local national school. As a compromise, the provision of a resource teacher was recommended, with a follow up review assessment in 12/18 months later. It would appear that this young person did at some point go to the special school, as there is reference on the file to problems there when she was 11 years old. She was provided with a place in the local youth project when the situation in school became untenable. This arrangement was short lived however as the young person soon dropped out. It is not clear if the social work department was aware of the extent of this young person's school absence.

A family case work leader was assigned but was discontinued by the mother as she did not want anybody in the home. It appears from the file that a Social Worker began engaging with this young person when she was aged 12, following a report that she was again being neglected. She was also given the benefit of a foster family as a respite care type facility. However this did not last long as she then refused to avail of the facility. A Case Conference was held at that time as the young person's mother felt that her behaviour was out of control. The mother did not attend this meeting.

It appears from the file that this young person's mother was confrontational with all services from the early years and she refused the recommended supports. It was evident from the initial point of contact that there was a serious problem with this young person's ability to function in a regular school environment. As she developed and became more out of control within the home, her behaviour became increasingly dangerous in the school and the community, with frequent displays of physical violence towards teachers and pupils in the school setting. There is reference on the file to discussions about sourcing a place in a residential unit for this young person. However this place never materialised due to a lack of an available placement.

This young person's behaviour deteriorated seriously the year prior to her death and she became a serious management issue in her community. The file states that she posed a risk to herself and others in her community.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 41

- HSE Social Work Department;
- Family Support Worker;
- Resource Teacher;
- NGO Family Support Service;
- Youth Project;
- Special Education;
- Gardaí; and

- Day Fostering.

Concerns Arising from File of Young Person Known to the HSE 41

- The files received from the HSE in relation to this young person were poorly organised with a poor level of recording evident. This made the task of extracting relevant information very difficult.
- While case conferences were held at least on a yearly basis in relation to this young person, no productive plan was produced.
- There was little action taken in relation to this young person except what the mother would agree to and that was very little by way of proper intervention.
- There should, on the facts that are documented on the file, have been care proceedings taken early in this young person's life.

Note: Report of Inquiry

The ICDRG has been provided with a copy of the review undertaken into the death of this young person. At the time of writing this report the HSE has informed the ICDRG that a decision has not yet been reached on the publication of this report. The review appears to have been a very comprehensive one, comprising of interviews with personnel from the HSE and a number of other agencies and the review also considered a large amount of documentary evidence from various sources. It made 78 recommendations covering measures required at both national and local level in respect of the concerns the review uncovered in relation to how the various services dealt with this family over many years.

4.2.42 Young Person Known to the HSE 42

This young person died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was initially referred to the HSE aged 11 as he was presenting a serious management issue for the school and his mother. In response to this referral, the Duty Social Worker had a number of meetings with him and with his mother. He was then referred to a youth project for individual work. There was also a referral made to a voluntary organisation for

work relating to this young person in terms of anger management and behavioural issues. It is not recorded if this work progressed.

This young person was also transferred to a Special Education Unit which he found less threatening. A psychological report was supposed to be drawn up in relation to him, however it appears that his mother was not supportive of this and the report was never completed. He appeared to be settling well in the new Education Unit and his case was very promptly closed by the HSE.

There is no detail on file as to the death of this young person, the supports (if any) offered to the family following his death.

This young person died in tragic circumstances and his death undoubtedly caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 42

- HSE Duty Social Work Department;
- NGO Youth Organisation; and
- Special Education Unit.

Concerns Arising from File of Young Person Known to the HSE 42

- The level of casework recorded was poor and left a lot of gaps in areas that structured interviews should have provided.
- There are no reports from any of the involved agencies on the file.
- It would appear that this file was closed prematurely with no attempt to ensure that this young person's needs were being adequately addressed.

4.2.43 Young Person Known to the HSE 43

This young person died in 2010. The death was registered on foot of a Coroner's certificate.

Case Summary

The School referred this young person to the HSE when aged 13, following a disclosure to the school guidance counsellor that she had attempted self harm. The young person added that her mother was aware of this, had taken her to their GP and that she was now in counselling. The Social Worker spoke with the mother the same day and she confirmed the information provided by the young person. She also said that this young person was sexually abused by a person outside of the family but they did not report this to the Gardaí.

The Social Worker then arranged an immediate meeting with this young person and her mother. The presentation of the young person was worrying to the Social Worker and she asked to see her alone. She admitted to feeling very low and asked that the Social Worker not leave her in the home. She was admitted to hospital to deal with her ongoing psychological issues. She was visited by the Social Worker while in hospital and appeared much better. It was decided to deal with the allegation of abuse later as her mental health improved.

It was decided 2 months later that this young person would be discharged and would be supported in the community by CAMHS and would be referred to an NGO mentoring programme. Her mother informed the Social Worker that she would also be returning to school and the school organised Art therapy and she was seeing the school counsellor.

One month later, the School Principal contacted the HSE to report that this young person had told her Art Therapist that she had not had a good weekend and had thought about self-harming. It appears her mother was aware of how she was feeling. The Social Worker contacted this young person's mother and recommended bringing her to her GP. An early appointment was in the process of being organised when this young person died.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 43

- HSE Social Work Department;
- General Practitioner;

- Child and Adolescent Mental Health Services;
- NGO Mentoring Service;
- Hospital;
- Counselling; and
- Art therapy.

Good Practice Observed on File of Young Person Known to the HSE 43

- Evidence of interagency cooperation.
- Generally, timely referral to the appropriate services.

Concerns Arising from the File of Young Person Known to the HSE 43

- Perhaps this young person should have been referred to Accident and Emergency Department at the hospital rather than waiting for a GP appointment given her state of mind and known history.

4.2.44 Young Person Known to the HSE 44

This young person died in 2004. The death was registered on foot of a Coroner's certificate. This child was a sibling of a child referred to in this report.

Case Summary

The family was first referred to the HSE when this young person was 4 years old and there were a number of further referrals from the school, the Public Health Nurse and the Gardaí regarding the children of the family. From the records furnished to the ICDRG it appears that there was ongoing contact with the family with "concerns of general welfare, neglect, query mother abusing alcohol, poor hygiene, regular head lice, mother having poor coping skills but trying her best".

Most of the concerns expressed and the work carried out was in relation to this young person's two older siblings. This young person went missing from the family home and this was reported to the Gardaí. Her body was found a number of days later. Bereavement counselling was offered to the family and respite care was offered for her siblings.

An older brother of this young person was found dead in 2006. The ICDRG does not appear to have received notification from the HSE of this young's person's death but has covered his death in this report.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 44 (and her siblings)

- Gardaí;
- Mental Health Services;
- HSE Social Work Department;
- NGO Services;
- HSE Public Health Nursing Service;
- Family Support Services;
- CAMHS; and
- NGO youth worker.

Concerns Arising from the File of Young Person Known to the HSE 44

- There was no comprehensive assessment of the needs of the children of this family and the parents' parenting capacity.
- The responses in relation to this young person and her family were reactive and dealt with on a day to day basis, with little proactive work undertaken.
- The case was closed a few times with no record of expected outcomes or targets reached.
- The files received by the ICDRG have very little detail relating to this young person. The files focus on the entire family, specifically the older children.
- The death of an older sibling was not referred to the ICDRG.

4.2.45 Young person Known to the HSE 45

This young person died in 2010. The ICDRG has been advised that this death has not yet been registered.

Case Summary

The files received by the ICDRG related mostly to this young person's family. Prior to the birth of this young person, the family was referred to the HSE Social Work Department from Social Services abroad. The eldest sibling in the family had been put on the Non-Accidental Injury Register in the foreign jurisdiction for being unsupervised for lengthy periods of time there.

From the records furnished to the ICDRG it appears that concerns in relation to this family have centred on poor parenting capacity, lack of supervision of the young children, lack of school attendance, domestic violence and a failure to take up the services offered. There were numerous referrals from the Gardaí, schools and the Public Health Nurse. The mother had a history of drinking, neglect and leaving children to care for themselves. She also drank frequently in the company of violent and abusive men. The father of this young person and his mother were no longer in a relationship.

A Supervision Order, pursuant to section 19 of the Child Care Act, 1991, was secured when this child was 8 years old. The following year the partner of this young person's mother was imprisoned for carrying out a serious assault on the mother. Prior to going to prison, this man had a very negative relationship with the children and particularly with this young person.

This young person's behaviour began to deteriorate to such an extent that he faced charges for theft and assault. He was dealt with by the Probation Service and was psychologically assessed. He was described as having a "conduct disorder". He continued to be oppositional, disruptive and aggressive in school and was refusing to attend school. His mother could no longer cope with him and following a review meeting when he was 12 years old it was decided to seek a place for him in a residential centre. He remained in the centre for 2 years. He was discharged home after he refused to return following a weekend visit home. This refusal continued despite a Court Order pursuant to section 47 of the Child Care Act, 1991 to return him to the school.

This young person's negative behaviour continued and on one occasion following his discharge from the residential school, he was reported missing to the Gardaí. He was found by the Gardaí asleep in the garden of another property very late at night.

Prior to his death the Gardaí made a referral regarding suspected emotional abuse and neglect of this young person when he was found in possession of a knife. Concerns were also expressed over him spending time in an environment where alcohol and illegal drugs were regularly abused.

Two weeks prior to the death of this young person, he was visited by a Social Worker. It was reported that he appeared well and there were no heightened concerns regarding him or his welfare. There is no reference to the referral from the Gardaí and there is no reference as to whether it was followed up.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 45

- HSE Social Work Department;
- Women's Refuge;
- Addiction Counselling Services;
- Women in Crisis Counselling Services;
- Family Support Worker;
- CAMHS;
- Residential Centre;
- NGO Support Service;
- Youth Support Service;
- HSE Community Psychological Services;
- School Completion Officer;
- Juvenile Liaison Officer;
- Youth Justice Programme;
- School services; and

- Probation Officer.

Good Practice Observed on File of Young Person Known to the HSE 45

- There were numerous Child Protection Conferences held with regard to this young person and his siblings.
- A Family Support Worker was retained to engage the children of this family in programmes to enhance their self-esteem.
- The interventions suggested were sourced and made available to the family.

Concerns Arising from the File of Young Person Known to the HSE 45

- The core issues of attachment and parenting capacity were not addressed; although a comprehensive range of family support services were put in place.
- There is little evidence of forward planning for this young person or his family and it appears that the Social Workers were dealing with issues on a day to day basis and from meeting to meeting.
- There was a failure to recognise the pattern of this family and its systemic way of operating. When situations were allowed to continue as agreed at case conferences it was rarely on the basis of improvements.
- When the supervision order was not effective, a care order should have been considered.

4.2.46 Young Person Known to the HSE 46

This young person died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that the family of this young person was first referred to the HSE when he was 1 year old. At that time concern was expressed that his mother's partner (who was the father of the older children in the family) was being violent towards her and this was being witnessed by the children. The HSE subsequently provided support in the form of financial assistance and parenting advice. The partner left the family home when this young person was 4 years old and the case was closed.

The case was reopened when concerns were expressed about this young person who was then 10 years old. These concerns centred on poor school attendance, incidents of alcohol abuse, and a lack of parental supervision. It was also suggested that there was inappropriate supervision of all the children and poor school attendance of all the children.

The older children in the family were referred to and participated in an NGO youth project. This young person also attended the CAMHS as he was self harming and abusing alcohol. At one point the younger children were admitted to a crèche by the HSE.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 46

- HSE Social Work Department;
- NGO Youth project;
- Family Support Services;
- Probation Services (for older siblings) ; and
- CAMHS.

Good Practice Observed on File of Young Person Known to the HSE 46

- Regular reviews were held to monitor the family's progress.
- The mother of the family was advised that if her relationship with her partner did not improve, the children would be taken into the care of the HSE. The partner subsequently left the family home.
- Good level of professional supervision and support evident from the file.
- Bereavement counselling offered to the family after the death of this young person.

Concerns Arising from File of Young Person Known to the HSE 46

- Perhaps a Supervision Order should have been considered as the young person's mother did not always engage with the proposals of the HSE and Family Support Services.
- There is very little detail on the file relating to this young person or his death.

4.2.47 Young person Known to the HSE 47

This young person died in 2008. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was part of a large family. From the records furnished to the ICDRG it appears that there have been many concerns expressed about parenting capacity in this case. Specifically, concerns were raised regarding poor hygiene, inadequate provision of food, lack of supervision of the children; poor follow up on children's immunizations, older children caring for the younger ones, lack of stimulation and poor interaction with the children. Referrals were made by the school, the Public Health Nurse, the family's GP and NGO services involved with the family.

When this young person was 4 years old an application was made by the HSE for Care Orders but the youngest children were taken into care on a voluntary basis. The older siblings were placed in a Residential Unit and the younger siblings were placed in foster care. This young person and most of her siblings were placed back home by order of the court and against the wishes of the HSE. She was then 9 years old.

The following year a Guardian ad Litem was appointed for the children of the family and remained involved for 4 years. In the year prior to the death of this young person all the windows in the house were broken. The mother of this family had no idea why they were being targeted. They stayed with friends until the windows were repaired.

The family appeared to be chaotic, with significant resources being invested in the family. After some of the children returned home the emphasis in the files is on the 2 who remained in foster care. This concerned their access to their parents and whether they should be returned home to the care of their mother.

There is no information on the file on the events leading up to the death of this young person or the circumstances surrounding his death except a note stating his mother had phoned the Social

Worker to say this young person had died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Support and counselling was offered to all the family.

Services Engaged for Young Person Known to the HSE 47

- HSE Social Work Department;
- Home help;
- Guardian ad Litem;
- Child Care Worker;
- Family centre;
- CAMHS; and
- Home school liaison officer.

Concerns Arising from the File of Young Person Known to the HSE 47

- There is little specific information in relation to this young person on the file.
- The files are disorganised with gaps in the recording.
- There is no evidence of professional supervision and support in the files.

4.2.48 Young Person Known to the HSE 48

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

From the record furnished to the ICDRG it appears that this young person's mother initially sought advice on how to secure a separation as there were marital difficulties. This young person was then 6 years old. Advice was provided and good support was available from her family at the time, so the case was closed thereafter.

The year prior to the death of this young person a referral was made with regard to presentation at school and school attendance. The referral was made by letter. Unfortunately, the letter has been misplaced and was not available to the ICDRG. This referral was placed on an Intake unallocated list at the time.

This young person died before any social work contact was made with him or his family. The Social Work Department was not formally informed of his death but became aware of it through the local media coverage at this time.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Concerns Arising from the File of Young Person Known to the HSE 48

- The referral made by the school principal was not followed up and was left unallocated for almost a year. Had this referral been allocated to a Social Worker and properly pursued, perhaps this young person could have been given the supports he needed. There is no suggestion that the lack of a follow up to the referral would necessarily have prevented the tragic events unfolding.
- The letter of referral from this young person's school principal could not be located.

4.2.49 Young Person Known to the HSE 49

This young person died in 2010. The death was registered on foot of a Coroner's certificate

Case Summary

When this young person was 3 years old a request was made to the HSE for a subsidy for a nursery placement for her. The application was successful and the case closed. At the age of 14, this young person was referred to the HSE both by a NGO for children and a GP. From the records furnished to the ICDRG it appears that this young person had made contact with the children's organisation and alleged that her father had physically assaulted her and this was reported to both the Gardaí and the HSE. The father subsequently moved out of the family home.

There were concerns about this young person's behaviour. She was refusing to come home in the evenings and staying out until the early hours, putting herself very much at risk. The family

received advice on managing her behaviour. She was not attending school regularly, and was keeping company with known drug users.

Just prior to her death this young person had a disagreement with her parents. The parents were trying to address the problems with this young person together. She left the house that night. The Duty Social Worker suggested that if she returned she should be taken in and the issue not discussed until the next morning when the Social Worker would call to mediate and agree on a plan for the next few days. A family group conference had also been convened to take place a few days later.

It appears that this young person went to stay with a friend. However she left there and did not return. She was reported missing to the Gardaí. Many and comprehensive attempts were made to locate her. She was found dead sometime later.

This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 49

- HSE Social work Department;
- GP;
- School services;
- NGO Children;
- NGO Young People; and
- Anger management sessions.

Good Practice Observed on File of Young Person Known to the HSE 49

- The HSE were in the process of responding to this young person's needs when she died.

Concerns Arising from the File of Young Person Known to the HSE 49

- The files received by the ICDRG are not very detailed however this young person had only been in contact with the HSE for 5 months prior to her death.

4.2.50 Young Person Known to the HSE 50

This young person died in 2006. This death was registered on foot of a Coroner's certificate.

Case Summary

This young person's family was known to the HSE prior to this young person's birth, as her mother was just 15 when she first became pregnant. The family later moved to live abroad for a short period.

When this young person was 3 years old her mother was seriously injured in a car accident and she was placed in a care facility for 6 years. This young person was placed in voluntary care by her father on many occasions from age 3. At one point she was placed with an aunt under Section 36 of the Child Care Act, 1991. On another occasion she was in supported lodgings and also spent some time with her grandmother. She was discharged back into the care of her father each time. She was described as a bright child who did well at school.

Over the years the father cared for the children on his own with the help of his mother. From the record furnished to the ICDRG it appears that this young person's father was known to have issues with alcohol consumption. However he ensured that the children were being cared for by his mother and he appears to have cared well for them when he was not drinking.

There are no details on the file regarding the lead up to the death of this young person. A Case Management Review was convened following her death which concluded that this young person presented well and was not a concern to the Family Support worker or others visiting the house. This appears to have been intended to be a review of the HSE work in this case.

This young person died in tragic circumstances and her death undoubtedly caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 50

- Schools;
- HSE Social Work Department;

- Public Health Nurse;
- Family Support Worker;
- Gardaí (older family member) ;
- Speech and Language therapist (for young person's mother) ;
- Occupational therapist (for young person's mother) ; and
- Physiotherapist (for young person's mother).

Concerns Arising from the File of Young Person Known to the HSE 50

- The majority of the file relates to this young person's sibling.
- No adequate risk assessment completed.
- Very poor recording on the file.
- There is no evidence on the file of direct work with or a plan for this family.
- There is no record of HSE work with this young person.

4.2.51 Young Person Known to the HSE 51

This young person died in 2002. The death was registered on foot of a Coroner's certificate.

Case Summary

From the record furnished to the ICDRG it appears that this young person's parents had a very tempestuous relationship. He was one of a large family. The records suggest that violence, alcohol and occasionally drugs were commonplace in the home, with the parents frequently separating and coming together again over the years.

This young person was taken abroad by his mother when he was four years old. He was made a Ward of Court in the foreign jurisdiction shortly afterwards, when his mother was found in an unfit state and was admitted to hospital. This young person remained in care abroad until he was returned to Ireland when 6 years old and went to live with his sister in residential care near the home area. He was returned to the care of his parents when he was 8 years old and appears to have settled back into the family at this point.

There is no detail leading up to the death of this young person or how he was progressing prior to same. This file was closed for a considerable number of years.

This young person died in tragic circumstances and his death undoubtedly caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 51

- HSE Social Work Department; and
- Residential Care.

Concerns Arising from the File of Young Person Known to the HSE 51

- No concerns have been identified as arising from this case.

4.2.52 Young Person Known to the HSE 52

This young person died in 2005. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was referred for assessment at a residential assessment unit when aged 12 years old and out of school. From the records furnished to the ICDRG it appears that there were concerns around his general welfare and association with a peer group that was often in trouble for petty criminal offending. The records show that the Probation Service held this case for some time and tried on many occasions to get the HSE involved.

His mother was unable to manage his behaviour and so was not in a position to care for him. Home conditions were very overcrowded and applications for more appropriate housing were being pursued. There were younger siblings in the home and the records show that other family members were involved in offending and drug misuse. There is no further record then until it is noted that at age 13 he was sent to a Residential school after he was convicted of a number of offences. It appears that he was then under the care of the Probation Service and the HSE Social Work Service had finally become involved. While in the school he absconded and accrued a number of additional criminal charges and he was moved to a more secure centre.

This young person was released from the children's detention centre on a 24 month probation bond with bail conditions attached. He breached his bail conditions and failed to appear in court. At age 15 he was remanded to a secure facility to allow for the preparation of a probation report and for the HSE to seek appropriate accommodation for him. It appears he was then placed back at home and then moved to relying on the Out-of-Hours Service for accommodation. His offending behaviour continued during this period.

A few months prior to his death this young person was placed in a probation hostel for a 4 week trial period, he was then positive about life and engaging with plans for a different future. He then appeared again in Court and received a two year sentence to a children's detention centre.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 52

- HSE Social Work Department;
- Probation Service;
- Gardaí;
- Juvenile Justice Services;
- A Number of Residential placements; and
- Out-of-Hours Service.

Good Practice Observed on File of Young Person Known to the HSE 52

- Outside agencies persistently tried to get the HSE to engage with this young person.

Concerns Arising from the File of Young Person Known to the HSE 52

- There was a dispute as to which Community Care Area had responsibility for this young person and his family and as such his family received practically no service for a lengthy period.
- There was no plan for the young person.

- There was no risk assessment of the situation in the family home even though the family was living in very cramped conditions and older family members were causing significant concerns.
- There was no direct engagement with this young person by the Social Work Department until the last few months of his life.
- The HSE failed to engage with Juvenile Justice Services and left this young person's case to be handled by whichever service he was attached to at the time.
- It must be questioned why this young person was not received into care when his mother had been stating that from the age of 12 she could not manage his behaviour.

Comment

This case highlights a recurring issue in relation to Social Work involvement when juvenile justice proceedings are taking place. Social Workers appear to take a secondary role in the case when a young person is detained in custodial care, almost suggesting that the young person's welfare issues and concerns are suspended until his custodial care is complete. It also highlights the difficulties that can arise when there is disagreement on which area has responsibility for a particular case. The system whereby young people are on the street accessing accommodation through Garda stations and the Out-of-Hours Service requires serious change.

4.2.53 Young Person Known to the HSE 53

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

From the record furnished to the ICDRG it appears that this young person's family was known to the HSE from when this young person was aged 7. At that time there were concerns in relation to childcare and drug addiction. The family spent 2 years on a waiting list for a service despite documented concerns about this young person who had been the victim of a serious assault as a young child. The perpetrator involved received a six month prison sentence for the assault.

It is recorded that this young person and his young sibling were living in appalling conditions in the home trying to manage without adequate food, heat or services. Parental drug addiction and chronic depression are also recorded. Referrals were made by the Gardaí in relation to neglect of the children and the home was raided on many occasions for drugs.

This young person was out of school and said to be involved in criminal activity. Parental supervision was limited and he was out of the house late at night. He was 10 years old. At one point he fell from a very high wall far from his home late at night and was admitted to hospital. His behaviour was very challenging. At inter-agency meetings around that time, it was decided that admission to care would not be appropriate and legal advice would be sought as to whether a supervision order would be appropriate.

There were a large number of services offered to this family, mostly revolving around home-making, general care and food for the children and counselling for the mother. The services did not appear to be coordinated in actually addressing this young person's issues and needs as his behaviour grew more out of control as time progressed and he seemed to quit school.

When this young person was 15 a series of Child Protection Case Conferences were put in place with ongoing reviews. He had come to the attention of the Gardaí for offending and appears to have spent time in a detention facility for non-attendance at court. This case appears to have been allocated on occasions to a student on a social work placement and at other times was held by the Duty Social Worker.

This young person was in placement on a Juvenile Liaison Officer programme in the month prior to his death.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 53

- Counselling;
- HSE Social Work Department;

- Breakfast Project for the children;
- Family skills worker;
- NGO Services;
- Gardaí; and
- NGO Support.

Good Practice Observed on File of Young Person Known to the HSE 53

- There is evidence of interagency cooperation on the file however it is not clear how effective this was for the family.

Concerns Arising from the File of Young Person Known to the HSE 53

- It was clear from the initial referral that this young person was living in a much compromised situation where basic care, food, clothing and warmth were not available yet nothing was done to address these deficits.
- This young person's case was allocated to a student Social Worker or held on the Duty Social Work System for many years.
- Nobody other than the Juvenile Liaison Officer would appear to have had any individual discussion with this young person. He was described as being very easy to engage and a likeable young person.
- Considering the level of neglect and the overall poor parenting capacity the ICDRG believe that an application should have been made to place this young person in care in his early years.

4.2.54 Young Person Known to the HSE 54

This young person died in 2005. The death was registered on foot of a Coroner's certificate.

Case Summary

From the record furnished to the ICDRG it appears that this young person referred herself to the HSE stating that she was being physically abused at home.

At the time of her referral, her mother indicated her behaviour had become difficult to manage at home. She often went missing from her home and stayed with older friends. The young

person's mother called the Gardaí to bring her home from this location on a number of occasions. This young person was linked with a youth support service in her area. She was also linked to psychology and attended counselling for her anger and behaviour difficulties. The young person's mother was facilitated to attend a course designed for parents of young people.

Concerns are expressed on the file that this young person had become friendly with a much older man. From the records furnished to the ICDRG it appears that this man may have been taking illegal drugs and there was also a concern that he was sexually involved with this young person and a friend. Her mother had asked for her to be taken into care. A strategy meeting had been organised to discuss this possibility when she died.
This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her.

Services Engaged for Young Person Known to the HSE 54

- Youth Support Service;
- Psychology Services;
- Social Work Department;
- General Practitioner;
- Gardaí; and
- Hospitals.

Good Practice Observed on File of Young Person Known to the HSE 54

- There was good inter-agency cooperation and communication.
- A good level of support was offered to this young person to help her overcome her problems by the various NGO and statutory agencies involved.

Concerns Arising from the File of Young Person Known to the HSE 54

- The fact that this young person was involved with an older man who was involved in illegal drug-taking should have been notified to the Gardaí at an earlier point.
- When the possibility of a sexual relationship between this young person and this older man became apparent there is no record on the file available to the ICDRG that a formal notification was made in relation to child protection concerns.

Note: Report of Internal HSE Review

A draft working document prepared by a HSE Manager is on the record furnished to the ICDRG. This is described as a review into the interagency and interdepartmental communication and coordination in respect of services involved with this young person. The review was conducted by considering chronological accounts prepared by 4 agencies that had contact with this young person and her family. The draft review document outlined the limitations of the review in that it did not interview any personnel but relied on the chronologies supplied. It made a number of recommendations including:

- the need for all agencies to raise awareness in relation to suicide; and
- the establishment of a forum to devise and implement strategies for cooperation between child protection, family support and alternative care systems. It is not known if those recommendations were implemented.

4.2.55 Young Person Known to the HSE 55

This young person died in 2003. The death was registered on foot of a Coroner's certificate.

Case Summary

The initial contact with the Social Work Department with respect to this young person was when he was 12 years. His mother was having serious problems managing his behaviour. He was described as being out of control, verbally abusive and running away when his mother tried to discipline him. He was then living in a local hostel. After a meeting with the mother, a supportive lodgings situation was agreed for the young person and organised.

The Duty Social Worker who dealt with the referral referred him to the CAMHS service. A Juvenile Liaison Officer was also engaged to talk to this young person as he was beginning to get involved on the fringes of criminal activity. This young person indicated that he had problems with his mother's boyfriend. He also expressed a wish to return to school, complete his Junior Certificate and get a trade qualification.

He suffered a bad fall from a high wall while trying to enter a nightclub illegally. He was admitted to hospital. Following this fall, his case was allocated to a Social Worker. He completed his Group Certificate and began working.

The last entry on the young person's file indicated that he had moved out of his family home and was living in rented accommodation. He was employed and enjoyed a good relationship with his family.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 55

- HSE Social Work Department;
- CAMHS;
- Juvenile Liaison Officer;
- School services; and
- Hospital.

Good Practice Observed on File of Young Person Known to the HSE 55

- Support and mediation services were provided to try to get this young person to return home.

Concerns Arising from the File of Young Person Known to the HSE 55

- There was no referral of this young person to alcohol counselling despite his drinking history at such a young age.
- The Social Work Department could usefully have pursued a Supervision Order as it could have had conditions attached that might have kept this young person at home at a very vulnerable and young age.

4.2.56 Young Person Known to the HSE 56

This young person died in 2007. This death was registered on foot of a Coroner's certificate.

Case Summary

This young person's parents were acrimoniously estranged from when he was 3 years old. The initial contact with the Social Work Duty Team was in relation to marital difficulties and requests for information and support on rights, custody and housing issues.

From the record furnished to the ICDRG it appears that numerous concerns were raised with the Social Work Duty Team by the father of this young person pertaining to the welfare of the young person when he was 11 years old.

When this young person was 16 a Child Protection Notification was received from the CAMHS service pertaining to physical abuse of this young person. From the records available it appears that his mother did not attend a scheduled meeting. There was no follow-up from the Social Worker and the case was closed a year later with a note that "outcome of child abuse notification was unconfirmed".

This young person went to live with his father for some time prior to his death and had an argument with his father . He later left his father's care.

This young person's death was recorded on the file following a contact from the Gardaí to the Duty Social Work Team to ascertain whether a young person who had died was the same young person about whom the Gardaí had previously received a Child Protection Notification. The Gardaí also inquired about the outcome of the Child Protection Notification. This is the only reference to the death of this young person on the record furnished to the ICDRG.

It is not possible to comment on how the death was handled as there is no information on file.

This young person died in tragic circumstances and his death undoubtedly caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 56

- HSE Social Work Duty Team;
- Gardaí;
- CAMHS;
- NGO Services;
- Public Health Nurse; and
- Family Support Services.

Good Practice Observed on File of Young Person Known to the HSE 56

- A number of years after the death of this young person, the father requested access to his son's files and a Social Worker met with the father to review the files with him.

Concerns Arising from the File of the Young Person Known to the HSE 56

- The files received by the ICDRG are badly organised with a poor level of recording.
- The concerns of this young person's father do not appear to have been taken seriously.
- There were no questions asked about the sustained nature of the referrals – each referral was treated episodically.
- There was no onward referral made when the father reported that this young person, at 12 years, said he didn't want to remain at home. The father was told to see his GP so that a referral could be made to CAMHS.
- The allegation of physical abuse was not followed up.

4.2.57 Young Person Known to the HSE 57

This young person died in 2005. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person's family was initially referred to the HSE by the Public Health Nurse due to alcohol abuse by both parents and the resultant neglect of the children. He was then 9 years old. At various times the younger children of the family were in the voluntary care of the

extended family. Care proceedings were finally initiated in respect of the younger siblings of this young person a year prior to his death.

This young person does not appear to have featured in any care proceedings or alternative care plans although his consumption of alcohol at an early age was recorded. Furthermore, it appears from the file that when the referral was made, he was already involved with the Probation Service and was therefore not involved in the care plans for the younger siblings.

The family frequently moved between various addresses and this meant that maintaining contact was very difficult. In the months prior to his death there is a reference on the file to this young person being before the court for criminal offences. There is further reference to a report being prepared as requested by the court but there is no copy of this report on the file. He was also referred to a NGO Youth Programme around this time.

This young person was described in the family file as generally quiet but with a temper that often got him into trouble, particularly when he had alcohol consumed. He did not continue his education beyond primary school. It is unclear if he had regular access to his siblings when they were taken into care.

This is very little detail on the files received by the ICDRG regarding the death of this young person.

This young person died in tragic circumstances and his death undoubtedly caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 57

- Gardaí;
- CAMHS;
- NGO Services;
- HSE Public Health Nursing Service;
- Family Support Services;
- Probation Services;

- Education and Training Programme; and
- NGO Youth Programme.

Good Practice Observed on File of Young Person Known to the HSE 57

- Good work carried out by an education and training programme with this young person. The young person requested the intervention of this service himself.

Concerns Arising from the File of Young Person Known to the HSE 57

- There is no explanation on the file as to why this young person was left in the care of his parents when his siblings were all taken into the care of the HSE due to the situation at home. This young person needed the same level of intervention as his young siblings and the HSE failed in its duty to this young person.
- No adequate risk or mental assessment was completed.
- This young person should have been referred for alcohol and drug counselling.
- There is little detail on the file specific to this young person.
- There was a failure to consider and provide for the welfare of this young person.

4.2.58 Young Person Known to the HSE 58

This young person died in 2008. This death was recorded on foot of a Coroner's certificate.

Case Summary

This young person was initially referred to the HSE Social Work Department at the age of 12 by his mother and father. They described his behaviour as being difficult and stated he was physically and verbally abusive to his mother and siblings. The CAMHS service was then engaged for him and it was discovered that he had morbid thoughts and had previously attempted self harm. The case was closed shortly afterwards.

His mother referred him to the HSE again at the age of 16 due to his challenging behaviour. She was concerned as he was again being physically and emotionally abusive towards his young siblings and was also aggressive towards her. This behaviour was identified as having its source in psychological problems and the Social Work Department suggested that the mother encourage him to engage with the mental health service. Again the case was closed.

A year and a half later, this young person's mother contacted the HSE again after he had self harmed. He attended the Accident and Emergency Department. However he left without having a psychiatric assessment.

At the time of his death he was taking prescribed medication. There is no further detail on the file regarding the death of this young person.

This young person died in tragic circumstances and his death undoubtedly caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 58

- HSE Social Work Department;
- Gardaí;
- CAMHS;
- NGO Services;
- HSE Public Health Nursing Service;
- Community Welfare Officer; and
- Family Support services.

Concerns Arising from the File of Young Person Known to the HSE 58

- No adequate risk or mental health assessment recorded.
- No long term involvement by any Social Work team. This young person's case was dealt with by the Duty Social Worker and from time to time there was no Social Worker assigned to this young person at all.
- Some referrals of this young person were not followed up.
- The files reviewed by the ICDRG show very poor interagency cooperation particularly between the CAMHS service and the Child Welfare and Protection Services. There was a departmental wrangle between the HSE Social Work Department and the CAMHS service in relation to the management of this case with the CAMHS service requesting that the HSE Social Work Department become involved. The Social Work Department did not appear to accept that their involvement was necessary.

- It is evident from the file received by the ICDRG that legal and Child Protection formalities were not adhered to.
- It appears to the ICDRG that this young person's case was not acted upon in a timely fashion when he first presented to the HSE.
- The impression garnered from the files is that once the young person was displaying mental health difficulties (even though medical opinion was that his problems were not psychiatrically based but behaviourally based) that his case should be handled by the CAMHS service and every opportunity was used to close the case from the HSE side.
- It is the view of the ICDRG that the system failed to provide support and protection to this young person and his family.

Comment

This case raises the recurring issue regarding young people at the age of 16 and their involvement with the Psychiatry Services. In this case, the CAMHS Services agreed to see this young person again when he was 17 as they had treated him prior to his 16th birthday. Nevertheless, the HSE Social Work Department recommended to his mother that she take this young person to Adult Mental Health Services rather than engage with him themselves.

4.2.59 Young Person Known to the HSE 59

This young person died in 2002. The death was registered on foot of a Coroner's certificate.

Case Summary

At age 15 a referral was made to the HSE by the Gardaí when this young person started to abscond from home and generally became unmanageable.

This young person was placed in voluntary care of the HSE around that time. Her initial placement with a foster family broke down due to her inability to comply with house rules. She availed of hostel accommodation as required, though the file states that she frequently stayed out at night or returned very late and was often found to have alcohol consumed. Three attempts at reconciliation with her home occurred only to break down in a matter of days or weeks. Supported lodgings were also offered but she refused that service.

During this time the young person had interacted with CAMHS and decided that she would prefer to live independently from her family. An independent flat was secured and she was linked with a youth training service as she did not wish to return to full time education.

Two episodes of self harm are recorded on the file. It appears from the files furnished to the ICDRG that she was mixing with others involved in criminal activity.

This young person died in tragic circumstances and it is recorded that her family were devastated by her untimely death.

Services Engaged for Young Person Known to the HSE 59

- Gardaí;
- Social Work Department;
- CAMHS;
- An Education and Training Programme;
- Homeless hostels; and
- Fostering.

Good Practice Observed on File of Young Person Known to the HSE 59

- Good interagency cooperation evident.

Concerns Arising from the File of Young Person Known to the HSE 59

- No adequate risk assessment recorded.
- A supervision order at an earlier stage may have been helpful to address the issues of this young person.
- This young person did not have the benefit of having an organised aftercare programme.
- Once she left her home area she did not have ongoing social work contact. A referral was made to the new area where she then lived but her link was to homeless services only.

4.2.60 Young Person Known to the HSE 60

This young person died in 2010. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person's mother contacted the HSE expressing concerns about her behaviour. She was then 14 years old. She was described as being heedless of boundaries, exhibiting poor behaviour at school, and was using drugs and alcohol. Two days later she was seen by a Social Worker, where she expressed difficulties regarding communication with her parents. She was referred to both CAMHS and to an NGO. The case was then closed by the HSE.

The case was reopened 1 year later as the situation had deteriorated. This young person presented herself at a Garda Station stating that her mother's ex-boyfriend assaulted her. He was charged with a Public Order offence and he moved out of the house and things improved for a period of time. The case was closed again.

Six months later, the HSE was again contacted by the mother stating that the young person's behaviour had deteriorated further; she had left the family home and the mother did not know where she was. This was reported to the Gardai. She was then referred to the Youth Homelessness Service pursuant to section 5 of the Child Care Act, 1991. She commenced living with a relative shortly thereafter.[28]

This accommodation situation was settling for this young person and she met the Youth Homeless Service to receive her cheque weekly. Support was provided to her regarding her current placement, relationship with her mother and her sisters, school attendance, upcoming exams and future educational plans. Contact was maintained with an education and training programme and reports on her were very positive. The case was then closed after 1 month.

[28] Section 5 of the Child Care Act, 1991 provides that where it appears to a health board that a child in its area is homeless, the board shall enquire into the child's circumstances, and if the board is satisfied that there is no accommodation available to him which he can reasonably occupy, then, unless the child is received into the care of the board under the provisions of this Act, the board shall take such steps as are reasonable to make available suitable accommodation for him.

A few months later the Social Work Team Leader met with this young person and reported that she was in good form and was pleased with the contact she now had with her mother and siblings.

On the day of her death she did not return to her accommodation and was reported missing to the Gardaí. This young person died in tragic circumstances and her death understandably caused much distress to all those who cared for her. Supports were put in place for her family and her friends.

Services Engaged for Young Person Known to the HSE 60

- HSE Social work Department;
- Children's NGO;
- Youth Homelessness Department;
- CAMHS; and
- Gardaí.

Good Practice Observed on File of Young Person Known to the HSE 60

- There is evidence of good interagency cooperation.
- This young person's issues were addressed and her behaviour and approach to her schooling improved.
- There were appropriate referrals to agencies to address her needs
- There is evidence of good work from the Social Work Department with a supportive response from management.
- This young person's Youth Homelessness Social Worker carried out exceptional work with her.

Concerns Arising from the File of Young Person Known to the HSE 60

- No adequate risk assessment recorded.
- Consideration should be given to HSE policy in relation to closing cases of troubled young people when the immediate presenting problem ceases in view of evidence that these problems reoccur in most cases.

4.2.61 Young Person Known to the HSE 61

This young person died in 2009. The ICDRG has been informed that this death has not been registered.

Case Summary

From the records furnished to the ICDRG it appears that the young person's father has a serious illness and had to travel abroad for treatment. As a result, this young man spent the first years of his life abroad and found it hard to settle in Ireland on his return. He had a particular difficulty with regard to the language. He was described as a polite, well-mannered young person. All of his siblings have an inherited syndrome which gives rise to learning difficulties. He did not have the syndrome.

When this young person was 13 years old his mother sought help from the HSE when a sibling was rushed to hospital. She was seeking care for the other children as her husband was abroad having treatment. The family was given 22 hours home help after which this young person's father returned home. The case was then closed.

Over the next two years this young person came to the attention of the Gardaí culminating in the administration of a caution. Meanwhile his parents were concerned that he was associating with young persons who were known to the Gardaí.

As a consequence of the caution a Juvenile Liaison Officer was appointed to work with him and he did not come to the attention of the Gardaí subsequently. There was a discussion around his leaving school after completing his Junior Certificate as he wanted to do an apprenticeship. He was persuaded to stay in school and complete his Leaving Certificate. The case was closed a year prior to his death.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 61

- HSE Social Work Department;
- Home Help;
- Juvenile Liaison Officer; and
- Gardaí.

Good Practice Observed on File of Young Person Known to the HSE 61

- The issues that this young person was presenting with were managed and viewed as his testing the boundaries like any teenager.

Concerns Arising from the File of Young Person Known to the HSE 61

- There is very little information on the file received by the ICDRG and no information about the death of this young person.

4.2.62 Young Person Known to the HSE 62

This young person died in 2007. This death was registered on foot of a certificate from the Coroner's court.

Case Summary

From the records furnished to the ICDRG it appears that when this young person was 11 years old his parents separated and his mother moved out of the family home. His father died when he was 14 years old and he was then cared for within the extended family for a period of time. He subsequently returned to live with his mother.

When he was 16 years old, there was a referral to the HSE in relation to his non attendance in school, his diet, and general presentation. A Child Protection Case conference was held and reviewed six months later. By then the school attendance issue appeared to have been resolved and the family appeared to have settled together.

This young person died in a road traffic accident and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 62

- HSE Social Work Department; and
- School Services.

Concerns Arising from the File of Young Person Known to the HSE 62

There is very little detail on the file received by the ICDRG

4.2.63 Young Person Known to the HSE 63

This young person died in 2009. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that when he was 13 years old the parents of this young person requested that he be placed in care. It appears this request arose after allegations were made of inappropriate risky behaviour towards younger members of the extended family. His parents had indicated that the level of anger within the extended family was such that he was not safe at home.

An initial placement was organised in a residential unit to enable a further assessment to be carried out and a plan to be formulated for this young person. It is recorded that the young person alleged that there were problems in the home from when he was young. He attended for therapy in relation to his inappropriate behaviour. He was then placed in a longer term residential care service.

Three years later, he was discharged back into the care of his mother. He was referred to an education and training programme upon his return home. Apart from this referral, support for this young person effectively ceased when he returned home. His mother was concerned that during this time he was dabbling in drugs and owed money to his drugs suppliers. He approached the Duty Social Work Service a month prior to his death seeking help with sourcing

accommodation. He is described as being in good form at that time. The record states that he was free to contact the HSE Social Work Department for support at any time.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him. Members of the Social Work Team visited the family after his death and attended his funeral.

Services Engaged for Young Person Known to the HSE 63

- Out of Hours Service;
- HSE Social Work Department;
- Residential Service;
- Specialist Child Sexual Abuse Unit;
- Gardaí; and
- Education and Training Programme.

Concerns Arising from the File of Young Person Known to the HSE 63

- No adequate risk assessment or medical health assessment recorded.
- There was minimal contact with this young person following his return home.
- Disorganised files supplied to the ICDRG with a poor level of recording.

4.2.64 Young Person Known to the HSE 64

This young person died in 2009. The death was registered on foot of a Coroner's certificate.

Case Summary

The files received by the ICDRG contain information following the death of this young person. It appears that the family was known to the HSE prior to that as there were concerns about the anti-social behaviour of older siblings and of the father. The father apparently died of a drug overdose and this greatly lessened the concerns about the children of the family. The case was then closed.

Following the death of the father, there was nothing to indicate child protection concerns and the case was transferred to the Family Support Worker, who worked with the mother on a weekly basis around parenting issues.

The family was again referred to the HSE as a result of non-attendance at school by the children. Contact was delayed as this young person died shortly after receipt of the referral.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 64

- Gardaí;
- Family Support Worker;
- Social Work Department; and
- School services.

Concerns Arising from the File of Young Person Known to the HSE 64

- There is very little detail on the files received by the ICDRG and the file mostly referred to events following the death of this young person although the family were known to the HSE before his death.

4.2.65 Young Person Known to the HSE 65

This young person died in 2003. The death was registered on foot of a Coroner's certificate.

Case Summary

From the records furnished to the ICDRG it appears that this young person's mother left the family home when she was pregnant with him; it is recorded that she had been subjected to domestic violence. His siblings remained with their father. In the following years she travelled between Ireland and a city in a foreign jurisdiction until the death of this young person. It appears that when she returned to Ireland she stayed in the family home.

Psychiatric and other professional reports completed in the foreign jurisdiction described the mother as having a major depressive illness, having an enmeshed relationship with her son and being overly protective of him.

The initial referral to the HSE occurred when this young person was 8 years when his mother had been ejected from the family home and was looking for support in relation to accommodation. When he was 14 years old there were three subsequent referrals from the mother. One referral concerned an attempt at self harm by this young person a year previously. He had a Social Worker who tried to engage with him; however he consistently refused to engage and the case was closed due to this failure to engage.

When he was 17 it appears that he was brought to the Social Work Department by his school counsellor as he was homeless and had been staying with a friend. An attempt was made to contact both his mother and father. He looked for financial support and it is recorded that he was told that the Social Work Department was not in a position to offer it. Moreover, there is nothing recorded as to what other supports were offered.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 65

- HSE Duty Social Work Department;
- Gardaí;
- Mental Health Services;
- NGO Services;
- HSE Public Health Nursing Service;
- Family Support Services; and
- Child Psychiatry Services.

Good Practice Observed on File of Young Person Known to the HSE 65

- The Social Worker continued to attempt to engage with this young person and his mother when they refused to avail of the services offered to them.
- This young person had good relationships in school and with his school counsellor.

Concerns Arising from the File of Young Person Known to the HSE 65

- No adequate risk or mental health assessment recorded.
- The files received by the ICDRG are disorganised with many of the records handwritten and difficult to read.
- There is limited evidence of supervision from the files.
- There seems to have been more focus on the financial difficulties of this young person's mother rather than his needs.
- When this young person presented just prior to his death as homeless there is no record of any supports or interventions being offered to him.

4.2.66 Young Person Known to the HSE 66

This young person died in 2006. The death was registered on foot of a Coroner's certificate.

Case summary

The family of this young person was known to the HSE for two and a half years prior to her death. She left her family home after an altercation and was referred to a homeless service where she spent short periods. She had very turbulent relationships at home and was increasingly involved in the abuse of alcohol resulting in engagement in criminal activity and anti-social behaviour. She returned home and the case was closed. The next year an addiction counsellor referred her to the duty social work team due to ongoing conflict in the home. A family welfare conference was arranged and she then went to live with a relative for a short period. This arrangement broke down as her anti-social behaviour increased.

This young person was made a Ward of Court in order to allow her to be admitted to a Special Care Unit. She was admitted for 3 weeks in order to complete preparatory work so that she

could engage with a residential addiction treatment service. She was discharged home from the special care unit when she refused to attend the residential addiction services but attended an addiction counsellor locally. Her trial period at home broke down and she was back depending on homeless services and extended family. A few months later she was sentenced to 15 months in prison for shoplifting and public order offences; this sentence was suspended on appeal. The HSE applied to discharge the wardship order shortly after she was sentenced but the Court declined the application. Following self harm a few months later and her refusal to be admitted to a Psychiatric Unit, she was returned to Prison and placed on a 24 hour watch.

The case was recommended for closure shortly after she reached 18 and letters were sent to all involved informing them that case was to be closed. The Social Worker advised that the Probation office might be of some assistance in linking her in with appropriate services. The Social Worker expressed regret that the case was being closed.

This young person died in tragic circumstances and her death undoubtedly caused much distress to all those who cared for her.
There is nothing on the record supplied to the ICDRG concerning the death of this young person.

Services Engaged for Young Person Known to the HSE 66

- HSE Social Work Department;
- HSE Child Care Service;
- Psychiatry;
- Gardaí;
- Addiction Services;
- Homeless Services;
- Emergency Residential Service;
- Probation Service; and
- Secure Care service.

Good Practice Observed on File of Young Person Known to the HSE 66

- The Social Worker made every effort to try to secure this young person's return to secure care when her trial placement at home failed.

Concerns Arising from the File of Young Person Known to the HSE 66

- No adequate risk or mental health assessment recorded.
- This young person was a troubled young person from the time she became known to the Social Work department and there is little evidence of forward planning for her.
- This young person on many occasions had said that she wanted to take her life yet there was a lack of consistent involvement by the Psychiatric Services. It is not recorded whether or not consideration was given to placing her on a compulsory basis in psychiatric services for her own protection, moreover a full psychiatric assessment was never completed.
- The appropriate documents are not filed under appropriate sections in this young person's file and significantly there is no copy of the Wardship Order on the records provided to the ICDRG.
- No aftercare service was offered by the HSE. The case was closed shortly after the young person turned 18. She was in prison at that time as a result of self harm and her refusal to be admitted to a psychiatric service.

4.2.67 Young Person Known to the HSE 67

This young person died in 2006. This death is registered on foot of a Coroner's certificate. This young person was a sibling of a child referred to in this report.

Case Summary

From the records furnished to the ICDRG it appears that when this young person was 8 years old his family was referred to the HSE. There were concerns expressed that the parent with whom the children were living was not providing proper care to them. Following that first referral there was a HSE Social Work response and this case appears to have been dealt with as issues arose rather than in a planned way. Over the next few years it is recorded that a number of concerns arose including ongoing concerns of general welfare, neglect of the children, alcohol abuse within the home and very poor hygiene. A sibling of this young person died two years prior to this young person's death.

The record supplied to the ICDRG is a composite family file and it is very difficult to garner information on the life and death of this young person. It appears he was out of school from the age of 16 with no record of what he was doing from then.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 67

- Education services;
- Gardaí;
- HSE Social Work Department;
- Private Child Care Organisation;
- Bereavement Counselling; and
- Respite Care for the young children in the family after the death of this young person.

Good Practice Observed on File of Young Person Known to the HSE 67

- There is evidence of an interagency support with Family support and a private organisation supplying some services.

Concerns Arising from File of Young Person Known to the HSE 67

- The family file supplied to the ICDRG is disjointed.
- There is no care plan or risk assessment for this young person.
- There is no comprehensive assessment of the parenting ability of these parents although many concerns regarding this were expressed to the HSE.
- There is no developmental assessment of the children's needs.
- There is a referral to the Psychology Department but there is no record of a report from the Department on the file and it is not clear if the referral was ever followed up.

4.2.68 Young Person Known to the HSE 68

This young person died in 2007. The death was registered on foot of a Coroner's certificate.

Case Summary

This young person was in the care of the HSE for a short period at the age of 14. His family had returned from abroad to live in Ireland and there was an allegation of physical abuse of this young person. The family agreed they were finding it difficult to cope with his behaviour and, following a Child Protection Case Conference it was agreed to receive him into voluntary care under Section 4 of the Child Care Act 1991. He was out of school and home tuition was organised until a school place became available. During the period of assessment it emerged that he was involved in substance abuse and was mixing with a group who were causing concern locally. There is a record on the files furnished to the ICDRG that a referral was made to the CAMHS in respect of this young person but no record of follow up.

After a 3 week placement in residential care he returned home. Family support services for both him and his family were provided locally by an NGO service. Shortly afterwards, this case was closed by the HSE and the family is not recorded as coming to the attention of the HSE in the following years.

This young person died in tragic circumstances and his death understandably caused much distress to all those who cared for him.

Services Engaged for Young Person Known to the HSE 68

- Home tuition services;
- Department of Education services;
- HSE Social Work Department;
- Residential Care;
- NGO offering structured family support service; and
- Substance abuse counselling.

Good Practice Observed on File of Young Person Known to the HSE 68

- Good prompt response to family situation.
- A plan to return home with supports to family built in was drawn up and accepted.

Concerns Arising From the File of Young Person Known to the HSE 68

- There are no concerns arising from this case.

A number of graphs below show a breakdown of figures and percentages in relation to the unnatural deaths of children and young people known to the HSE.

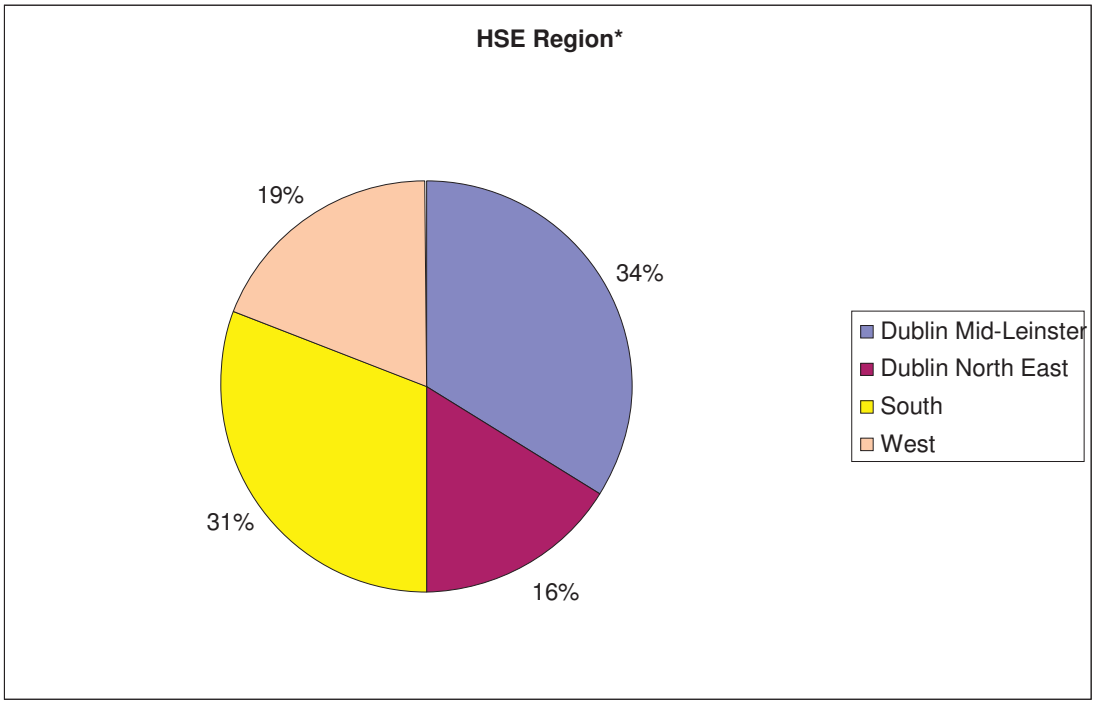


Fig. 3.2.1 - HSE Region (Non-Natural Deaths of Children Known to the HSE)

*Child Known to the HSE 028 was known to HSE Areas Dublin Mid-Leinster and West.

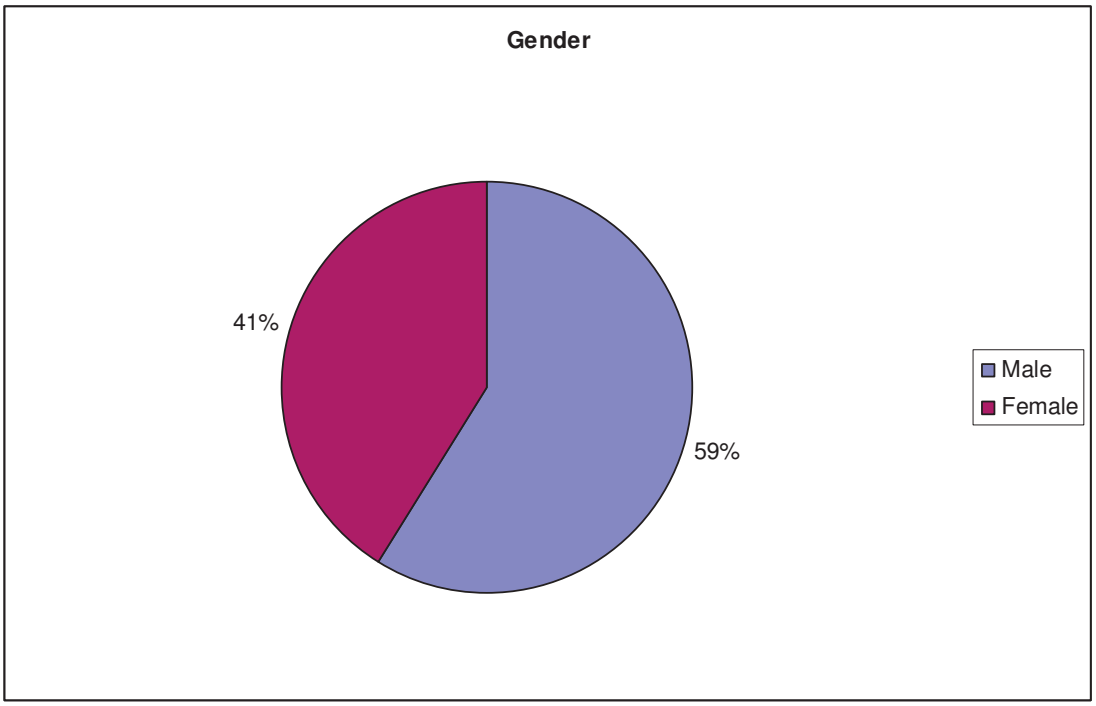


Fig. 3.2.2 - Gender (Non-Natural Deaths of Children Known to the HSE)

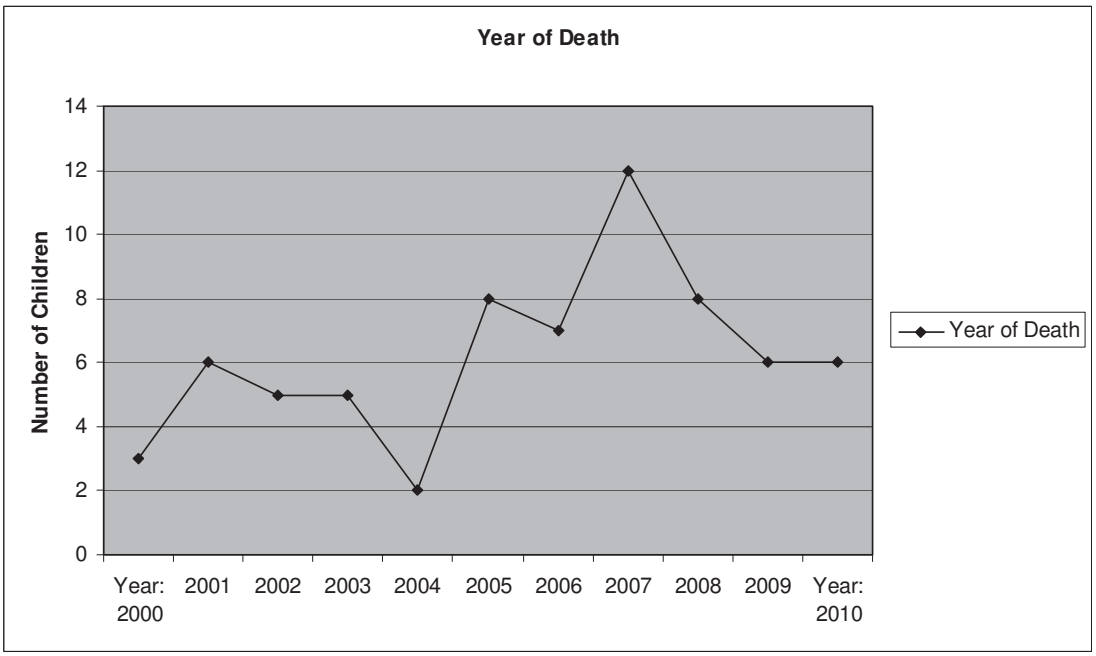


Fig. 3.2.3 - Year of Death (Non-Natural Deaths of Children Known to the HSE)

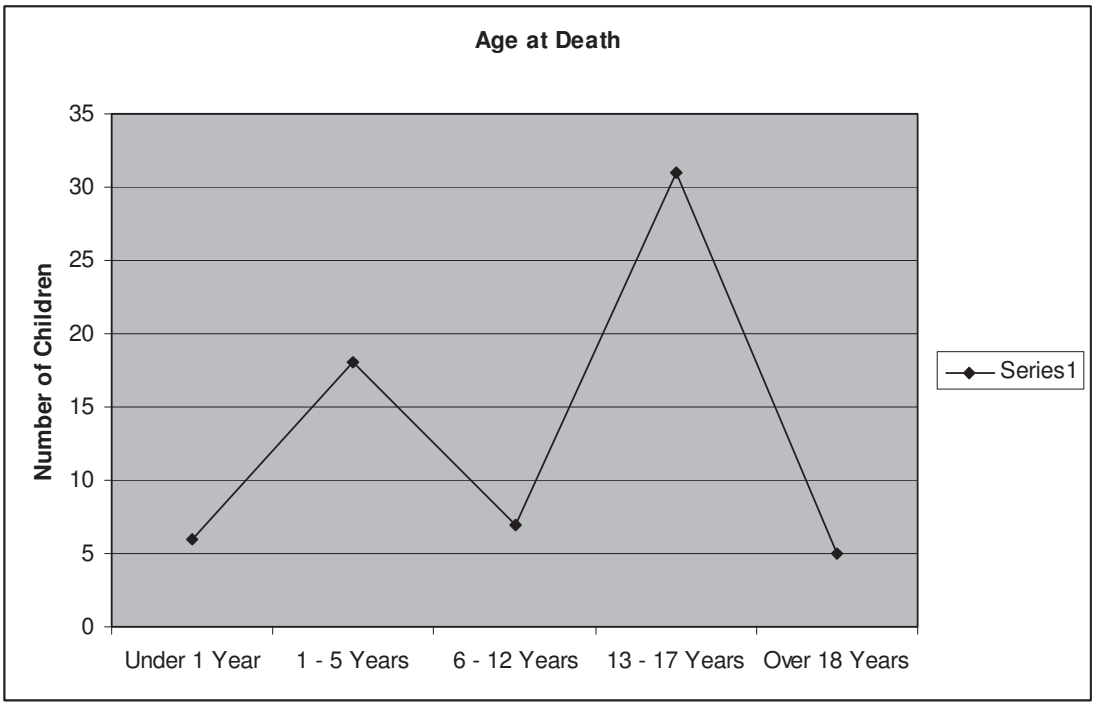


Fig. 3.2.4 - Age at Death (Non-Natural Deaths of Children Known to the HSE)

PART 3: DEATHS OF CHILDREN AND YOUNG PEOPLE KNOWN TO THE HSE – SUMMARY OF GOOD PRACTICE

This section firstly summarises the good practice the ICDRG found in reviewing the files of 128 children and young people who were known to the HSE at the time of their death. It includes the cases of children and young people who died of natural causes.[29] The section then goes on to outline the concerns the review found again in summary fashion. The ICDRG has commented both in respect of good practice and in respect of concerns only where the feature is clearly evident i.e. where the good standard of practice is clearly evidenced and visible or conversely where there is a concern about files this can be taken to signify that the file is significantly lacking in information, in record keeping or in presentation. This means that if it is noted that the ICDRG observed, for example, good record keeping on a number of files; it is not implied the remaining files necessarily showed evidence of poor record keeping. Not every aspect is commented on in relation to every file.

There is also considerable overlap in relation to the effect that poor practice in one area has on other areas of the conduct of cases; for example, when a case file is in complete disorder it is unlikely that key information on risks to the well being of the child or young person will be fully picked up or understood and a new worker will not be aware of the past history. Good interagency work is likely to lead to a fuller exchange of information, better support to children and families and a common understanding of risk levels and how best to manage risk. It can also signpost significant improvements in family functioning or the re-emergence of risk e.g. abuse of alcohol or drugs or re-emergence of domestic violence.

4.3.1 Risk assessment and Planning in respect of children and young people

The HSE Social Work Department reacted quickly and appropriately to concerns about 17 families and maintained appropriate contact despite the evasiveness by the parents at times. In one case the Social Worker followed up the concerns that had previously arisen in another jurisdiction and carried out a risk assessment for this young family in a timely manner. In these cases risk assessments were carried out and there was consistent follow up from services. There is clear evidence of excellent decision making processes and follow through, in some cases

[29] These case summaries fall outside the terms of reference of this review.

Supervision Orders were sought appropriately and the Court was properly involved. Regular reviews were held to monitor progress against the agreed plans. Other examples include where the child was returned to the care of the parents with appropriate supports built in and where safe access was organised.

4.3.2 The voice of the child or young Person

In 8 of the cases reviewed the voice of the child or young person came through strongly. Some examples include a child who was seen on his own a number of times to ascertain his feelings on issues that arose, children and young people being provided with a voice in a difficult situation, a young person's youth homeless Social Worker carried out exceptional work with the young person to assist him. Schools were also evident in this regard and in particular a positive relationship with a school counsellor was a key support for one young person. In another case the hospital personnel were very supportive to a child and aware of her distress.

4.3.3 Prompt follow up of referrals

It is important that concerns expressed to the HSE are promptly followed up and the result of the assessment be made known to the referrer wherever possible. In total 14 of the cases considered showed good work in this area: examples include an immediate referral from the Hospital Early Intervention Team when the parents did not take a child for a significant appropriate medical follow up appointment. There were timely referrals by the NGO Services and the Public Health Nurse in relation to concerns regarding a child that led to the child's needs being assessed and appropriate services being put in place.

4.3.4 Support to family

Another key area where practice was evidenced in these files was support to families. In 28 cases there was clear support given to families including help in coping with depression, support with dealing with the emotional impact of the birth of a child with intellectual disability, support in securing accommodation, addiction, finances and the provision of home help. Parenting courses were provided, respite care and family support workers were appropriately organised, and after school help was put in place to assist with homework. It can be very difficult for support to be offered when there is strong resistance from families and in a number of cases there was an admirable persistence by the Social Worker involved for example the Social

Worker continued to attempt to engage with a young person and his mother when they refused to avail of the services offered to them, and in two other cases the family of the children did not work cooperatively with the HSE for some time but the persistence of the Social Worker changed the situation for the better. In another case compromise was reached with parents to engage with positive parenting plans and care of the young person.

4.3.5 Support for family or guardians post death of child or young person

In 15 cases reviewed there was evidence of ongoing support to the family or guardians following the death of the child or young person. Included in this was bereavement counselling with specialist services, assistance with funeral arrangements and costs. In some cases there is ongoing involvement with the family.

4.3.6 Child Protection Concerns identified and discussed

In 14 cases the Child Protection concerns were explored with parents and guardians and fully explained. Child Protection Plans were put in place to meet the risks to the well being of the children and young people. Child Protection Case conferences were appropriately held and a multi-disciplinary response was put in place. It is clear that where the system worked children were protected within families with Supervision orders working in a positive way to enhance the authority of the statutory agency. Examples include children being taken into care on Interim Care Orders due to well founded concerns over child sexual abuse. Child protection notifications and case conferences and reviews were held and recorded.

4.3.7 Supervision

Professional supervision of staff was evidenced in 4 cases reviewed in this cohort of cases. While welcome in these 4 cases this is a very low recorded level of professional support to staff dealing with complex cases and situations.

4.3.8 Interagency Cooperation

Good Interagency cooperation and good communication between services was evident in 29 cases reviewed**.** The evidence of professionals working well together is very welcome and there can be no doubt that it greatly enhances the chances of the needs of children and young people being met. Where numerous professionals are involved with a family cohesive work across the

agencies is essential. One example is where the Social Worker involved with a family regularly organised meetings of the relevant services to ensure consistency of needs assessment and common understanding of tasks to be completed, and all services had the same information. The family in this situation experienced consistent care services. In another case where the parent was reluctant to engage the interagency cooperation ensured the ongoing concerns were monitored and intervention strategies were planned. Positive learning opportunities were evident when interagency work reached a high standard.

4.3.9 Record Keeping and Files

The ICDRG noted that 11 files were well presented and organised with recording to a high standard and closing summaries completed. It is crucial that each child's file is well organised with dividers to segregate key information and transfer and closing summaries.

4.3.10 Critical Incident report

In just 7 cases the ICDRG was able to identify that a critical incident report was completed in respect of children and young people in this cohort.

4.3.11 Need for appropriate accommodation

In 2 cases there was a lack of appropriate accommodation to meet identified needs and there is evidence of that the Social Work Teams involved constantly sought to address the situation.

4.3.12 Family issues/ Risk Indicators

The files received by the ICDRG evidenced significant problems within some of the families of the deceased children. There were indications of considerable drug abuse, alcohol abuse, gambling addictions and domestic violence by many of the children's parents. Such drug and alcohol abuse was carried out in some cases by the mother while she was pregnant with the child the subject matter of the report or his/her siblings. In some cases, it is clear from the files that the HSE closed the child's or family's file while these issues were ongoing and that such early closure of the file should have been avoided to ensure that the family was coping. The presence of such addictions within the home meant that neglect of the children was also evident in many of the cases. If there is a history of drug/alcohol use by parents or children then this is a serious risk indicator and it is critical that the effects of such addictions on parenting capacity are fully assessed.

School exclusion or threatened school exclusion is another risk indicator that requires immediate intervention to prevent children or young people experiencing more serious problems and to get them back into appropriate education at the earliest opportunity.

The files received by the ICDRG show that, in some cases, risk factors were not fully addressed. In one case a Supervision Order was allowed to lapse on the basis that there was an improvement in the home situation, yet the file states that the mother and her children were living in a refuge the next month. In another case, the presence of risk factors indicated that a Child Protection Conference should have been held at an earlier point where consideration could have been given to making an application for a Supervision Order. In yet another case, it was found that the Social Work Department had failed to recognize the dysfunctional pattern of the family in question and to proactively tackle it. The family situation was allowed to persist despite numerous case conferences.

In some cases, despite the presence of family difficulties, there were periods when there was no Social Worker allocated to the family.

The existence of mental health difficulties in either the parent or the child/young person appears to present particular difficulties for the HSE and greater links between the Social Work Department and the Child and Adolescent Mental Health Services need to be forged to ensure the provision of proper support to children and young people suffering from mental health problems.

One other issue which needs to be addressed within this category is the failure to provide sufficient support to parents. In a number of cases, the parent(s) of the child were failing in their duties as parents and this issue was not addressed in a clear manner with them by the Social Worker.

Most of the very complex cases will need weekly contact with Social Work for support and even after all the professional services have been involved and diagnoses are fully made some families will be unable to survive safely in the long-term without weekly support by some worker. These are highly dependent complex cases. It is likely that parenting skills support will be required usually on an individual basis. It is important that there is a plan for family support interventions, that realistic outcomes are established for each child/family and that the system regularly check that real progress is in fact occurring.

4.3.13 Resource Requirements

In a number of cases, there were difficulties as a result of a lack of resources. This is particularly evident in relation to the lack of an Out of Hours Social Work Service. In one case, children were removed from their family under a Safety Order by the Gardaí when they were found in high risk circumstances. They were placed in the local hospital from where they were forcibly removed the next day. It is recorded that there was no alternative placement available and no out-of-hours social work service available. In another case a mother presented with her two children at the local hospital and a Social Worker however there was no out-of-hours service available. In yet another case, when the young person left her home area she did not have an ongoing social work contact but merely a link to homeless services.

Another concern emerging from the files received is the over-use of the duty Social Work team. A number of cases were dealt with solely by the Duty Social Work team and were never

assigned a Social Worker. This occurred even when children had come into the care of the state. This is not an acceptable standard of care provision.

There is a need for suitable accommodation to be available for mothers and children in circumstances where emergency needs emerge. Hostel type accommodation is not adequate particularly where there are concerns such as substance misuse. In another case, a young person presented as being homeless and there does not appear to have been any supports or interventions offered to him. One family appear to have been left to sleep in a car during the winter months because of housing arrangements in another jurisdiction. Notwithstanding the procedural issues that can be involved here it cannot be acceptable that this knowingly continues for children.

There appear to be difficulties in accessing experts and professionals outside the Social Work service such as psychologists. In one case, the young person was waiting for over a year for an appointment with a psychologist and had no other assessment of his needs in the meantime.

In one file, the young person did not have the benefit of having an organised aftercare programme in his area. In another case, the young person was not offered an aftercare service at all where her case was closed shortly after she turned 18. She was in prison at the time as a result of her attempted suicide bid and her refusal to be admitted to a psychiatric service.

There is also evidence in the files of lack of supervision and support from some Social Work Team Leaders and Managers. Social Workers who are coping with very complex and risky family situations need support and supervision from line managers.

Care must also be taken to ensure that resource issues within the family are not allowed to overshadow other problems. In one case, there seems to have been more focus on the financial difficulties of the young person's mother rather than on the needs of the young person. While the adult needs of parents overlap with and affect how the needs of children and young people are met, in many cases priority appears to be given to the adult to the detriment of the child or young person.

4.3.14 Delays

Delays in the provision of services have arisen in a number of files. This issue is obviously linked with the issue of resources; however lack of resources is not necessarily the reason for every delay. In one case, there was a delay of a year before the HSE Child Protection Services were made aware of the death of a child.

There have been delays in the response to referrals evident on a number of files. In one particular case the referral made by the school principal was not followed up and was left unallocated for almost a year. Had this referral been allocated to a Social Worker and properly pursued, perhaps this young person could have been given the supports he needed. There was no action taken in another case where the young person presented at the age of 12 and made a report of physical abuse within the family which was later confirmed.

As noted in the category above, one young person was waiting over a year for an appointment with a psychologist with no evidence of any other assessments being carried out in the meantime.

Delay is also evident in identifying the key issues for the particular child and producing a proactive plan in respect of the child's care. In one particular case, while case conferences were held at least on a yearly basis in relation to the young person, no productive plan was produced.

4.3.15 Information Flow

It is clearly evident from the files received by the ICDRG that there are significant problems with communication:

- within the HSE
- between the HSE and external agencies and/or bodies
- between the HSE and the children/young persons and the families it is engaged with
- between the HSE and the ICDRG

Communication within the HSE

The files show that, within the HSE, there is a problem with communication. This has manifested itself in a number of areas. First there appears to be **a failure in a number of circumstances to discuss cases in full and review options for the child/young person and his or her family**:

- In one case, despite the knowledge that there was alcohol and drug abuse in the family, there was no Child Protection Case Conference convened to consider all the known information on the family or fully assess the risks to the children
- In another case, it appears that despite concerns about a pregnant mother's ability to care for her child, there was no follow up involvement by the Social Work Department and the case was actually closed prior to the birth
- There was a failure to consider a Supervision Order evident in one file where the conditions attached to it might have kept the young person at home at a very vulnerable age
- A referral made by a school principal was not followed up and was left unallocated for nearly a year
- There was a failure to consider the sustained nature of referrals in relation to another child – each referral was treated as an individual issue
- Another case details a very troubled young person who became known to the HSE Social Work Department and there is little evidence of forward planning for the young person
- In one file, it appears that the HSE seems to have merely accepted the wishes of the young mother to remain with a violent partner despite the fact that she had previously been seriously hurt by this man. No complete risk assessment of the dangers both to this young mother and her child was undertaken
- A number of cases show a failure by the Social Work Department to deal with the issue of poor parenting and neglect

A second manifestation of the problems with communication is **the lack of professional supervision or support for Social Workers in relation to a case:**

- One file was allocated to a student Social Worker with no evidence of supervision
- There is evidence on a number of other files of a lack of supervision and/or support from management. In fact it is unusual to see evidence of professional supervision.

There also appears to be a difficulty with the **information flow between the various HSE regions**:

- In one case, where the mother moved to a new HSE area, there does not appear to have been any follow-up in the new area despite the mother being in a vulnerable position. While the file received by the ICDRG states that the case was open in the new area, there is no record of any work having been completed in the new area
- In another case, while the Social Work Department contacted their counterparts in the area where the child had been living, the full circumstances of the family had not been communicated. There was a failure to disclose the alcohol abuse of the mother and the previous accidental house fire. The information should have been communicated earlier to ensure a full and complete risk assessment could be carried out

There is evidence on the files that there are **communication difficulties between bodies within the HSE**:

- In one particular case, the Social Work Department had been aiding the mother in accessing housing. The Public Health Nursing Service had described her as an excellent mother but it later emerged that she had a history of depression; however on the records supplied to the ICDRG, it was unclear who had held the information. It was also unclear whether the effects of this on the mother had been considered in light of the domestic abuse she was suffering and her accommodation issues
- In another case, a child's mother had been referred to a Consultant Psychiatrist however the Consultant felt that there was no place for the Child Protection Social Worker in the discussions on the mother's mental health assessment
- In yet another case, there was a communication to the HSE from Specialist Child Sexual Abuse Unit that the family in question was not attending for meetings and a request to discuss how to deal with this. The request appears to have gone unanswered. It is also unclear if the Gardaí were informed of the child sexual abuse allegation in this case
- In one file there is evidence that the Central Mental Hospital requested information on the alleged perpetrator shortly after the death of the child. The HSE Social Work Department informed the hospital of the sexual abuse allegations but did not inform the hospital of the violence towards the mother of the child and indicated that they had no relevant reports on file

- One young person stated on a number of occasions that she wished to take her life yet there was a lack of consistent involvement by the Psychiatric Services. It was not recorded whether or not consideration was given to placing the young person on a compulsory basis in the psychiatric services for her own protection. Moreover, a full psychiatric assessment was not undertaken
- There is evidence on one file of a departmental wrangle between the HSE Social Work Department and the Child Psychiatry Services in relation to the management of this case with the Child Psychiatry Services requesting that the HSE Social Work Department become involved and the Social Work Department querying what support the Psychiatry Services felt was needed
- There does not appear to have been a full exchange of information between the Drug Treatment Services and Community Care in one case
- Communication between Adult and Child Psychiatry is essential as young people move towards adulthood. The Adult Psychiatric Service in common with all adult focused services must engage fully with Child Protection Services when the adult is a parent and their behaviour, illness, disability or addiction has implications for their ability to provide adequate and safe care for their children

Communication between the HSE and External Agencies/Bodies

Communication difficulties between the HSE and external agencies/bodies are evident in the files both in terms of a failure to communicate important information and delays in communicating important information.

There are a number of cases where instances of crimes or potential crimes have not been communicated to the Gardaí or there has been a delay in such communication. In one case, a young mother had been violently assaulted by her partner and there was no evidence that the HSE had informed the Gardaí of this assault. One young person's file indicated that she had been involved with an older man who was abusing illegal drugs and this was not immediately notified to the Gardaí. When the HSE and the Gardaí became aware that there was the possibility of a sexual relationship between the young person and this older man, no formal notification was made in relation to child protection concerns and there was no investigation into this.

In another case, there was reluctance by the Methadone Clinic to share information with the Social Worker regarding a parent who was abusing drugs. The HSE also failed to refer one young person to alcohol counselling despite his drinking history at a very young age.

Communication between the HSE and the Child/Family

The most basic relationship between the HSE and the family and/or child it is engaging with is also suffering from significant communication difficulties as evidenced from the files received by the ICDRG.

In one case, a child had died as a result of a fall. While the post mortem was being carried out the parents agreed that their younger child could be placed with a close relative until the results were known. The family of this child expressed their unhappiness with the hospital and the HSE over the long time that elapsed before the matter was resolved and their child was returned home.

There are a number of files where profound **Child Protection concerns raised by the parents of the child or young person have gone unheeded:**

- In one case, the mother of the child had been stating that she could not handle her son from the age of 12 and yet the young person was never received into care
- The father of a young person made known his concerns to the HSE on repeated occasions and they were not taken seriously
- Another file details that when a father reported that at 12 years old, the young person indicated he did not want to continue living with his mother, the HSE told him to bring his son to his General Practitioner to get a referral to Child Psychiatry Services

In a number of files, there is a complete **lack of engagement by the Social Work Department with the child or young person in question:**

- In one case, while there was an allocated Social Worker, there is no evidence that there was any contact between the Social Worker and the young person
- In another case, there is no evidence of any contact between the Social Work Department and the young person

- Another files evidences that nobody other than the Juvenile Liaison Officer appears to have had any individual contact with the young person
- A number of files evidence no long term involvement by any Social Worker and the case being dealt with on an ongoing basis by the Duty Social Work Team
- In two other cases, there was a failure to follow up with the child or young person after they left the care of the HSE. One young person returned to the care of his mother and there was minimal contact with him. In the other case, there was no contact with the young person with the Social Work Department did not know where the young person was living at the time of his death

Communication between the HSE and the ICDRG

There were ongoing profound difficulties during the review in obtaining information from the HSE. Many of the files supplied to the ICDRG are not in order and are very difficult to follow with high levels of poor recording. There have been lengthy delays in accessing other relevant information which should have been supplied from the outset for example Death Certificates and reviews that were recorded as having been carried out. These were necessary to fulfil the Terms of Reference of the ICDRG.

CHAPTER 5: MODELS OF CHILD DEATH REVIEWS, THE *IN CAMERA* RULE AND RECOMMENDATIONS ARISING FROM THE REVIEW

Introduction

There are a significant number of recommendations which flow from the above review of files by the ICDRG. First it must be considered what mechanism should be put in place for the future. It is patently clear that a permanent child death review procedure has to be established so that where the death of a child in care or a child known to the HSE occurs, the death and the circumstances leading up to the death are reviewed to ensure any failures by the HSE or its agencies are identified and learned from.

Secondly, the operation of the *in camera* rule and the difficulties attached thereto must be considered. Legislation was rushed through the Oireachtas as the HSE expressed concern that it could not legally pass the relevant files to the Review Group due to the restrictive nature of the *in camera* rule. It is recommended below that the rule be reviewed and reformed.

5.1 INTERNATIONAL MODELS

Ireland is one of the few countries in the so-called developed world that does not have some system which reviews the deaths of children in care. Presented below is a review of a broad range of child death review procedures internationally, and a detailed summary thereof.

A list of key questions was developed, the answering of which was believed to provide the best basis for a thorough analysis of each child death review procedure.

The questions used are listed as follows:

- Should there be an individual case review or an approach which examines broader trends at a demographic level?
- What ages should the mechanism cover?
- Should all deaths be investigated, or only those resulting from abuse, neglect, or other child protection concerns? Should there be flexibility about selecting certain cases for more in-depth review?
- Is it worth having an independent child death review mechanism, if there are already review processes examining specific groups of children?
- Should the review mechanism be in a position to examine serious incidents which do not result in death?
- What should the composition of the review mechanism team be?
- Should it be a standing body or an ad-hoc group?
- How do you guarantee independence of the mechanism, and at the same time maintain links with state agencies and service providers?
- What should the remit of the child death review body be?
- Would the body have the power to compel information?
- What level of confidentiality should be guaranteed to those providing information?
- How would a child death review team interact with other agencies investigating particular aspects of a child's death?
- What principles should underpin the involvement of family members in the process of a child death review?
- Where should recommendations made by the child death review body be sent? How should implementation be monitored?

- What sort of dataset should be sought? (e.g. social circumstances, previous medical history etc)
- What should the sources of that information be?
- How accessible is that information? If there are gaps in it, how should they be addressed?

A summary of the most common methods of dealing with the questions listed above is provided at the end of this section.

5.1.1 UNITED KINGDOM: LOCAL SAFEGUARDING CHILDREN BOARDS, CHILD DEATH OVERVIEW PANELS, SERIOUS CASE REVIEWS

Basic Structure

The basis of the review structure in England and Wales revolves around Local Safeguarding Children Boards (LSCB), which are now established in each Local Authority area. In circumstances of child death and serious incidents involving harm to a child, the LSCB delegates responsibility for investigation to its sub-committees – the Child Death Overview Panel or the Serious Case Review Committee. These sub-committees are responsible for reporting back to the LSCB.

LOCAL SAFEGUARDING CHILDREN BOARDS (LSCBS)

Each local authority in the UK was required by Section 13(1) of the Children Act 2004 to establish a Local Safeguarding Children Board by 1st April 2006.[30] This legislation followed concerns over child abuse in the wake of a critical report published in January 2003.[31] The legislation is further supported by a statutory guidance document, *Working Together to Safeguard Children*,[32] which aims to provide regulation for an inter-agency approach.

The two core objectives of an LSCB are to coordinate what is undertaken by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority, and to ensure the effectiveness of what is undertaken by each such person or body for that purpose.[33]

These core objectives are complimented by a number of functions attributed to the LSCB by the LSCB Regulations 2006.[34] These functions include undertaking reviews of "serious cases" and

[30] Pursuant to The Local Safeguarding Children Boards Regulations 2006 (S.I. 90/2006) (hereafter the LSCB Regulations 2006).
[31] The Victoria Climbie Inquiry Report. This Inquiry, carried out by Lord Laming, was published on 28th January 2003.
[32] *Working Together to Safeguard Children*; A Guide to Interagency Working to Safeguard and Promote the Welfare of Children, Department of Children, Schools and Families (March 2010). Available for download at: http://publications.education.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010
[33] Sections 14(1)(a) & 14(1)(b) of the Children Act 2004. *Working Together to Safeguard Children* at p. 87.
[34] These functions are set out at Section 5 of the LSCB Regulations, 2006.

advising the Local Authority and the Board partners of any lessons to be learned.[35] A serious case is defined as one where abuse or neglect of the child is known or suspected *and* either the child has died or been seriously harmed and there is cause for concern as to the manner in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In addition, from 1st April 2008, each LCSB is now required to collect and analyse information about the deaths of all children in their area with a view to identifying:

- Any "serious case" giving rise to the need for the review
- Any matters of concern affecting the safety and welfare of children in the area of the authority
- Any general public health or safety concerns arising from deaths of children

The LSCB must also put in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death of a child.[36] Child Death Overview Panels, discussed further below, were the vehicles chosen to carry out the function relating to child deaths.

Information Supply to the LSCB

Registrars

Under the Children and Young Persons Act 2008, Registrars of births and deaths are obliged to provide LSCBs with information which they have about two types of deaths: those of persons under 18 in respect of whom they have registered the death, or those in respect of whom the entry of death is corrected and it is believed that person was or may have been under the age of 18 at the time of their death.[37] This information must be provided within 7 days of the date of registration, or of making the correction to the entry of death.

Each LSCB is statutorily required to make arrangements for the receipt of notifications from registrars and to publish these arrangements,[38] and is therefore required to notify the

[35] Section 5(1) (e) of the LSCB Regulations 2006.
[36] Section 6 of the LSCB Regulations 2006.
[37] See Section 31 of the Children and Young Persons Act 2008.
[38] Section 31(9) of the Children and Young Persons Act 2008.

Department for Children, Schools and Families of the name and email address for the Child Death Overview designated person in each LSCB to whom death notifications should be sent.

Coroners

Coroners are required to inform the LSCB for the area in which a child died, of the facts of an inquest or post-mortem. They also have powers to share information with LSCBs for the purposes of carrying out their functions.

In turn, on receipt of an initial report of a child death, the relevant LSCB should inform the coroner of the address to which future information should be sent, and LSCBs are encouraged to supply the relevant coroner with any information which comes to their attention that they feel would be valuable.

Medical Examiners

It is anticipated that in future, medical examiners will be required to share information with LSCBs about child deaths that are not investigated by a coroner, but this is not yet the case.

Data

National templates for the collection of data regarding child deaths by LSCBs have been created. Warwick University was commissioned to develop them, and they are regularly updated in response to feedback. The Department for Children, Schools and Families is looking at the possibility of creating web-enabled forms for LSCBs to use to enter and collate data.

A number of forms have been created specific to various types of deaths, such as poisoning, apparent substance abuse, drowning and road accidents.[39] Each form is designed to gather data specific to the type of death in detail, but common data that is generally sought is: predisposing/ risk factors in relation to the family and the specific child; circumstances of death; information regarding the response of professionals post-death.

[39] See: http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths

These forms are sent by a designated person from the LSCB in each case, to the agencies and professionals who have been involved with the relevant child. Once all agency reports are collected by the designated person, the information is then collated onto a single form, Form B, anonymised and entered into a suitable database. Each LSCB is entitled to create its own database.[40]

Annual Reports

Each Child Death Overview Panel is required to prepare an annual report of information for their LSCB. The information to be reported on in this report includes:

- the total numbers of deaths reviewed
- recommendations made by the panel about future actions to prevent child deaths and
- any further description of the deaths that the panel considers appropriate

The Annual Reports should also contain a review of actions taken to implement the recommendations from the previous year's report, and identify any recommendations which have not been implemented and need to be carried forward. Responsibility for distributing the lessons to be learned from the child death review process to relevant organisations lies with the LSCB.

Information which could lead to the identification of individual children or family members cannot be included in the report.

CHILD DEATH OVERVIEW PANELS (CDOPS)

Child Death Overview Panels are sub-committees of the LSCBs responsible for reviewing information on all child deaths, and are accountable to the LSCB Chairs.

Occasionally LSCBs may share a CDOP, depending on the local configuration of services and population served.[41] In the experience of the UK, panels responsible for reviewing deaths from a

[40] *Working Together to Safeguard Children* at p. 218.
[41] *Working Together to Safeguard Children* at p. 214.

total population of at least 500,000 gain experiences more quickly and review a sufficient number of deaths to be better equipped to identify significant recurrent contributory factors.[42]

Guiding Principles[43]

A number of principles have been enunciated in the statutory guidance document to aid the death review procedures in the UK. Within these principles, there is a strong emphasis on the manner in which families of the deceased child should be treated. This can be seen from the following principles:

- An appropriate balance should be kept between forensic and medical requirements and the family of a deceased child's need for support. The needs of all family members, particularly any other children in the household, and any lessons to be learnt about how best to safeguard and promote child welfare in future should be considered
- Families should be treated with sensitivity, discretion and respect at all times and professionals should approach their enquiries with an open mind
- The unexpected death of a child with a life limiting or a life threatening condition should be treated as any other unexpected death in order to determine the cause of death and contributory factors

Scope of CDOP Reviews

The CDOP reviews the deaths of all children under 18, whether or not the child was in the care of the State. There is no separate review process dealing exclusively with the deaths of children in care. The definition of a child in care is: all children being looked after by a Local Authority; those subject to a care order; and those looked after on a voluntary basis through an agreement with their parents.[44]

Child Death Review Process

The child death review procedures in the UK are outlined in the statutory guidance document, *Working Together to Safeguard Children*. The procedures which have been put in train to respond to the death of a child in the UK involve two distinct but related processes. First, a rapid

[42] *Working Together to Safeguard Children* at p. 214.
[43] *Working Together to Safeguard Children* at p. 209.
[44] For further information on the provision of care to children in need in the UK see The Children Act 1989, in particular Section 20 & Section 31. .

response team composed of a group of key professionals will enquire into and evaluate each unexpected death of a child. An unexpected death of a child is defined in *Working Together to Safeguard Children* as one which "was not anticipated as a significant possibility, for example, 24 hours before the death or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death."[45]

Secondly, a panel will undertake a review of all child deaths which have occurred[46] in the Local Safeguarding Children Board area. The information put together by the rapid response team should be considered by the panel reviewing all child deaths.

Composition of a CDOP

The CDOPs have a fixed core membership to review cases, with the ability to involve other professionals when appropriate.[47] Members are drawn from the key organisations represented on the LSCB,[48] but not all members are necessarily involved in discussing all cases. The key organisations are listed in the Children Act 2004[49] and are as follows:

- District Councils in local government areas
- The Chief Officer of Police for any area which falls within the area of the local authority
- The Local Probation Trust
- The Youth Offending Team
- Strategic Health Authorities and Primary Care Trusts
- NHS Trusts and NHS Foundation Trusts for all of whose hospitals, establishments and facilities are situated in the local authority area
- The Connexions Service
- The Children and Family Courts Advisory and Support Service
- The Governor or Director of any Secure Training Centre in the area of the local authority
- The Governor or Director of any prison in the local authority area

[45] *Working Together to Safeguard Children* at p. 212.
[46] Excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law.
[47] *Working Together to Safeguard Children* at pp. 214, 102 & 103. See also the LSCB Regulations 2006 on the composition of the LSCB.
[48] See Section 3 of the LSCB Regulations 2006
[49] Section 13(3) of the Children Act 2004.

Working Together to Safeguard Children also states that the Panel should include both child health and public health professionals. In addition to this, the Panel may include other members to reflect for example, the values or traits of the local community, the views of the independent or voluntary sector or to provide input on certain types of child death.

The LSCB should also be in contact with a consultant paediatrician whose designated role is to provide advice on commissioning paediatricians with expertise in conducting enquiries into unexpected child deaths and medical investigative services such as radiology, laboratory and histopathology services.[50]

The Panels are chaired by the Chair of the LSCB or their representative. The Chair should not be involved directly in providing services to children and families in the area.[51] The Panel is required to meet "at regular intervals" to enable each child's case to be discussed in a timely manner.[52] What counts as regular intervals is left to the discretion of each LSCB.

Responsibilities of the CDOP[53]

The statutory guidance document sets out a number of responsibilities for the CDOP. First it is required to assess the actions of the professionals involved with the child including their involvement before and at the time of death and the appropriateness of their response to the child's death. Furthermore, the review must consider the relevant "environmental, social, health and cultural aspects of each death".[54] The purpose of this is to consider how such deaths could be prevented in future.

The Panel must make a determination as to whether or not the child's death was preventable.[55] This has to be agreed by the Panel and approved by the Chair of the CDOP but cannot be undertaken until other, related investigations, have been completed.

[50] *Working Together to Safeguard Children* at p. 214.
[51] *Working Together to Safeguard Children* at p. 214.
[52] *Working Together to Safeguard Children* at p. 213.
[53] *Working Together to Safeguard Children* at pp. 213 & 214.
[54] *Working Together to Safeguard Children* at p. 213.
[55] A preventable death is defined as one in which "modifiable factors may have contributed to the death" as set out in *Working Together to Safeguard Children* at p. 213.

The final responsibilities of the Panel involve the making of swift recommendations to the LSCB and other bodies to ensure that such deaths can be prevented in the future and to identify and report on any patterns or trends in the local data to the LSCB.

Functions of the CDOP[56]

The functions of the CDOP as set out in the statutory guidance document are manifold, and are listed here in full:

- reviewing the available information on all deaths of children aged up to 18 years (including deaths of infants aged less than 28 days but excluding those by legal termination, or those of stillborn babies) to determine whether the death was preventable. This decision should always be approved by the Chair of the CDOP
- implementing, in consultation with the local coroner, local procedures and protocols on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood
- collecting and collating an agreed minimum data set on each child who has died and, seeking relevant information from professionals and family members
- meeting frequently to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children
- having a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigations is known
- monitoring the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team on each unexpected death of a child, including the extent to which the team has brought together any recorded wishes and feelings of the child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings

[56] *Working Together to Safeguard Children* at pp. 216 & 217.

- referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review, and explore why this had not previously been recognised
- informing the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities
- providing relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family
- monitoring the support and assessment services offered to families of children who have died
- advising and monitoring the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
- organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by LSCBs) for any additional data to be collected locally
- identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training and
- co-operating with regional and national initiatives – for example, by the Centre for Maternal and Child Enquiries (CMACE) – to identify lessons on the prevention of child deaths

Procedures followed by local CDOPs[57]

All child deaths within an LSCB area are to be notified to the Board. The Chair of the LSCB has the responsibility of appointing a person within the Board to receive such notifications and information on the deaths of children.

A standard notification form has been created to aid the professional who is notifying the LSCB of the death.[58] The aim is to provide as much detail as possible in relation to the child, family

[57] *Working Together to Safeguard Children* at pp. 215 & 216.
[58] The notification form, Form A, is available for download at: http://www.education.gov.uk/

and circumstances of death, as well as of any professionals known to be involved with the child or family. Once notification has been made, the LSCB member with responsibility to receive the information must determine what agencies and/or professionals had been involved with the child or family. Within each agency, a key professional should be appointed as a liaison. An Agency Report form has been compiled for agencies reporting to the LSCB.[59] The agency (or their designated professional) is required to use the case files they have on the deceased child or the child's family to complete the agency report form and return it to the LSCB member, normally within three weeks. When the LSCB member has obtained all the agency report forms, they are to be collated into a single form, anonymised and entered into a suitable database.

These forms should be sent to each member of the relevant CDOP prior to panel meetings to ensure that there is sufficient time for the forms to be assessed. The panel should consider whether any specialist should be involved in the review or whether any similar deaths should be discussed at the panel meetings. The review carried out by the CDOP looks to determine any factors contributing to the death of the child. The death is given a designated classification. The CDOP will also determine if there are any lessons to be learnt from the child's death or any patterns of similar deaths in the local area.[60]

Where the deceased child has been involved with agencies in more than one LSCB area, the LSCB in the area where the child was normally resident when he or she died will conduct the review into the death of the child.

Family Involvement in the Death Review Process

Mechanisms for appropriately informing and involving parents and other family members of the death review process are considered "vitally important".[61] A detailed booklet has been developed to inform parents and carers of children who have died about the death review

childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths

[59] The Agency Report form, Form B, is available for download at http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths

[60] A Case Analysis Form, Form C, is available for download at http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths

[61] *Working Together to Safeguard Children* at p. 209.

process.[62] It explains areas such as the role of a Coroner, inquest procedure and the stages involved in a post-mortem examination.

It also gives a summary of the work of the Child Death Overview Panel. Parents and carers are reassured about their child and family's confidentiality, and are given the opportunity to make comments regarding their child's case to a contact person named on the leaflet. The CDOP should communicate to the family, preferably through a professional known to them, information which has been agreed upon.

Recommendations by CDOPs

Recommendations by CDOPs are expected to be few in number, and to be capable of classification as 'specific, measurable, achievable, relevant and timely'.[63] The recommendations should be with a view to making interventions that could help to prevent future deaths, or improve the safety and welfare of children in the local area and beyond. Importantly, the panel will not normally make any recommendations in relation to individual case management.

Once recommendations have been decided upon, they should be submitted to the LSCB or to any other relevant body identified by the CDOP. It is then the responsibility of the LSCB to make arrangements for following up on the recommendations to ensure that appropriate actions are taken.[64]

SERIOUS CASE REVIEWS (SCRS)

The core aim of a SCR, according to the statutory guidance document, is "for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children".

This aim is supported by three purposes:

- to establish what lessons are to be learned about how local professionals and organizations work individually and together to safeguard the welfare of children

[62] Available for download at: http://media.education.gov.uk/assets/files/pdf/t/the%20child %20death%20review%20a%20guide%20for%20parents%20and%20carers.pdf
[63] *Working Together to Safeguard Children* at p. 219.
[64] *Working Together to Safeguard Children* at p. 220.

- to identify what those lessons are and how and when they will be acted on, and what is to change as a result
- to improve intra and inter-agency working and better safeguard and promote the welfare of children

Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, on the basis of recommendations from the SCR sub-committee, whether a review should take place. SCRs should be completed within six months of the date of the decision to proceed, with the possibility to extend this time period if necessary.

Circumstances in which SCRs are undertaken

Section 5(1)(e) of the LSCB Regulations 2006 states that it is a function of the LSCB to undertake reviews of serious cases and advise the Authority and its Board partners on lessons to be learned. Section 5(2) of the Regulations defines a serious case as one where abuse or neglect of a child is known or suspected and either:

- the child has died or
- the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child

The statutory guidance document however draws a distinction between when a SCR should be undertaken by the LSCB and when the LSCB should *consider* undertaking such a review. When a child dies, and abuse or neglect is known or suspected to be a factor in the death a SCR should always be undertaken, regardless of whether or not the local authority's social care team was involved with the child or his/her family. A SCR should also always be conducted when a child dies in custody.[65]

The LSCB should consider undertaking a serious case review whenever a child has been seriously harmed in any of the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and mental health and development through abuse or neglect

[65] *Working Together to Safeguard Children* at p. 235.

- a child has been seriously harmed as a result of being subjected to sexual abuse
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004 or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children.[66]

In the statutory guidance document the following questions are listed as potential indicators as to whether a SCR should be carried out.[67] The answer 'yes' to one or more of these questions is likely to indicate that a SCR could be of benefit:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
    - not recognised by organisations or professionals in contact with the child or perpetrator
    - not shared with others
    - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?

[66] *Working Together to Safeguard Children* at pp. 235 & 236.
[67] *Working Together to Safeguard Children* at pp. 236 & 237.

- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

SCR Sub-Committee[68]

Many LSCBs have a standing SCR sub-committee for the purpose of overseeing and quality assuring all SCRs undertaken within the area, and to advise as to whether the criteria for conducting a SCR have been met. The sub-committee must consider, in the light of current information known in each case, the scope of the case review and draw up terms of reference for the review. The following questions are listed in *Working Together to Safeguard Children* to be considered by the sub-committee when determining the scope and terms of reference of a review:[69]

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion (discussed below)? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/ background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the SCR, and who should be responsible

[68] *Working Together to Safeguard Children* at p. 237.
[69] *Working Together to Safeguard Children* at pp. 239 & 240.

for facilitating their involvement? How will they be involved and contribute throughout the overall process?

- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the SCR including, where appropriate, for example the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?
- Is there a need to involve organisations/professionals working in other LSCB areas, and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?
- Who should be appointed as the independent author for the overview report (bearing in mind that this person should not be the Chair of the LSCB, the SCR sub-committee or the SCR Panel)?
- Might it help the SCR Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence or MAPPA Serious Case Review process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a coordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident (SUI) investigation into the provision of healthcare should be coordinated with a SCR.

- How will the SCR terms of reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), and family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?"

Executive Summary of Each Review

Following each serious case review, an executive summary is produced and is made public. This summary should include:

- information about the review process
- key issues arising from the case
- recommendations and an action plan

It is critical that the information contained in the executive summary be suitably anonymised in order to protect the identity of children, relevant family members and others, but should include the names of the LSCB Chair, the SCR Panel Chair, the overview report author and the job titles and employing organizations of all the SCR Panel Members.[70]

Individual Management Reviews (IMRs)[71]

When an organisation knows that a case is being considered for review, it is expected to secure its records relating to the case, and begin to draw up a chronology of their involvement with the child and family:

[70] An outline of a standard format of a serious case report is available at pp. 247 & 248 of *Working Together to Safeguard Children*, and of a serious case review executive summary at pp. 250 & 251.
[71] *Working Together to Safeguard Children* at p. 243.

> "IMRs should aim to look openly and critically at individual and organisational practice, and at the context within which people were working to see whether the case indicates that improvements should be made, and if so to identify how those changes can be brought about."[72]

Following completion of an IMR, feedback is given to each staff member involved in advance of completion of the overview report.[73] An outline has been prepared to guide the preparation of IMRs and is reproduced here in full:

[72] *Working Together to Safeguard Children* at p. 243.
[73] *Working Together to Safeguard Children* at p. 244.

Scope and format of individual management reviews

What was our involvement with this child and family?

Construct a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference. (This chronology should clearly set out when the child was seen and whether the wishes and feelings of the child were sought). Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

Where an agency has had relevant contact with the alleged perpetrator, the chronology should also cover these actions and should ask whether everything was done which might reasonably have been expected to manage effectively the risk of harm posed by the alleged perpetrator to the child.

Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but **why** something either did or did not happen. Consider specifically the following:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

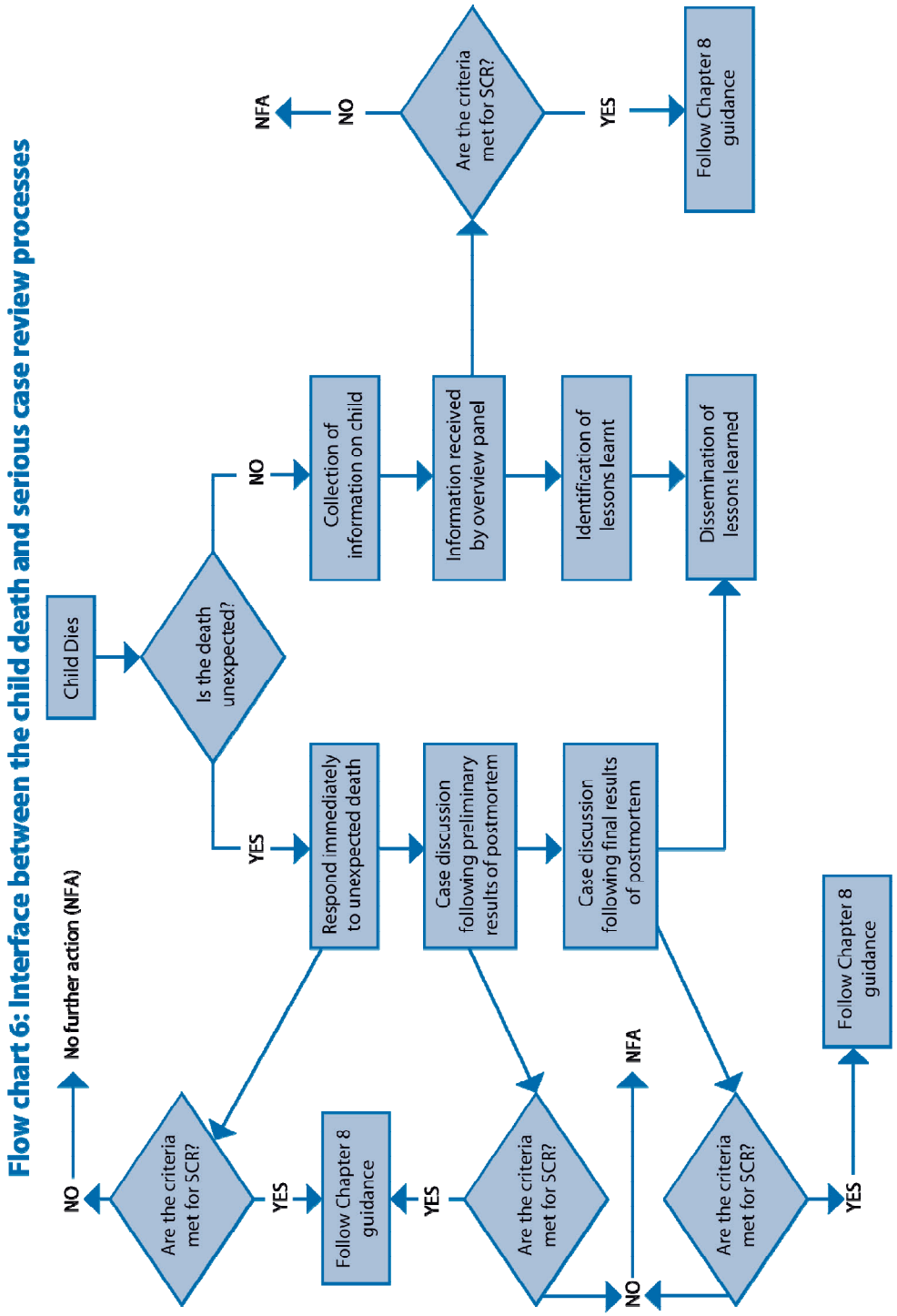
What do we learn from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?

Recommendations for action

What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

Flow Chart Outlining the Relationship between the Child Death Review Process & Serious Case Reviews[74]



[74] Note that 'Chapter 8 Guidance' referred to in the flow chart refers to Chapter 8 of *Working Together to Safeguard Children*. They key points are discussed above.

5.1.2 VICTORIA: CHILD DEATH REVIEW COMMITTEE, OFFICE OF THE CHILD SAFETY COMMISSIONER

There are two main bodies which deal with child death review in Victoria, albeit from different perspectives: the Victorian Child Death Review Committee (VCDRC) and the Office of the Child Safety Commissioner (OCSC).

Relationship between the Victorian Child Death Review Committee and the Office of the Child Safety Commissioner

The OCSC is responsible for establishing and overseeing inquiries into the deaths of all current and recent clients of Victoria's child protection service. These inquiries are used as the basis for the reviews carried out by the VCDRC. The OCSC also provides administrative support to the VCDRC.

The VCDRC is purely a review body, and does not play any investigative part in the child death inquiry process. Its role is to review the reports furnished to them by the OCSC and to advise the Minister for Community Services regarding policy, practice and procedural issues arising from those inquiries.

The VCDRC's recommendations may be case-specific or address issues that have been identified in a number of cases. The Minister for Community Services is formally notified of the Committee's deliberations on each child death, and any recommendations resulting from such deliberations. Similarly, the VCDRC considers group analysis if it has taken place and reports on this to the Minister.

Death Review Process[75]

When a child dies in Victoria, the following bodies will be involved in the aftermath of that death:

- Registrar of Births, Deaths and Marriages
- Coroner's Court of Victoria
- Victorian Institute of Forensic Medicine
- Department of Human Services
- Office of the Child Safety Commissioner

[75] VCDRC Annual Report 2010 pp. 5 – 7.

- VCDRC
- Consultative Council on Obstetric and Paediatric Mortality and Morbidity[76]

Relevant Legislation

The Child Wellbeing and Safety Act 2005 requires the Office of the Child Safety Commissioner to initiate a child death inquiry in relation to the deaths of all children and young people who were clients of Child Protection at the time of their death or within 12 months of their death.[77] The OCSC then monitors the implementation of recommendations arising from the child death inquiry process and provides administrative support to the VCDRC.

OFFICE OF THE CHILD SAFETY COMMISSIONER[78]

Establishment of a Child Death Inquiry

Where the Coroner is investigating a child death, he/she will notify the Department of Human Resources which will ascertain whether the child was known to child protection services. If the child was a current or recent client of child protection services, OCSC will be notified by the Department of Human Services.

In any case where a child death is under investigation by the Coroner, the Department of Human Services is notified to determine whether the child was known to child protection services. When a current or recent client of child protection services dies, the Department of Human Services notifies the OCSC. All children who were clients of Child Protection when they die or within 12 months of their death have their death registered by the OCSC on the Child Death Register within the Inquiries and Review Unit. Once the death has been registered the OCSC will set up an inquiry within their terms of reference (see below). Pursuant to Section 33(3) of the Child and Wellbeing Act 2005, the inquiry must relate to the services provided or omitted to be provided to the child prior to his/her death.

[76] For information regarding their respective roles, see VCDRC Annual Report 2010 at pp. 3 – 5.
[77] Section 33(1) of the Child Wellbeing and Safety Act 2005. Section 33(1) has recently been amended by the Children Legislation Amendment Act 2009 to provide that children who were clients of Child Protection within 12 months as opposed to 3 months of their death would be covered by the child death inquiry process.
[78] www.ocsc.vic.gov.au

The Department of Human Services furnishes the OCSC with comprehensive documentation about the death of each child, including critical incident reports and ministerial briefings. The child death inquiry process is considered to have begun on receipt of these documents. The actual process of the review is carried out by a practice reviewer within the Inquiries and Review Unit. Their responsibility is to conduct case-related research, analysis and generate a report which will be placed with the VCDRC. Practice reviewers generally work closely with external case analysts who provide expert advice and opinion, due to the complex nature of most inquiries.

Conducting a Child Death Inquiry

The purpose of child death inquiries by the OCSC is threefold:

- to establish the facts of the child protection case
- to ascertain whether established child protection procedures, standards, guidelines and protocols were followed in the management of a case
- to examine whether the case management decisions and actions of the Department of Human Services and other agencies were adequate and appropriate in providing a service to the client

The process is not one which aims to assign blameworthiness; the aim is to allow the professionals involved with the child to consider the actions that were taken regarding the child and also why such actions were taken. The entire case history is reviewed in an effort to distil lessons to be learned for future practice and policy.

There is a standard format for conducting and reporting individual child death inquiries. An examination takes place of: risk assessment, case planning, record management, service collaboration and regional contextual issues.

The terms of reference used by the OCSC when conducting an inquiry are:

- To establish the facts of the case
- To examine the services provided to the child before his or her death

- To promote continuous improvement and innovation in policies and practice in relation to the protection, safety and wellbeing of children[79]

Participants in the death inquiry process include: relevant workers within the Department of Human Services, community agencies, and experts in relevant fields. The direct input of practitioners, a standard part of methodology within the Victoria child death review process, is considered one of the approach's key strengths.[80] Families and carers to the child are also invited to contribute.

Support for participants in the Death Review Process

The Inquiries and Review Unit briefs participants on the inquiry process and ensures that debriefing and support services are made available to them.

Access to Information

Section 34 of the Child Wellbeing and Safety Act 2005 provides for the OCSC's access to information to ensure that they can properly conduct their reviews. The Commissioner and any authorised person[81] are entitled to access:

- any information on the central register in relation to a child whose death is the subject of an inquiry under this Division that the Commissioner or authorised person reasonably requires
- any other information, documents or records held in or by the Department in relation to a child whose death is the subject of an inquiry under this Division that the Commissioner or authorised person reasonably requires
- any information, documents or files held by an out of home care service relating to a child whose death is the subject of an inquiry under this Division that the Commissioner or authorised person reasonably requires
- any information, documents or files held by the health service or human service relating to a child whose death is the subject of an inquiry under this Division that the Commissioner or authorised person reasonably requires

[79] Email correspondence with Ms. Karen Elford, Executive Officer, VCDRC, 1st September 2010.
[80] VCDRC Annual Report 2010 at p. 62.
[81] Wide powers are given to the Child Safety Commissioner regarding authorised persons. Section 22 of the Child Safety & Wellbeing Act 2005 provides that the Child Safety Commissioner may authorise any person to assist them in carrying out their functions, provided they are appropriately qualified to do so.

Disclosure by Health Professionals and Welfare Practitioners

Section 35(1) of the 2005 Act empowers the Child Safety Commissioner or an authorised person to request information "reasonably required" from a health professional or welfare practitioner. Section 35(2) permits disclosure by health professionals and welfare practitioners. They are not compelled to provide information, but in determining whether to disclose information they must consider the objective of Section 35 and the public interest in releasing the information, from the point of view of child protection systems being run effectively, and the Child Safety Commissioner being able to conduct effective inquiries.

Protection for Disclosers

Section 36 provides that a disclosure made in good faith under Sections 34 or 35 does not constitute a breach of professional ethics or unprofessional conduct. Such a disclosure will not make the discloser subject to any liability in respect of it. Section 37 states that it is considered reasonable for a natural person to refuse or fail to give information if to do so would tend to incriminate that person.

Confidentiality

Section 40 of the 2005 Act forbids those involved in collecting information for the review process disclosing to any other person, either directly or indirectly, any information acquired by reason of being involved in the process if a child whose death is the subject of an inquiry or a member of that person's family will or may be identified from that information. The penalty for doing so is 60 penalty units.[82]

Exceptions to the above provision are made in the cases of: prior written consent in writing having been provided from the person to whom the information relates, or if that person has died, with the express or implied consent of the senior available next of kin of that person; to a court or tribunal in the course of criminal legal proceedings, or pursuant to an order thereof; disclosure to a legal practitioner for the purpose of obtaining legal advice or representation.

[82] 60 penalty units in Victoria are equivalent to a fine of $7,167.

Child Death Inquiry Reports

When a child death inquiry report has been drafted it is forwarded to the Department of Human Services and other key stakeholders for comment. The report takes into account both regional action in response to the death and state-wide programme development relevant to the issues in the case. The final inquiry report is sent to the VCDRC together with key Department of Human Services documents and coronial documentation. The VCDRC then reviews each report and advises the Minister for Community Services of its deliberations in each case as well as trends and patterns identified.

Group analysis of child deaths

The OCSC may conduct an analysis of a group of child deaths with similar themes, for example cases where abuse has been the primary issue. It is open to the VCDRC to request that the OCSC initiate a group analysis based on its consideration of child death inquiry reports over time. The group analysis process is considered particularly beneficial in the identification of best practice principles, and current gaps or deficits in service provision.

VICTORIAN CHILD DEATH REVIEW COMMITTEE[83]

Remit

The VCDRC is a review body specific to children who "were clients of the Victorian Child Protection Service at the time of their death or within 12 months of their death." A child is considered to be a person up to and including the age of eighteen.[84] Every child death within this category is reviewed. The rationale for this is as follows: "By looking at all child deaths rather than just those cases with unintended and tragic outcomes, it is possible to build knowledge and understanding of how services operate in general and, in turn, to identify patterns associated with either enhancing or hindering effective service delivery to clients. In this way, the child death review system provides a window into routine practice and contributes to fostering a learning and development culture."[85]

[83] http://www.ocsc.vic.gov.au/vcdrc/index.htm
[84] Child Wellbeing and Safety Act 2005.
[85] VCDRC Annual Report 2010 at p. 12

Definition of a Client of the Child Protection Services

The definition of a client has been amended since the creation of the VCDRC. Initially, pursuant to the Children, Youth and Families Act 2005, a child protection client was defined as "a child who is the subject of a protective intervention report." Cases that were in the intake phase of intervention awaiting decision when the child died were therefore outside the scope of the child death inquiry process.

The 2005 definition was amended by the Children Legislation Act 2009 to include children who are the subject of wellbeing reports, as well as those who are the subject of protective intervention reports.

As noted above, the eligibility timeframe for a child to be considered a client of the child protection services was extended from 3 to 12 months by the 2009 Act. The rationale for this change was that the longer timeframe increases the ability to identify lessons and strengthens accountability and transparency in relation to the deaths of children who are the subjects of reports to Child Protection.[86]

Aim

As with the review carried out by the OCSC, the purpose of the review is not to determine culpability but to reflect on the practices of Child Protection. The VCDRC identifies common themes and analyses the responses of services to vulnerable children and families. There are clear boundaries between the work of the VCDRC and the State Coroner and Victoria Police – the latter two bodies are responsible for determination of culpability.

Terms of Reference of the VCDRC[87]

The terms of reference of the VCDRC are listed as follows:

- To review the deaths of all children and young people who were clients of the Victorian Child Protection service at the time of their death or within 12 months of their death and advise the Minister for Community Services of the committee's deliberations
- To identify particular groups of child deaths that may benefit from further investigation

[86] VCDRC Annual Report 2010 at p. 15
[87] VCDRC Annual Report 2010 at p. 10.

or research

- To analyse and comment on any themes, trends or patterns that emerge from the review of inquiry reports
- To comment on service and system responses to children and families arising from the review of inquiry reports and receive feedback on the implementation of service system reforms
- To provide advice to the Minister for Community Services on the child death inquiry process
- To prepare an annual report for the Minister for Community Services
- To perform other functions in relation to child deaths as directed by the Minister for Community Services

Approach to Reviewing

The VCDRC initially examines case practice for each case which is reviewable by them, and then looks at them in aggregate, to identify common themes and emerging trends.[88] All cases falling within the above criteria are reviewed, as opposed to deaths in certain categories only.

Composition of the Team

The VCDRC's membership is drawn from the health, welfare, police, Guardian ad Litem and academic fields, mirroring the many professional groups involved in Victoria's Child Protection system.

Independence

The VCDRC operates as an independent ministerial advisory body. The Office of the Child Safety Commissioner of Victoria (further discussed above) is required to conduct individual inquiries into the deaths of children known to Child Protection, and these reports are the main source material used by the VCDRC.

Confidentiality, Access to Information and Disclosure of Information

Unlike the OCSC, the VCDRC is not specifically bound by the Child Wellbeing and Safety Act 2005, but as a ministerial body reporting directly to the Minister for Community Services,

[88] VCDRC Annual Report 2010.

observes the standard confidentiality, access to information and disclosure principles and ministerial protocols.[89]

Annual Reports

The Committee include in their annual report a categorised list of those child deaths that are reviewable by them.[90] Deaths are categorised by manner of death, age, gender, category of death by age grouping, Aboriginal versus non-Aboriginal and Stage of Child Protection involvement at the time of death. Characteristics of the children and their families are also analysed.

The Committee decide on certain themes which require particular attention in any given year. 'Assessment, Responding to Adolescents with High Risk Behaviours and Partnership' were chosen as themes for special examination in 2010, for example.

Implementation of Recommendations

Recommendations made by the VCDRC may be either case specific or relating to issues arising from a theme of child deaths reviewed. They are made to the Department of Human Services through the Minister for Community Services.[91] The Office of the Child Safety Commissioner is responsible for monitoring implementation of recommendations resulting from the child death inquiry process.

The VCDRC also participates in consultative processes to enhance and reform services for vulnerable children and families. The VCDRC relays its findings to practitioners and also to the Child Protection Professional Development Unit to ensure that learning which happens as a result of the review process is reflected in staff training programmes.

The VCDRC receives twice-yearly feedback from the Department of Human Services. The Executive Director of the relevant Division attends the VCDRC meeting periodically. The Child Safety Commissioner also provides advice directly to the Minister.[92]

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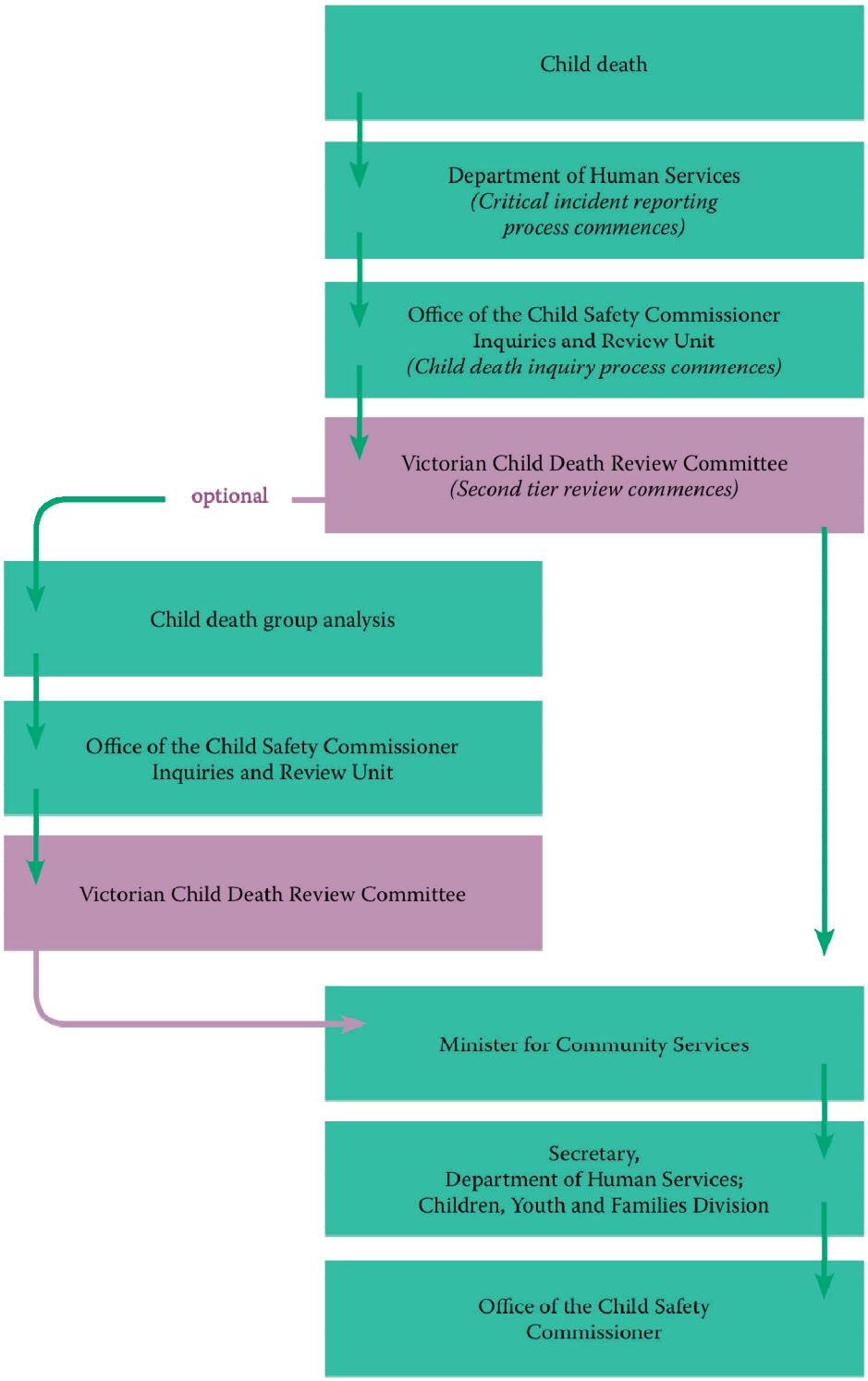
[89] Email correspondence with Ms. Karen Elford, Executive Officer, VCDRC, 1st September 2010.
[90] For an example, see VCDRC Annual Report 2010 at p. xii.
[91] VCDRC Annual Report 2010 at p. v.
[92] Email correspondence with Ms. Karen Elford, Executive Officer, VCDRC, 1st September 2010.

CONSULTATIVE COUNCIL ON OBSTETRIC AND PAEDIATRIC MORTALITY AND MORBIDITY

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity is a statutory body established under the Public Health and Wellbeing Act 2008 and is the body which advises the Minister for Health on mortality, perinatal, and paediatric deaths. When a child dies, the certifying medical practitioner prepares a report to the Council, including a range of demographic and descriptive data.

Child death inquiry model for the 2009 – 2010 reporting period[93]



[93] VCDRC Annual Report 2010 p. 8.

5.1.3 NEW SOUTH WALES: CHILD DEATH REVIEW TEAM, OMBUDSMAN FOR NEW SOUTH WALES

Reviews of child deaths in New South Wales are currently carried out by two bodies: the New South Wales Child Death Review Team and the Ombudsman for New South Wales. Until the passing of the Child Legislation Amendment (Wood Inquiry Recommendations) Act 2009, the Child Death Review Team fell under the control of the Commission of Children and Young People however this Act had the effect of moving the Child Death Review Team to the office of the NSW Ombudsman.

While their functions overlap, these bodies have different remits. The Child Death Review Team (CDRT) reviews child deaths on a wider scale by maintaining the Province's Child Death Register, examining child deaths from all causes in New South Wales and carrying out research into patterns/trends relating to child deaths and the prevention or reduction of child deaths. The CDRT also makes recommendations to the NSW Government and to non-governmental agencies with the aim of preventing further child deaths.

The Ombudsman for New South Wales (ONSW) conducts reviews into "reviewable deaths" pursuant to the Community Services (Complaints, Reviews and Monitoring) Act 1993.[94] The Child Death Review Team uses information gathered by the Ombudsman as part of their reviews.

NEW SOUTH WALES CHILD DEATH REVIEW TEAM

The NSW Child Death Review Team was formed in 1996. The Team is governed by the Commission for Children and Young People Act 1998,[95] as amended by the Children Legislation Amendment (Wood Inquiry recommendations) Act 2009.[96]

[94] Part 6 of the Community Services (Complaints, Reviews and Monitoring) Act 1993 requires the Ombudsman to review the deaths of specific categories of child deaths. See below for further information.

[95] See http://www.legislation.nsw.gov.au/xref/inforce/?xref=Type%3Dact%20AND%20Year%3D1998%20AND%20no%3D146&nohits=y.

[96] See http://www.legislation.nsw.gov.au/maintop/view/inforce/act+13+2009+cd+0+N. This piece of legislation was enacted following an inquiry by the Hon. James Wood AO QC to determine what changes were needed in the child protection system, commissioned by the New South Wales Governor.

Purpose and Functions

The overall purpose of the CDRT is stated as being "to provide information about child deaths and to reduce the number of deaths in NSW of children from birth to 17 years."[97] The functions of the body are provided for in the main statute:[98]

- To maintain a register of child deaths in NSW
- To classify these deaths according to cause, demographic criteria and other relevant factors
- To identify patterns and trends relating to the deaths
- To make recommendations to government and non-government agencies for the prevention of further child deaths
- To identify areas requiring further research by the Team or other agencies or persons

Composition of the CDRT

The Team is composed of both independent experts from a range of fields and representatives from government departments. It must consist of a minimum of 14 members (in addition to the Convenor) and not more than 20 members (in addition to the Convenor) at any one time.[99] Prior to the Children Legislation Amendment (Wood Inquiry recommendations) Act 2009 the CDRT was convened by the NSW Commissioner for Children and Young People, but since November 2010 the NSW Ombudsman is the Convenor. The Team is also required to have a Deputy Convenor, to be elected from among the team members.[100]

The current independent experts are all medical doctors drawn from a range of fields. The government representatives are present on behalf of: the NSW Police, the Department of Ageing, Disability and Home Care, the Department of Human Services,[101] the Department of Education and Training, NSW Health, the Attorney General's Office and the NSW Coroner in accordance with legislation requiring representatives of each of these Departments.[102]

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[97] See http://kids.nsw.gov.au/kids/about/who/childdeathreviewteam.cfm
[98] Section 45(N)(1) Commission for Children and Young People Act 1998.
[99] Section 45 (C)(6) Commission for Children and Young People Act 1998.
[100] Section 45 (D)(1) Commission for Children and Young People Act 1998.
[101] Prior to the Commission for Children and Young People Amendment Act 2009, this was the Department of Community Services.
[102] Section 45(C)(1) and (2) of the Commission for Children and Young People Act 1998. See details of the current independent experts at http://kids.nsw.gov.au/kids/about/who/childdeathreviewteam.cfm.

Members hold office for a maximum of 2 years, in accordance with their instrument of appointment, but are eligible, if otherwise qualified, for re-appointment.[103] Members other than the Convenor or a representative of a government department, the Police Force, or a statutory body, are entitled to be paid such remuneration and allowances (such as travelling or subsistence allowances) as may be determined by the Minister.[104] The team is to meet a minimum of four times per year.[105]

Provision of Information to the Team

People who fall within certain categories are required to provide the Team with "full and unrestricted access to records that are under the person's control, or whose production the person may, in an official capacity, reasonably require, being records to which the Team reasonably requires access for the purpose of exercising its functions."[106] These categories include: the Director-General, the Department Head, chief executive officer or senior member of any department of the government, statutory body or local authority; the Commissioner of the Police; the State Coroner; a medical practitioner or health care professional who, or the head of a body which, delivers health services to children; a person who, or the head of a body which, delivers welfare services to children; the principal of a non-government school.[107]

Confidentiality

Section 45(U) of the Commission for Children and Young People Act 1998 deals with the confidentiality of the work of the CDRT. Making a record of or disclosing, directly or indirectly to anybody, information that was acquired by virtue of being a Team-related person, is forbidden, with certain exceptions.

Such actions will be covered by an exception if:

- the record or disclosure is made in good faith for the purpose of exercising a Team-related function

[103] Section 45(E) Commission for Children and Young People Act 1998.
[104] Section 45(F) Commission for Children and Young People Act 1998.
[105] Section 45 (J)(2) Commission for Children and Young People Act 1998.
[106] Section 45(T)(1) Commission for Children and Young People Act 1998
[107] Section 45(T)(1) (a)-(f) Commission for Children and Young People Act 1998

- it is authorised by the Convenor in connection with research that is undertaken for the purpose of preventing or reducing child deaths in NSW[108]
- it is made by the Convenor for the purpose of:
    - providing information to the Commissioner of Police in connection with a possible criminal offence
    - reporting to the Director-General of the Department of Human Services that a child or class of children may be at risk of harm
    - providing information to the State Coroner that may relate to a death that is within the jurisdiction of the State Coroner
    - providing information to the Domestic Violence Death Review Team
    - providing information to the Ombudsman concerning the death of a child that is relevant to the exercise of any of their functions
- it is made by a member of the Team to a Minister, a Department Head, chief executive officer, or senior member of any department of the government or a statutory body, in connection with a draft report prepared for them

The penalty for failing to comply with the above confidentiality provisions is 50 penalty units (a value of $5,500) or 12 months imprisonment or both.

The 1998 Act also provides that a Team-related person is not obliged to produce any document or other thing, or reveal any information, that has been obtained by reason of being a Team-related person.

Reports and Recommendations

The CDRT produces annual reports.[109] The Annual Report publishes the overall number of child deaths and then classifies them.[110] Under section 45(P)(1) of the Commission for Children and Young People Act 1998, the annual report must be completed within four months of the end of the period and furnished to the Presiding Officer of each House of Parliament.

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[108] In 2008, for example, one request for information was made to the Convenor. (See NSW Child Death Review Team Annual Report 2008 at p. 3).

[109] See for example the NSW Child Death Review Team Annual Report 2009 (published 28th October 2009) at http://kids.nsw.gov.au/kids/resources/publications/childdeathreview.cfm?itemID=EFCEE1769E4FE94B73FA34070A3D1DB8

[110] See for example NSW Child Death Review Team Annual Report 2009 pp. 7 – 359.

Section 45(P) (2) of the Commission for Children and Young People Act 1998 provides that these reports must include:

- a description of Team activities during that year in relation to each of its functions
- details of the extent to which its previous recommendations have been accepted
- whether any information has been authorised to be disclosed by the Convenor
- if the Team has not presented a report to Parliament within the previous 3 years, the reasons why such a report has not been presented

These requirements are further supported by the functions as dictated by the 1998 Act which requires the CDRT to recommend ways to prevent or reduce the likelihood of child deaths, on the basis of its maintenance of the Register of Child Deaths or its research.[111]

The annual reports invariably comment on responses to the Team's recommendations and the extent to which the recommendations have been implemented. The Team contacts annually all relevant agencies for a report on progress and proposed actions. When it is discovered that a recommendation has not been acted on, agencies are asked to give reasons for failing to do so, and to provide information about any alternative action which may have been taken.[112]

Review of Team-Related Legislation

Under Section 45(X) of the Commission for Children and Young People Act 1998, the Minister is required to conduct a review of relevant legislation every five years to determine whether the policy objectives remain valid, and the legislation is appropriate for securing relevant objectives.[113]

[111] Section 45(N)(1)(e) of the Commission for Children and Young People Act 1998.
[112] NSW Child Death Review Team Annual Report 2009 at p.359.
[113] Section 45(X), Commission for Children and Young People Act 1998.

THE OMBUDSMAN, NEW SOUTH WALES

Since 2002, the Ombudsman has been responsible for the reviewing certain categories of child deaths. Pursuant to the Community Services (Complaints, Reviews and Monitoring) Act 1993 (hereafter the 1993 Act), the Ombudsman reviews the deaths of the following children:

- A child in care
- A child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances
- A child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place)
- A child who, at the time of the child's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for the handicapped

Investigations carried out by the Ombudsman are to be made 'in the absence of the public'.[114] Under section 41 of the 1993 Act, the Ombudsman has the power to establish advisory committees for the purpose of assisting him in the exercise of his functions.

In addition to the function of reviewing individual deaths, the Ombudsman is also required to:

- formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths of children in care, children at risk of death due to abuse or neglect, children in detention centres, correctional centres or lock-ups or persons in residential care
- maintain a register of reviewable deaths occurring in New South Wales after a date prescribed by the regulations classifying the deaths according to cause, demographic criteria or other factors prescribed by the regulations and
- undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable

Definition of a 'child in care'

A detailed definition of such a child is provided by Section 4 of the 1993 Act. A "Child in care" is defined as a child or young person under the age of 18 years:

[114] Section 17, Ombudsman Act 1974.

- who is under the parental responsibility of the Minister, or
- for whom the Director-General of the Department of Community Services or a designated agency has care responsibility, or
- who is a protected person within the meaning of section 135 of the Children and Young Persons (Care and Protection) Act 1998, or
- who is the subject of an out-of-home care arrangement, or
- who is the subject of a sole parental responsibility order, or
- who is otherwise in the care of a service provider

Functions of the Ombudsman's Reviews

The aim of the Ombudsman is to discern ways in which deaths could be prevented or reduced. His/her specific functions are to:

- monitor and review deaths of certain children, and people with disabilities (as listed above) to identify patterns and trends
- analyse information relating to reviewable deaths and make recommendations about policies and practices that could prevent or reduce deaths, and enhance the safety of children and people with disabilities
- maintain a register of reviewable deaths in NSW
- undertake research or other projects focussing on strategies to reduce or remove risk factors associated with reviewable deaths that are preventable
- prepare an annual report to Parliament relating to reviewable deaths

Notification of Deaths

Pursuant to Section 37 of the 1993 Act, the Registrar of Births, Deaths and Marriages, the Director-General of the Department of Ageing, Disability and Home Care and the State Coroner are obliged to notify the Ombudsman within 30 days of receiving information on or notification of a reviewable child death.

Provision of Information to the Ombudsman

Certain bodies and professionals are required to provide the Ombudsman with "full and unrestricted access to records that are under the person's control, or whose production the

person may reasonably require, being records to which the Ombudsman reasonably requires access for the purpose of exercising the Ombudsman's functions". [115]

These people include: a service provider (whether or not it is a government agency); the chief executive officer of a service provider; the relevant Minister for a service provider; the Department Head, chief executive officer or senior member of any department of the government, statutory body or local authority; the Commissioner of Police; the Commissioner for Children and Young People; the State Coroner.

Reports[116]

The Ombudsman is required to prepare a report every two years on his/her work for the previous two years. The report is provided to the Presiding Officer of each House of Parliament as soon as practicable after 30 June. The reports are to include:

- a report as to data collected and information relating to reviewable deaths that occurred in the State during the reporting period
- any recommendations made
- information with respect to the implementation or otherwise of previous recommendations

Deaths are categorised in detail according to certain criteria: age, gender, Aboriginality, child and family circumstances (where the children lived; family size; care status; place of death; disability), manner of death, coronial and criminal status of the death.[117]

Type of Action Taken[118]

Generally, the Ombudsman's reviews do not identify concerns about agency responses to the child and their family. Occasionally, they identify practice, procedural or policy issues that warrant further action. The type of action that the review may recommend relate to the child who died, their surviving siblings or both, and includes:

[115] Section 38 of the Community Services (Complaints, Reviews and Monitoring) Act 1993.
[116] Governed by Section 43 Community Services (Complaints, Reviews and Monitoring) Act 1993.
[117] See for example Ombudsman Report 2007 – 2009 at p. 11 - 19.
[118] Ombudsman Report 2007 – 2009 at p. 20.

- Providing reports to agencies, service providers, or other appropriate persons about issues relating to a reviewable death, or arising from their work. These reports range from providing information to assist the work of an agency, to raising concerns about how an agency managed a case or incident
- Making preliminary inquiries of agencies to determine whether their conduct should be the subject of an investigation
- Conducting investigations into the conduct of an agency in relation to a child and / or their family

Recommendations

The Ombudsman is required to formulate recommendations to be implemented by government and service providers to prevent or reduce reviewable deaths, and to provide information in the annual report about the implementation or otherwise of previous recommendations.

The Ombudsman acknowledges that it may take time for agencies to fully implement recommendations and that priorities within an area subject to recommendation may change. He therefore reviews the recommendations each year and in cases where they have not been fully implemented, they are updated to take into account progress to date. In the event of a commitment being made by an agency, the Ombudsman seeks progress reports to monitor and report accurately on how agencies are working to address the issues identified through their work.[119]

Involvement of Family Members

There does not seem to be strong family involvement in the death review process in New South Wales.

[119] Ombudsman Report 2007 – 2009 at p. 76.

5.1.4 MICHIGAN: KEEPING KIDS SAFE

Overview

The Michigan Child Death Review Programme, also known as *Keeping Kids Safe* builds and supports local multidisciplinary teams in each of Michigan's 83 counties. The Michigan programme is seen as a pioneer model and has been used as the foundation for child death review teams in other jurisdictions. They have developed an excellent website with very detailed guidelines for local teams, and with very useful information about the death review process.[120]

History

In 1995, Michigan began planning the implementation of a child death review mechanism and a grant of $225,000 was made available to fund the project. A programme was piloted in 17 counties. Following on from the pilot, legislation was amended to enable child death review, promote expansion to all counties in Michigan, mandate a Child Death State Advisory Committee and require an annual report on child deaths.[121] By 1999, the Department of Human Services had allocated $450,000 per annum to the programme, and by 2010 all counties in Michigan had organised local death review teams. Michigan's approach, in contrast to most other states which only review child abuse deaths, was to review all preventable deaths of those under 19 years of age, using a public health model.

Purpose[122]and Objectives

The purpose of the child death review system in Michigan is to improve agency systems and to take action to prevent other deaths.[123] One guiding principle for review is that the death of a child is a community problem, and that in most deaths, responsibility is multidimensional.

The CDR programme's objectives are stated to be:

- Accurate identification and uniform reporting of the cause and manner of every child death

[120] See www.keepingkidsalive.org
[121] The Michigan Child Protection Act (167 of 1997) inserts section 7b into the Child Protection Law Act (238 of 1975) which provides for the establishment of Child Fatality Review Teams.
[122]http://www.keepingkidsalive.org/Tools_for_Teams/The_process/General_Process/purpose.htm
[123]http://www.keepingkidsalive.org/About_the_Programme/programme_overview_and_history.htm

- Improved communication and linkages among agencies and enhanced coordination of efforts
- Improved agency responses to child deaths in the investigation and delivery of services;
- Design and implementation of cooperative, standardized protocols for the investigation of certain categories of child death
- Identification of needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths [124]

The above objectives are achieved through the provision of a forum to ensure that relevant information is shared and available to determine why a child has died and to better understand all the contributing factors leading to a death. The existence of the local CDR teams enhances information sharing. Meeting regularly to talk about child deaths is seen to significantly improve interagency cooperation and coordination. Confidentiality was initially found to be a significant obstacle to inter-agency information sharing, until the point where trust was built up among local team members.

It is envisaged that local CDR teams promote quicker, more efficient notification of child deaths, enabling investigators to conduct more timely investigations. Their reviews may form part of the investigative process, or may be more retrospective and a tool to improve future investigations. These teams can also help local agencies to develop standardized protocols to investigate and deliver services.

In line with the programme's aim to prevent future child deaths, every child death review finishes with a discussion of how the team can prevent another similar death in the community in which the team is based. Reviews are intended "to catalyse community action".[125]

Teams have been organised in all Michigan counties, the vast majority of which meet regularly to review deaths. These teams are made up entirely of volunteers, and receive no funding from the overall CDR body.

[124] http://www.keepingkidsalive.org/Tools_for_Teams/The_process/General_Process/purpose.htm
[125] See http://www.keepingkidsalive.org/Tools_for_Teams/The_process/General_Process/purpose.htm#achieving

The average team consists of 15 members, including always the prosecutor, state, county and/or local law enforcement, representatives from the Department of Human Services (DHS), local public health and the county medical examiners. Mental health, education and hospital staff, including paediatricians and other health care practitioners may also serve on local review teams.

Teams are given wide discretion to choose their coordinator, team membership and operating procedures. Most teams initially focused on death investigation and data collection, but now focus on recommending action to prevent deaths.

Reviewable Deaths*[126]*

The goal for local teams is to review as broad a category of deaths as possible, to improve their ability to identify trends leading to enhanced prevention and policy development.[127] The three predominant criteria to be assessed when selecting cases for review by a team are age, cause of death and residence.[128] It is advised that in selecting the cases for review, the medical examiner and one other team member carry out the selection on the basis of exact criteria set down by the team.

Age

Regarding age, all deaths of those aged 18 and below are recommended to be considered for review, and in many counties deaths of those aged up to and including 21 are reviewed. Local teams are permitted to focus reviews on specific age groups or on other criteria based on interest and resources.

Cause of Death

Regarding which causes of death to focus on, a review team is free to review deaths in all categories, but at a minimum are expected to review: all medical examiner cases; homicides; accidents; suicides; undetermined causes; sudden or unexpected deaths; all cases with previous

[126] See generally http://www.keepingkidsalive.org/Tools_for_Teams/The_process/Protocols/reviewable_deaths.htm

[127] http://www.keepingkidsalive.org/Tools_for_Teams/The_process/Protocols/reviewable_deaths.htm

[128] It is recommended that teams keep a list of cases not selected for review, along with their reasons for not choosing to review them.

Department of Human Services involvement; and all cases under investigation by law enforcement.

It is stressed that teams ought not to focus only on cases involving abuse, neglect or homicide. While deaths clearly due to natural causes are not frequently reviewed, it is emphasised that it is important to inform teams of all natural deaths and to understand the cause and manner of such deaths to determine whether patterns exist, for example clusters of deaths due to cancer.

Teams are encouraged to review natural deaths to infants due to conditions originating in the perinatal period, as a review by one team found that approximately 50 percent of such deaths could have been prevented. Teams are encouraged to determine whether local hospitals conduct foetal infant mortality reviews, and if so, to work alongside them to share findings.

Residence

Regarding residence, CDR teams ought to review all preventable deaths that occur in their counties and attempt to review the deaths of children who are resident in their counties but die in other counties. In cases where a team reviews a non-resident death, communication is encouraged between the coordinator of that team and the resident county review coordinator. This is seen to be particularly important in rural counties where children are often transported to tertiary care centres when they are pronounced dead.

CDR Support Services

There are currently four full time workers and one part time worker employed by the CDR programme. Annual training is provided for new team members, and state wide training on specific causes of death and child death investigation procedures is also provided. Annual meetings of local team coordinators are held regularly throughout the state. Paid CDR personnel visit local review meetings to offer technical assistance and encourage prevention efforts. Programme support materials have been developed, including resource guides for effective reviews, protocol manuals, training manuals, investigative protocols, local and state mortality data, prevention resources and a resource website.

Child Death Investigation Policies

The following policies are implemented.

- A policy whereby police always visit the scene of an unnatural death to a child under the age of one
- A policy to notify Michigan Department of Human Services in the event of all accidental deaths to children
- Efforts to provide special training to Emergency Medical Services providers for working effectively, yet with empathy, for the victims and families at the scene

Reporting Review Findings[129]

A case report is completed for each death that is reviewed. A web-based reporting system is used. The case reports are confidential, as protected by legislation.[130] Local counties are able to get full reports of their reviews, and the annual report on child deaths in Michigan is developed using these findings, alongside Michigan Department of Community Health child mortality data.

Child Death State Advisory Team

Under Section 7b (1) (4) of the Child Protection Law Act (238 of 1975)[131] it was required that an advisory committee be established "to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide state wide prevention, education, and training efforts". The Child Death State Advisory Team (CDSAT) was set up and its purpose is stated as being to "provide guidance, expertise and consultation in analysing and understanding the causes, trends and system responses to child fatalities, and to make recommendations in law, policy and practice to prevent child deaths in Michigan."[132]

The CDSAT also supports CDR local teams, recommends improvements in protocols and procedures and reviews Michigan's child mortality data and local review team reports to identify causes, risk factors and trends in child deaths.

[129] http://www.keepingkidsalive.org/About_the_Programme/programme_overview_and_history.htm
[130] The Michigan Child Protection Act, Section 7b (Public Act 167 of 1997).
[131] As inserted by the Michigan Child Protection Act (167 of 1997).
[132] http://www.keepingkidsalive.org/About_the_Programme/state_advisory_team.htm

The team meets at least quarterly. Administrative responsibility for the team is held by the Michigan Department of Human Services. The Director of the Department of Human Services appoints members, who are permitted to serve indefinitely.

By law, the team must include a member from the Department of Human Services, Michigan Department of Community Health, a county prosecuting attorney, law enforcement, a medical examiner, and the Children's Ombudsman.[133] Other members may be appointed to bring expertise on various causes of child death and prevention. The Department of Human Services chairs the meetings. Meetings usually consist of presentations by state experts, data on specific causes of death, review of local findings and development of recommendations for the annual report.

The CDSAT staff are also responsible for creation of an annual report on child deaths in Michigan which is presented to the Governor and the Legislature. Michigan law requires, at least, annual tabulation of the total number of child fatalities, by type and cause; the number of fatalities that occur while a child is in foster care; the number of cases where the death occurred within five years of family preservation or unification, and trends in child fatalities.[134]

Citizen Review Panel

Under federal legislation,[135] Congress has required that States who wish to receive funding from the Child Abuse and Neglect States Grants programme establish a Citizens Review Panel. The purpose of this panel is generally to review child welfare agencies within the state and recommend improvements which should be made to child protective services. In Michigan, the State Advisory Team also acts as the state's Citizen Review Panel on Child Fatalities. This sub committee meets regularly to conduct case reviews of suspected child maltreatment deaths and to develop recommendations for improvements to the child welfare system. Three annual reports have now been presented.

[133] Section 7b (5) of the Child Protection Law Act (238 of 1975) as amended by the Child Protection Act (167 of 1997).
[134] Section 7b (6) of the Child Protection Law Act (238 of 1975) as amended by the Child Protection Act (167 of 1997).
[135] Section 106 of the Child Abuse, Prevention and Treatment Act (Public Law 93-247) as amended.

5.1.5 CONNECTICUT: CHILD FATALITY REVIEW PANEL

Overview

The Connecticut Child Fatality Review Panel (CFRP) was established in 1995 by Connecticut Statute § 46A-131 (1995), and reviews have been carried out since 1996. The programme is based in the Office of the Child Advocate, which was created after the Child Fatality Review Panel's first review was carried out. The annual budget of the team is $92,000, and is funded by the State of Connecticut. One full-time staff member is employed to devote full attention to the programme.[136]

Mandate and Purpose

The CFRP is required by legislation to "review the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state".[137] The purpose of the review is to develop prevention strategies to address identified patterns of risk and trends and to improve coordination of services for children and families in the state. The CFRP is not required to review every child death, or every death in State care.

Individual Reviews

The Medical Examiner identifies the deaths for the CFRP to review.[138] The Panel is also empowered by statute to review any death that occurs in the State. They place a particular emphasis on children who are placed in out of home care.

Agencies responsible for the custody or care of children are also required to provide timely notice to the Child Advocate and the chairperson of the CFRP of the death of a child or a critical incident involving a child in its custody or care.[139]

Standardised data forms are completed for all cases reviewed. These are completed by family members, who the CFRP recognise as key to the prevention of future child deaths.[140] A database

[136] http://www.childdeathreview.org/spotlightCT.htm.

[137] Connecticut Statute § 46A-13l (c). See http://www.ct.gov/oca/cwp/view.asp?a=1303&Q=254872&ocaNav

[138] Connecticut Statute § 46A-13l (f).

[139] Connecticut Statute § 46A-13l (g).

has been developed to record the information, to assist with identification of trends and patterns.

The Child Advocate may occasionally conduct a further, in-depth investigation into the death of a child. This will happen upon the request of two-thirds of the members of the CFRP, the Governor or at the Child Advocate's discretion.[141]

Composition of the Team[142]

The team is a standing body and is composed of thirteen members as follows:

- The Child Advocate, or a designee
- The Commissioners of Children and Families, Public Health and Public Safety, or their designees
- The Chief Medical Examiner or a designee
- The Chief State's Attorney or a designee
- A paediatrician, appointed by the Governor
- A representative of law enforcement
- An attorney
- A social work professional
- A representative of a community service group
- A psychologist
- An injury prevention representative

The team meets monthly. A maximum of three expert advisors may be appointed as temporary members at the request of a majority of the team. The panel is required to, as far as possible, represent the ethnic, cultural and geographic diversity of the state. Members of the team are not paid for their services, but may be reimbursed for necessary expenses incurred in the performance of their duties.

[140] CFRP Annual Report 2000. See http://www.childdeathreview.org/reports/CT_CDR_2000_3425k.pdf
[141] Connecticut Statute § 46A-13l (e).
[142] Connecticut Statute § 46A-13l (b). See http://www.childdeathreview.org/spotlightCT.htm

Access to Information

The CFRP has certain statutory powers of access to information.[143] These include:

- access to, including the right to inspect and copy, any records necessary to carry out their responsibilities. If access is denied, a subpoena may be issued for the production of books, papers and other documents
- permission for the Child Advocate to communicate privately with any child or person who has received or is receiving services from the State
- power to issue subpoenas to compel attendance and testimony of witnesses

Confidentiality of Information

All information obtained in the course of an investigation and all confidential records obtained is to be kept confidential and not subject to disclosure under the Freedom of Information Act.[144]

However, the Child Advocate is permitted to make a disclosure if he/she considers it:

- to be in the public interest
- necessary to enable the Child Advocate to perform his/her responsibilities
- necessary to identify, prevent or treat the abuse or neglect of a child

Annual Reports

The CFRP is required to issue an annual report, including its findings and recommendations, to the Governor and the General Assembly on its review of child fatalities for the preceding year, on or shortly before the 1st January each year. Information is categorised by age and cause of death, and is not as detailed as in the reviews of many other types of child death review panel.[145]

[143] Connecticut Statute § 46A-13m (a)-(d).
[144] Connecticut Statute § 46A-131 (1995) s. 46(a)-13m
[145] See http://www.ct.gov/oca/cwp/view.asp?a=1301&q=254888.

5.1.6 BRITISH COLUMBIA: CHILD DEATH REVIEW UNIT, REPRESENTATIVE FOR CHILDREN AND YOUTH, MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT

For the purposes of this report, there are three particularly relevant bodies who review the deaths of children in State care in British Columbia: the Child Death Review Unit, the Representative for Children and Youth of British Columbia, and the Ministry of Children and Family Development. The role and methods of each is explained below.

CHILD DEATH REVIEW UNIT (CDRU)[146]

Overview

The CDRU was first established in 2003 and was modelled on existing child death review programmes framed within a public health model.[147] Its first Annual Report was released in 2005, chronicling its work from 2003 – 2005.

The CDRU exists under the umbrella of the British Columbia Coroners Service (BCCS) and cases are referred to it following a Child Death Investigation carried out by the Coroner. The rationale for placing the CDRU within the Coroner's Service is that it provides easy access to necessary information, given how much child death review teams typically rely on coroner and medical examiner offices to provide data, and also that it ensures that coroners are obtaining the best and most consistent data possible during a death investigation.[148]

The legislative basis for the CDRU is now found in the Coroner's Act 2007, sections 47 – 51, which mandates the creation of a child death review unit within the Coroner's Service, and lists the powers of the unit, specialist death review panels and their powers, and reporting of reviews.[149]

The CDRU reviews the deaths of all children up to and including the age of 18 which occur in British Columbia (BC), including those deaths which are expected due to pre-diagnosed

[146] See generally http://www.pssg.gov.bc.ca/coroners/child-death-review/index.htm
[147] CDRU Annual Report 2005 at p. 2. See http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-2005annualreport.pdf
[148] CDRU Annual Report 2005 at p. 1
[149] See http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_07015_01

diseases.[150] Its aim is to monitor child deaths in the long-term, and this will be achieved by monitoring trends over subsequent years through the establishment of a database.[151]

Aim of Review

A CDRU child death review aims "to understand who the child was in life and to learn about the factors that may have contributed to death".[152] Reviews are sometimes carried out on individual cases, and sometimes on groups of cases together. A child death review will normally take place approximately one year after the coroner's investigation has been completed. Family involvement may be requested in a review as well as in an investigation.

The focus of the reviews is on prevention of future child deaths, as well as improving the health, safety and well-being of BC's children, by seeking to understand how and why children have died. Fault is never assigned in a child death review.[153] Members of the CDRU are forbidden by legislation from making any finding of legal responsibility or expressing any conclusion of law.[154]

Goals and Objectives of the CDRU

The CDRU lists its goals as follows:

- To accurately establish the cause of child deaths
- To develop uniform, consistent and retrievable data collection involving on-going surveillance of all childhood fatalities to allow for the formulation of prevention strategies
- To identify significant risk factors and trends in child deaths
- To facilitate the linkage of identified patterns and trends in child deaths with agencies and organisations
- To influence and develop education and deterrent/ prevention strategies to reduce the mortality of children
- To provide ongoing and relevant training to personnel involved in child death investigation

[150] http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/ChildDeathInfo-English.pdf at p. 2
[151] CDRU Annual Report 2005 at p. 36
[152] http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/ChildDeathInfo-English.pdf at p. 2
[153] CDRU Annual Report 2005 at p. 4
[154] The Coroner's Act 2007, s. 51 (4)

- To initiate local, community and provincial activities to prevent childhood injuries and fatalities.[155]

The objectives of the CDRU are:

- To ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death; and the establishment of a minimum data set on the causes of child deaths
- To facilitate communication and information-sharing among agencies and other review teams to enhance the coordination of the BCCS review team's efforts
- To ensure a multi-disciplinary agency response to child deaths through the delivery of services
- To identify and forward recommendations to appropriate individuals or agencies that will improve the health, safety and well being of children
- To identify specific barriers and systemic issues involved in the deaths of children and work collaboratively for solutions with the appropriate agency
- To identify preventable factors and work collaboratively with individuals in professional and community education regarding the health, safety and well being of children.[156]

Composition of the CDRU

The CDRU currently consists of a Director, a Programme Assistant and case reviewers with expertise in paediatric medicine; forensics; investigation; child welfare; project management; and injury prevention.[157] From time to time, child death review experts from other jurisdictions will assist with case reviews and development of the child death review protocol.[158]

Notification of Deaths to the CDRU

The CDRU is notified within 12 hours of an unnatural, sudden or unexpected child death being reported to a Coroner, in accordance with Section 9 of the Coroner's Act. In the case of natural, expected deaths, the CDRU is not required by legislation to be notified, but the CDRU receives

[155] CDRU Annual Report 2005 at p. 5
[156] CDRU Annual Report 2005 at p. 5.
[157] CDRU Annual Report 2008 at p. 4
[158] CDRU Annual Report 2006 at p. 71

information on these deaths from BC's Vital Statistics Agency on a regular basis.[159] The data collected in individual cases is used to highlight trends in child deaths on a provincial level. National trends in child deaths are also analysed by CDRU staff.

Investigative Powers

The Coroner's Act 2007 confers investigatory powers on members of the CDRU.[160] They are empowered to use any information acquired through an investigation or inquest conducted by the Coroner, and to exercise the same powers of investigation that apply to a coroner conducting an investigation. These include powers to examine the body, inspect locations relevant at the time of the child's death, seize anything believed to be relevant to the investigation, require a person to attend before the reviewer, and to inspect, copy and seize relevant records.[161] Those who receive requests for records from a CDRU member are obliged to comply with the request, despite any claim of confidentiality or privilege.[162]

Death Review Process

The CDRU's review process is made up of three main elements: case reviews; recommendation development, monitoring and implementation; and reporting on activities and review findings.[163]

Once cases have been reviewed by the Coroner, they are forwarded to the CDRU. A case reviewer conducts an initial examination of the case. If the reviewer considers that further information is required, this will be obtained, and the reviewer will then work through a protocol covering data on demographics, circumstances of death and risk factors.

Following the initial examination, cases are assessed by an internal multidisciplinary review team. They review the circumstances of the cases, and discuss risk factors that may have contributed to the child's death. The team considers and determines whether a death could be considered preventable.

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[159] CDRU Annual Report 2005 at p. 6.
[160] The Coroner's Act 2007, section 48 (3).
[161] The Coroner's Act 2007, section 11 (1) (a – h).
[162] The Coroner's Act 2007, section 11 (2).
[163] CDRU Annual Report 2009 at p. 7.

Once case reviews are complete, the CDRU considers review findings to determine areas of child deaths which should be the focus of targeted action or further action.

Reporting and Recommendations

The production of reports and the making of recommendations by the CDRU are governed by Section 51 of the Coroners Act 2007.

Reports

Following each review by the CDRU or by a death review panel, a member is required to report to the Chief Coroner any findings respecting the circumstances surrounding deaths that were the subject of a review, and any recommendations respecting the prevention of similar deaths, and submit to the chief coroner all records relevant to the review.[164]

The CDRU reports in three different formats – annual reports; special reports and status reports.[165] Annual reports focus on the unit's activities over the previous year and discuss progress on recommendations made. The report provide tables of data summarising the most common causal factors in child deaths, as well as trends in terms of ethnicity, age and areas of residence. The information gathered is categorised by the manner of death for reporting purposes and a breakdown is made of the percentage of deaths that occurred in various manners. This information is usually displayed in a pie chart.[166] The annual report concludes with a summary of the year's findings.

Special reports focus on child deaths that occurred under similar circumstances, for example drowning. Status reports examine child deaths by year of death, which it is believed increases timeliness of the review findings and allows for more detailed analysis of trends in child death rates and risk factors. The reports contain detailed, but non-identifying information.

The BC Coroner's Service and the Ministry of Children and Family Development (MCFD) share information about children in the care of MCFD who or who have received services under the Child, Family and Community Service Act in the twelve months prior to their death. The MCFD's

[164] The Coroner's Act 2007, s. 51 (1) (a) & (b).
[165] CDRU Annual Report 2008 at p. 13.
[166] See for example, CDRU Annual Report 2009 at p. 12.

reviews of child deaths are sent to the CDRU and they are then sent to the Coroner.[167] Each annual report contains a section specific to children who were known to the MCFD at the time of their deaths.

In 2010, the CDRU commenced issuing yearly reports with statistics on the state of child deaths in British Columbia. The focus of these reports is on annual trends in the rates of child death and the risk factors in child death. Again, the purpose is the making of recommendations which will prevent child death.[168]

Recommendations

The power to make recommendations related to the protection of the health, safety and well-being of children is conferred on members of the CDRU by Section 51(3) of the Coroner's Act 2007. The Annual Report concludes with a series of recommendations focussed on the strategies of "education, engineering, enforcement and economics".[169] The CDRU considers publication of the Annual Report to fulfil the objective of education of the public. The other three strategies are addressed through recommendations that result from collaboration between the CDRU and communities and local, national, and international agencies.[170] The unit reviews best practice for death prevention and considers interventions that have worked in other jurisdictions to form the foundation for making recommendations.[171]

The focus of recommendations will either be enhancement of existing prevention efforts or the addressing of gaps within the system. To facilitate this, the CDRU "identifies appropriate target agencies, assesses feasibility of suggested interventions and establishes timelines and activities involved."[172] Prior to the recommendations' release, they will be finalised in consultation with the target agency.

Recommendations range from specific actions which should be promoted in all communities, such as using seatbelts, to recommendations to specific agencies and government departments

[167] CDRU Annual Report 2005 at p. 12
[168] CDRU Annual Report 2009 at p. 8.
[169] See CDRU Annual Report 2009 at pp. 25-30.
[170] CDRU Annual Report 2005 at p. 32.
[171] CDRU Annual Report 2008 at p. 12.
[172] CDRU Annual Report 2008 at p. 12.

regarding their policies and practice, and often to the Chief Coroner.[173] The CDRU monitors the implementation of recommendations made by it by reporting on the progress of previously made recommendations in the Annual Report.[174]

Confidentiality

Disclosure of information is covered by the Coroner's Act 2007. Members of the CDRU are prohibited from disclosing any information in respect of a deceased person or a person connected with them or any information provided or record compiled in the course of an investigation or review.[175] CDRU members may however disclose information or a record "as necessary or incidental to the carrying out of an investigation, an inquest or a review".[176]

Despite BC's Freedom of Information and Protection of Privacy Act, a member of the CDRU may refuse to disclose any information collected in the course of a review until the review is completed.[177] The Chief Coroner is entitled to refuse to disclose any part of a record that contains confidential information to a person who has a right of access under the Freedom of Information Act.[178]

The Chief Coroner or the chair of the CDRU is authorised to disclose information obtained by the CDRU, including personal information, to the Representative for Children and Youth.[179]

The Chief Coroner may disclose any report made to him/ her in the category of 'report after investigation', 'report of jury's verdict' or 'report of review' to the public or a person who, at the judgement of the Chief Coroner, has a valid interest in the findings and recommendations contained in the report,[180] subject to two conditions. The Chief Coroner is required to consider whether the disclosure is necessary to support the findings and recommendations contained in

[173] CDRU Annual Report 2005 at pp. 32 – 35.
[174] See for example CDRU Annual Report at pp. 30 – 33.
[175] The Coroner's Act 2007, Section 63 (1) and (2).
[176] The Coroner's Act 2007, Section 63 (2).
[177] The Coroner's Act 2007, Section 64 (1)(c).
[178] The Coroner's Act 2007, Section 64 (3).
[179] The Coroner's Act 2007, Section 68.
[180] The Coroner's Act 2007, Section 69 (1).

the report, and whether the public interest in the disclosure outweighs the personal privacy of the individual whose information is disclosed in the report.[181]

Family Involvement

The CDRU believes the input of the family of a deceased child to be of high importance. Letters are sent to the child's primary caregiver or next of kin informing them that the death is being reviewed, inviting them to join in the process and to contact the unit with any questions.[182] The CDRU reports a frequent concern of family's being that of their child's privacy.[183] Family members have occasionally participated as members of a child death review panel.[184]

Special Child Death Review Panels

Occasionally, special child death review panels may be recommended by the CDRU "for the purpose of providing advice to the Chief Coroner respecting medical, legal, social welfare and other matters that may impact public health and safety, and the prevention of deaths"[185]. The authority to convene such a panel is vested in the Chief Coroner by the Coroner's Act 2007.[186]

The powers of death review panel members are equivalent to those of CDRU members.[187] Two such panels were convened, for example, in April 2008 and July 2008 to examine the deaths of six Aboriginal youths who had died between 2004 and 2005 in various regions of BC.[188]

[181] The Coroner's Act 2007, Section 69 (2).
[182] CDRU Annual Report 2008 at p. 14.
[183] CDRU Annual Report 2008 at p. 14.
[184] CDRU Annual Report 2008 at p. 14.
[185] The Coroner's Act 2007, Section 49 (1).
[186] The Coroner's Act 2007, Section 49 (1).
[187] The Coroner's Act 2007, Section 50.
[188] See http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/death-review-panel-aboriginal-youth.pdf

REPRESENTATIVE FOR CHILDREN AND YOUTH

Overview

The Representative for Children and Youth (RCY) supports children, youth and families in dealing with the child welfare system, provides input to the Ministry of Children and Family Development, and advocates for improvements to the child welfare system. [189] The Representative serves all those in British Columbia under the age of 19, with a particular emphasis on young people in government care, such as those in foster homes, group homes or youth custody.

The RCY is an Independent Officer of the Legislature and does not report through a provincial ministry, and does not work for the government. The first Representative for Children and Youth was approved in 2006.

The mandate of the RCY is stated as being "to improve services and outcomes for children in BC through advocacy, accountability and review".[190] Part of the improvement of services and outcomes through accountability arises from the independent review and investigation of deaths of and critical injuries to children and youth receiving services. The purpose of such review is, amongst other things, preventing children and youth from being harmed.[191] The Representative is permitted to establish a multidisciplinary team for the purposes of child death and critical injury review.[192]

Child Death Review Goals

One of the named goals of the RCY is to "work collaboratively with public bodies, including the chief coroner and public guardian and trustee, to build an integrated, responsive process for the review and investigation of critical injuries and deaths." [193]

The RCY aims to achieve these goals by:

- Sharing best practices with governmental and non-governmental agencies and officials

[189] http://www.rcybc.ca/Content/AboutRCY/Introduction.asp
[190] http://www.rcybc.ca/Content/AboutRCY/MandateAndScope.asp
[191] http://www.rcybc.ca/Content/AboutRCY/MandateAndScope.asp
[192] Representative for Children and Youth Act 2006, Section 15.
[193] http://www.rcybc.ca/Content/AboutRCY/Goals.asp

- Overseeing and monitoring progress continually
- Developing protocols and practices for reviews of critical injuries and deaths
- Establishing a strong, multidisciplinary team to review and identify effective measures to prevent child injuries and deaths
- Providing a range of advocacy services for children and youth and their families. [194]

Jurisdiction to Review Child Deaths and Critical Injuries

The RCY's role and jurisdiction are defined in the Representative for Children and Youth Act. Part 4 relates specifically to the review of critical injuries and deaths. "Critical Injury" is defined by legislation as injury to a child that may:

- result in the child's death, or
- cause serious or long-term impairment of the child's health[195]

The RCY may conduct a review for the purpose of identifying and analysing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service, or to inform improvements to broader public policy initiatives. [196]

A reviewable service is defined as any of the following designated services:

- services or programmes under the *Child, Family and Community Service Act* and the *Youth Justice Act*
- mental health services for children
- addiction services for children
- additional designated services that are prescribed under section 29 (2)(b).[197]

After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death the public body must provide information respecting the critical injury or death to the

[194] http://www.rcybc.ca/Content/AboutRCY/Goals.asp
[195] Representative for Children and Youth Act 2006, Section 1.
[196] Representative for Children and Youth Act 2006, Section 11.
[197] Representative for Children and Youth Act 2006, Section 1. Such services are those prescribed as additional designated services by the Lieutenant Governor in Council.

Representative for a review.[198]

All deaths and critical injuries undergo an initial screening by the Representative and staff to determine whether the injury or death meets the criteria for a RCY review.

Investigations of Critical Injuries and Deaths[199]

Pursuant to Section 12 of the Representative for Children and Youth Act 2006, the RCY may investigate the critical injury or death or a child if, after the completion of a review under Section 11 the RCY determines that:

- a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death and
- the critical injury or death was, or may have been due to one of the following circumstances (which can essentially be summarised as occurring in unusual or suspicious circumstances; if the injuries are self-inflicted or inflicted by someone else; and whether they appear to be associated with maltreatment[200]):
    - physical harm by the child's parent
    - sexual abuse or exploitation by the child's parent
    - physical harm, sexual abuse or sexual exploitation by another person and if the child's parent is unwilling or unable to protect the child
    - physical harm because of neglect by the child's parent
    - emotional harm by the parent's conduct
    - deprivation of necessary health care
    - if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment
    - if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care
    - if the child is or has been absent from home in circumstances that endanger the child's safety or well-being
    - if the child's parent is dead and adequate provision has not been made for the

[198] Representative for Children and Youth Act 2006, Section 11(1).
[199] Representative for Children and Youth Act 2006, Section 12.
[200] RCY's Report, July 7, 2010, available at http://www.rcybc.ca/Images/PDFs/Reports/CID%20Update%209%20-%20July%207%2010%20FINAL.pdf

child's care

- if the child has been abandoned and adequate provision has not been made for the child's care
- if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.[201]

There is also a Select Standing Committee on Children and Youth in British Columbia with the power to refer a critical injury or death to the RCY for investigation, which the Representative may or may not choose to do.[202]

The RCY may not investigate a death or critical injury until a criminal investigation and criminal court proceedings have been completed. Similarly, an investigation may not take place if a public body responsible for the provision of a reviewable service has written procedures in place for investigating critical injuries or deaths and the public body investigates them, until the earlier of: the completion of the investigation and one year after the critical injury or death of the child.[203]

Power to Compel Persons to Answer Questions and Order Disclosure

Wide powers to compel information have been bestowed on the RCY by the Representative for Children and Youth Act 2006. [204]

When conducting an investigation, the Representative may make an order requiring a person to:

- attend, in person or by electronic means, before the Representative to answer questions
- produce a record or object in the person's possession or control

In the event of persistent non disclosure, the RCY may apply to the Supreme Court for an order directing a person to comply with an order made by the Representative.

[201] See Section 13 (1) Child, Family and Community Service Act 1996.
[202] Representative for Children and Youth Act 2006, Section 12 (2) – (4).
[203] Representative for Children and Youth Act 2006, Section 13.
[204] Representative for Children and Youth Act 2006, Section 14.

Reports after Reviews and Investigations

Legislation permits the RCY to aggregate and analyse the information received from reviews and investigations and to produce a report that does not contain information in "individually identifiable form".[205] The RCY is required to provide a report to:

- The Select Standing Committee
- The public body or director responsible for the provision of a reviewable service that is the subject of a report
- Any other public body, director or person that the Representative considers appropriate.[206]

After an investigation of the critical injury or death of a child, the Representative must make a report.[207] The report made must contain the RCY's reasons for undertaking the investigation and may contain the following:

- recommendations for
    - the public body, or the director, responsible for the provision of a reviewable service that is a subject of the report, or
    - any other public body, director or person that the representative considers appropriate
- personal information, if, in the opinion of the representative
    - the disclosure is necessary to support the findings and recommendations contained in the report, and
    - the public interest in the disclosure outweighs the privacy interests of the individual whose personal information is disclosed in the report
- any other matters the representative considers relevant.[208]

MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT (MCFD)

The MCFD also has a responsibility to review the deaths of children in the care of the region of British Columbia. [209]

[205] Representative for Children and Youth Act 2006, Section 16(1).
[206] Representative for Children and Youth Act 2006, Section 16(2).
[207] Representative for Children and Youth Act 2006, Section 16(3).
[208] Representative for Children and Youth Act 2006, Section 16(4).
[209] For further information see http://www.mcf.gov.bc.ca/about_us/accountability.htm.

Notification of the MCFD

A director within the MCFD must be notified immediately regarding the death, critical injury of or serious incident involving a child in care or a child who has been in receipt of child protection services in the 12 months prior to death, critical injury or serious incident.

At this point, the Director will review the circumstances, receive feedback and aim to learn from the events which have taken place. The Director may seek additional information regarding the case. The Director may decide that there are no outstanding issues or questions, which is typically the case where a natural, expected death has occurred, where there is no reason to believe that practice had an impact on the outcome for the child.

The Director may also decide that a case review is required. This decision will be made no later than 20 days following the occurrence of the incident.

Case Reviews

There are two types of case reviews which may be carried out – a comprehensive review and a file review.

A comprehensive review is "a review that involves the examination of case files as well as interviews of relevant staff, caregivers and service providers".[210] A comprehensive review will be carried out due to the severity of an occurrence, a potential link between case practice and the outcome and the level of response required for public accountability. Such a review must be completed within 11 months of the incident, but cannot be conducted until after an ongoing criminal investigation and court proceedings have been completed.

A file review is the second type of case review, and is usually more limited in scope than a comprehensive review. It usually consists of a review of the case files, and can assist the Director to determine whether a comprehensive review is required. A file review must be completed within 6 months of the incident.

[210] http://www.mcf.gov.bc.ca/about_us/accountability.htm.

The Executive Director of Practice at the regional level makes the decision regarding which type of case review to conduct. Factors such as the severity of the situation and the level of perceived public accountability are considered in the decision making process

Recommendations and Reports

Recommendations may be made following on from either type of case review. Implementation is monitored by the regional Director of the MCFD.

The Ministry publicly releases, on a six month basis, all case review summary reports to reinforce its commitment to openness and accountability. The case review summaries do not provide any identifying information "to balance the need for the ministry to hold itself to a high level of public accountability, with its obligations to protect personal information."[211]

[211] A typical report on a death is available at http://www.mcf.gov.bc.ca/about_us/directors_case/2010/BY_FOI_2009-00881_Executive_Summary.pdf and of a serious incident at http://www.mcf.gov.bc.ca/about_us/directors_case/2010/MJ_FOI_2009-00999_Executive_Summary.pdf

5.1.7 NEW ZEALAND: CHILD AND YOUTH MORTALITY REVIEW COMMITTEE; FAMILY VIOLENCE DEATH REVIEW COMMITTEE; OFFICE OF THE CHILDREN'S COMMISSIONER; CHILD, YOUTH AND FAMILY DEPARTMENT

In New Zealand, many bodies have the authority to conduct a review of the death of a child in the care of the State; however, none carries a mandate to do so. The relevant bodies for the purposes of this review are the Child and Youth Mortality Review Committee (CYMRC), the Family Violence Death Review Committee (FVDRC), Child, Youth and Family (CYF), the New Zealand Police and the Office of the Children's Commissioner. CYF and the FVDRC are the most likely organisations to conduct a detailed analysis, while the CYMRC will gather relevant data in every case but may or may not carry out an in-depth report. Reviews into the deaths of children in State care will only very occasionally be conducted by the Office of the Children's Commissioner.[212]

CHILD AND YOUTH MORTALITY REVIEW COMMITTEE (CYMRC)

Overview

The CYMRC, following a nine year existence, and having published five annual reports, is the best developed of the mortality review committees in New Zealand. It is an independent statutory body which gathers information on every child death that occurs, and does an in-depth analysis in as many cases as is feasible. It is not required to conduct such an analysis in every case. Therefore, in the context of deaths of children in the care of the State, it will gather information as in all other cases, and may or may not choose to conduct an in depth analysis of a specific case. Child and youth mortality for the purposes of CYMRC review relates to persons aged 4 weeks to 24 years.[213]

Local mortality review committees select which deaths to review in-depth on instruction from the national committee.[214] The criteria used to determine which cases are subject to an in-depth

[212] Email correspondence with Dr. Marie Connolly, Chief Social Worker, Ministry of Social Development of New Zealand, 19th April 2010.
[213] CYMRC Terms of Reference, Section 6. See Terms of Reference at http://www.cymrc.health.govt .nz/moh.nsf/indexcm/cymrc-aboutus-terms?Open&m_id=2.3
[214] CYMRC Annual Report 2003, p. 4.

review include the Committee's interest and expertise, current media or political interest, and/or types of deaths that are preventable or that provide the opportunity for systems improvement.[215]

The CYMRC came into existence in 2001 at the appointment of the Minister for Health and pursuant to the Minister's powers created by Sections 11, 12 and 18 of the Public Health and Disability Act 2000. Section 11 vests in the Minister for Health the power to create committees. Section 12 essentially outlines the Minister's responsibilities in terms of notifying the House of Representatives as to basic information regarding a committee which has been set up which is to be made public, such as the number of members and their names, and the function of the committee. Section 18 relates specifically to mortality review committees. It plainly sets out that their goal is to be that of reviewing deaths among certain classes of people with a view to reducing those deaths.[216] The CYMRC was the first mortality review committee to be created in New Zealand.

Following a review of overseas mechanisms for reviewing child deaths in its first year of operation, the Committee adapted a system used in Michigan, USA (discussed earlier in this chapter). The structure is two tiered, using local review committees based in various districts supported by an overall national committee, allowing for the making of both local and national recommendations.[217]

Function, Aim and Goals

The function of the Committee is threefold – to review and report to the Minister of Health on the deaths of children and young people with a view to reducing the numbers of those deaths; to advise the Minister on issues related to mortality; to develop strategic plans and methodologies designed to reduce morbidity and mortality.[218]

[215] Email correspondence with Ms. Brandy Griffin, Senior Policy Analyst, Mortality Review Committees, Ministry of Health of New Zealand, 24 April 2010.
[216] Section 18 (1) of the Public Health and Disability Act 2000.
[217] CYMRC Annual Report 2003 at p. vii.
[218] Public Health and Disability Act 2000, Section 18 (1) & (2).

The overriding aim of the CYMRC is to discern how preventable child deaths can be reduced in future.[219] This aim applies to all areas of child death review, including those related to children in the care of the State. To fulfil its purpose, the Committee aims to monitor deaths; educate regarding mortality review; encourage creation and nurture of local child death review groups; act inter-organisationally and alongside the community, collect information from all relevant sources; conduct investigations into particular types of child and youth deaths; produce an annual report for the Minister of Health, and advocate policy change which would increase protection for vulnerable children.[220]

On creation of the CYMRC by the Minister, specific goals were outlined for its first year of existence. Over the years, goals have been developed on an annual basis and outlined in the annual reports. The CYMRC is free to develop its own goals. Progress has been gradual but definite and consistent. The nature of recommendations made by the CYMRC has changed through time. Initially, the recommendations were focused on system changes, such as to accessibility of data, but in more recent years have turned to detailed recommendations in terms of practices which can be introduced to reduce and prevent child deaths.[221]

Analysis of Specific Areas

The Committee also occasionally commissions studies and reports on specific areas. Maori child and youth mortality, and transport injuries were two special foci in 2005/2006 for example.[222] A considerable amount of work on and awareness of methods of prevention of Sudden Unexpected Death in Infancy (SUDI) has been carried out by the CYMRC.[223]

Foundational Values

In the first year of its operation, the CYMRC developed the following four foundational necessities for carrying out child death reviews:

- The centrality of local involvement in mortality review
- Expediting reviews by supplying all available information as quickly as possible

[219] CYMRC Terms of Reference, Section 4 (a) & (c).
[220] http://www.cymrc.health.govt.nz/moh.nsf/indexcm/cymrc-aboutus-statement
[221] See for example CYMRC fourth Annual Report, 2007 at p xv.
[222] CYMRC Annual Report 2006 at p. xii
[223] See all Annual Reports.

- Ensuring confidentiality and trust by using a small, multidisciplinary team as opposed to an open system that might allow more people to be involved in the process as an educational opportunity
- Central processes to provide data must be matched with central processes that measure the process, record the recommendations and document as far as possible the results of the recommendations so that the effects of mortality review can be reported.[224]

Composition and Operation of the Committee[225]

The Committee holds a maximum of ten members appointed by the Minister for Health. One member will always be from the Child, Youth and Family Service of New Zealand, one will be from the Ministry of Health and one will be a coroner. Outside of these positions, membership is drawn from a range of disciplines and contexts including clinicians, health service providers, child and youth advocacy groups, and people representing Māori and Pacific peoples' interests. The Committee must collectively hold expertise in mortality review systems; issues affecting children and youth; epidemiology, research and health systems; culture.

Terms of office last for up to three years and are staggered to guarantee continuity of membership. Provision is made for members remaining on the Committee for a longer duration than six years in exceptional circumstances to a maximum of seven years, in the case of, for example, there being an exceptional need for continuity of knowledge and skills.[226]

The Committee is a standing body, which meets approximately once every six months. These meetings may be face to face or by teleconference.

The Terms of Reference of the CYMRC deal with the issue of conflicts of interest by providing for it in its terms of reference. Section 26 states that "Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it retains public confidence." In the case where a conflict of interest arises, members must declare this and remove themselves from relevant

[224] CYMRC Annual Report 2003 at p. 2.
[225] CYMRC Terms of Reference October 2009, Sections 13 – 18.
[226] CYMRC Terms of Reference October 2009, Sections 19 & 20

discussion and activity.[227] The Terms of Reference of the CYMRC are reviewed every three years.[228]

The Death Review Process

In its most recent report, the CYMRC stated that after its seven years in operation, a precise process has evolved as to how review takes place and is completed. It lists the following steps:

- National organisations and some individuals provide information directly to the Mortality Review Data Group
- The information held centrally is available for use at local review meetings via appointed District Health Board (DHB) co-ordinators
- After each death is reviewed, these DHB coordinators add further information to the national database
- The Mortality Review Data Group collates and analyses information held in the national collection for the CYMRC
- The CYMRC reviews the collated case information as well as locally identified issues and recommendations. This provides a detailed overview of regional and national trends, which can be used to inform prevention strategies and support recommendations at both a local and national level
- Subject experts use collated case information to prepare sections of the report and the CYMRC advisors review recommendations
- Finally the CYMRC considers all available information and feedback in order to make recommendations to the Minister of Health, health professionals and members of the public in the Committee's annual report.[229]

The Committee takes a two-pronged approach to reviewing, examining both individual cases and broader trends at a demographic level. Reviews are conducted into individual cases at a local level, and information gathered in these reviews is subsequently added to a central data collection point – the Mortality Review Database - to paint a broader picture of "national trends and patterns of illness, incidents and accidents leading to death which may indicate where health, education, social or environmental systems are not functioning to protect children and

[227] CYMRC Terms of Reference October 2009, Section 26 (b).
[228] CYMRC Terms of Reference, October 2009, Section 41.
[229] CYMRC Fifth Annual Report 2008, Appendices, p. 7

young people."[230] On the basis of their analysis of both individual cases and national trends, the Committee then proceeds to recommend policies which could be implemented on both governmental and non-governmental levels to further increase the protection of children.

The Committee focuses only on gathering data once a death has occurred, rather than on serious events which have not resulted in death. However, the local groups focus on the 'causal pathway' which led to the death of the child, with a view to recommending policy changes to intervene in similar circumstances for other children.[231]

Local Review Groups

The role of the local review groups has evolved and been refined over time.[232] The CYMRC agreed 'local' to mean areas as divided by New Zealand's District Health Board boundaries.[233]

A local review group consists of a Chair, a paid co-ordinator and other group members who represent various relevant organisations. On the death of a young person falling within the CYMRC's remit, the co-ordinator of the region in which the young person was resident will gather initial information on the deceased from the secure Mortality Review database. The members of the local review group will be called upon by the co-ordinator to access their organisation's records to identify and collect any information relevant to the review process. This information, which remains confidential, is brought to the local review meeting, which is facilitated by the chair. The authority to seek information on behalf of the committee is found in the fact that each local review group member is appointed as an 'agent' of the CYMRC in accordance with the New Zealand Health and Disability Act 2000.[234]

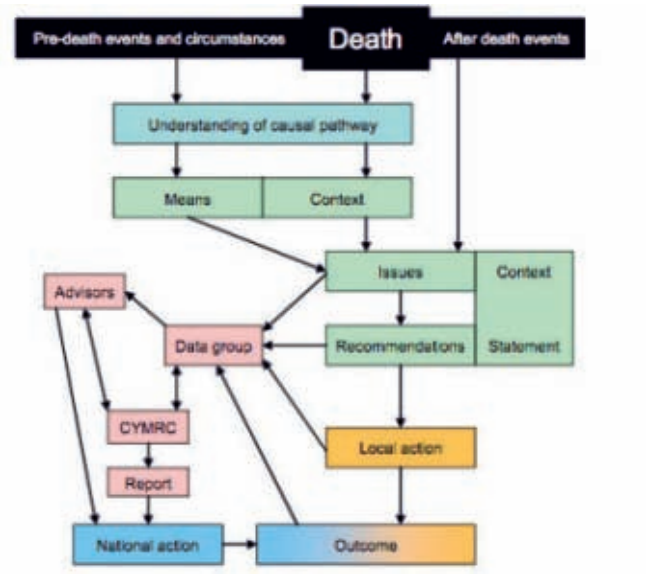
When all necessary information has been gathered, the group may highlight issues or make recommendations. Local recommendations are sometimes delegated to specific group members if the agency they represent are key players in facilitating implementation of recommendations. On completion of a local death review, the co-ordinator enters the data into the national

[230] http://www.cymrc.health.govt.nz/moh.nsf/indexcm/cymrc-aboutus-home
[231] CYMRC Annual Report 2008 at p. 10
[232] See generally CYMRC fifth Annual Report 2008, Appendices, pp. 9 – 10.
[233] CYMRC Annual Report 2003 at p. 3.
[234] Email correspondence with Ms. Brandy Griffin, Senior Policy Analyst, Mortality Review Committees, New Zealand Ministry of Health, 2nd June 2010.

database, and relevant issues, recommendations and follow-up actions are communicated to the CYMRC.

The CYMRC has observed that the advantage of local review groups is that high levels of detail about the context of death can be ascertained, and that the challenge lies in refining this detail into recommendations that can work nationally.[235]

The following diagram has been used by the CYMRC to explain the process of analysing the causal pathway to death, making recommendations on the basis of that information, storing and communicating this information to the relevant groups, and making national and local changes.[236]



As of August 2009, "only a small proportion of all deaths had been reviewed locally". This appears to be due to the fact that the preliminary years of the existence of local review groups seem to have been focused on establishment of the groups, and development of their smooth running and data collection processes. It is anticipated that given the increase in the number of areas covered by the local review process the scope for system improvements will widen.[237]

The CYMRC piloted two local review committees in 2003. Both groups initially spent time forming the committee – developing their shared vision for mortality review, consulting with

[235] CYMRC fifth Annual Report 2008, Appendices, p. 9.
[236] CYMRC fifth Annual Report 2008, Appendices, p. 9.
[237] CYMRC fifth Annual Report 2008, Appendices, p. 9.

local groups, identifying sources of information and determining how to conduct reviews. The next stage involved getting underway the process of information gathering for review meetings and to input to the Mortality Review Database. At that stage, the local review groups encountered various obstacles including "access to information; missing records; inadequate or illegible documentation; and the need for adequate death scene investigation."[238]

The pilot projects were successful overall, and their review methodology revealed local trends, unique cases of concern and missing information, as well as conclusions and recommendations from in-depth review of selected cases.[239]

The learning from the pilot projects are relevant for the purpose of this report and include the following:

- the need to articulate a nationwide methodology with documented expectations of processes and practices for information gathering and review
- establishing strong confidentiality boundaries to enable high levels of confidence in the process
- clarifying the role and responsibilities of local review groups with regard to their relationship with the national committee, communication and reporting structure and degree of autonomy
- developing an annual work programme between the CYMRC and each local group which takes into account nationwide goals, local issues and available resources
- continuing discussion between the local groups and the CYMRC regarding the place of families in the review process
- continuing CYMRC activities to assist local groups in accessing information from local agencies
- refining the process of local group information gathering and data entry to the Mortality Review Database to ensure alignment with future strategies for national reporting and review

[238] CYMRC Annual Report 2004 at p. 15.
[239] CYMRC Annual Report 2004 at p. 16.

- developing a strategy to evaluate the outcomes of the CYMRC and local group activity; ensuring that there is sufficient support for the work of both the national and local committees.[240]

Training workshops are provided by members of the CYMRC to members of local review committees.[241] Also, as well as local co-ordinators, there is a national co-ordinator who provides regular training to their local counterparts.[242]

Information supply

Issues surrounding information gathering and inter-organisational sharing are one of the major obstacles to progress in the area of death review. Various measures have been provided for the CYMRC through legislation in an attempt to combat this, and the CYMRC itself has developed practices to centralise data.

The Health and Disability Act 2000 confers on the CYMRC very broad data collection privileges. Schedule 5 of the Act confers a power to compel information from individuals on the chairperson of the committee, or an agent acting on behalf of the committee. It states that "[i]f a mortality review committee gives its chairperson, or an agent the committee appoints for the purpose, authority in writing to do so, the chairperson or agent may, by notice in writing to any person, require the person to give the committee information in the person's possession, or under the person's control, and relevant to the performance by the committee of any of its functions"[243] and Clause 2(3) requires that such a person must take reasonable steps to comply with the request.[244] Up until now, these powers have not been used, but the CYMRC has instead chosen to work with organisations to get them to share as much as they can and to make them feel comfortable sharing the data. To do this, they firstly highlight that the CYMRC is not allowed to share data with anyone before it has been thoroughly de-identified and approved by the

[240] CYMRC Annual Report 2004 at p. 16.
[241] CYMRC Annual Report 2004 at p. 3.
[242] Email correspondence with Ms. Brandy Griffin, Senior Policy Analyst, Mortality Review Committees, New Zealand Ministry of Health, 2nd June 2010.
[243] Public Health and Disability Act 2000, Schedule 5, Clause (2)(1).
[244] Public Health and Disability Act 2000, Schedule 5, Clause (2)(3).

Minister of Health and secondly, emphasise that the CYMRC is not about assigning blame to any person or agency.[245]

In the first year of operation, the Committee invested time in establishing detailed specifics as to how to protect information in accordance with Clause 3, Schedule 5 of the 2000 Act, including for example using passwords and holding records in a locked filing cabinet.[246]

In their first annual report, the Committee identified the lack of consistent, detailed data collection at the investigative stages after a death as the main obstacle to ongoing child death reviews in New Zealand.[247] In their second report, the Committee again highlighted that much work needed to be undertaken to clarify what information needed to be collected from the coronial system.[248] The CYMRC has consistently recognised the central importance of their relationship with the Coroner's office. They have highlighted the need for "a coronial system that is more consistent and professional; better resourced; reflective of modern society and able to be used to facilitate societal change and system improvement."[249]

An information collection system was set up by the Committee where relevant agencies and organisations communicate information to the CYMRC on a regular basis. Individual coroners fax information when available; Births, Marriages and Deaths send information weekly; New Zealand Health information Service, Water Safety New Zealand, the Ministry of Justice and Land Transport New Zealand transmit information monthly.[250]

Confidentiality

The confidentiality of information held by the CYMRC is very strongly protected by the New Zealand Health and Disability Act 2000. Schedule 5, Clause 12 of the Act outlines that committee members, executive officers and agents are prohibited from disclosing information gathered in the course of their reviews, or making any record of it, except for the purposes of carrying out

[245] Email correspondence with Ms. Brandy Griffin, Senior Policy Analyst, Mortality Review Committees, Ministry of Health of New Zealand, 24th April 2010.
[246] CYMRC Annual Report 2003 at p. 6.
[247] CYMRC Annual Report 2003 at p. 7.
[248] CYMRC Annual Report 2004 at p. 6.
[249] CYMRC Annual Report 2006 at p. 2.
[250] CYMRC Annual Report 2004 at p. 6.

the Committee's functions or in accordance with a ministerial authority, or in accordance with one of a list of exceptions also listed in the schedule.[251] These exceptions cover information which does not either expressly or by implication identify a particular individual, disclosure of information with the consent of anybody who would be identified either expressly or by implication, or to the Minister or somebody appointed by him or her for the purpose of deciding whether a ministerial order should be made. Disclosure may be made for the purposes of prosecution of an offence under s. 18 (7) where the Act states that "every person who discloses information contrary to Schedule 5 commits an offence and is liable on summary conviction to a fine not exceeding $10,000".[252] The Act also provides that it is an offence carrying a penalty of $10,000 for any person to "fail, without reasonable excuse, to comply with a requirement imposed under Schedule 5 by the chairperson of a committee appointed under subsection 1."[253]

Clause 6 of Schedule 5 of the 2000 Act confers power on the Minister for Health to disclose information for the purposes of investigation or prosecution of an offence, if he/she is convinced that it relates to conduct that constitutes or may constitute a serious offence.

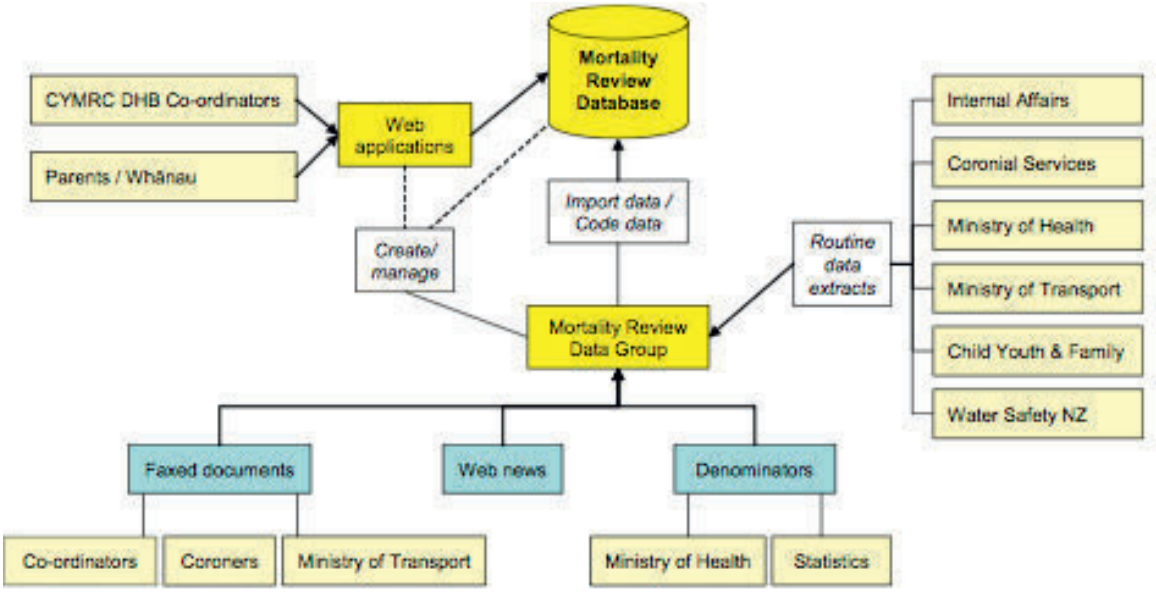
All members of the CYMRC, the local review groups and the Data Group are required to sign a confidentiality agreement prior to commencing in their post.[254]

Central Data Collection Processes

The Mortality Review Data Group was created during the first year of the CYMRC's existence to develop the mechanisms for collecting, collating and analysing data from government and non-government agencies. It was initially run by the chairman of the CYMRC and another part-time staff member.[255]

[251]http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM82828.html?search=ts_act_new+zealand+public+health+and+disability+act+2000_resel&p=1.
[252]http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM82829.html?search=ts_act_new+zealand+public+health+and+disability+act+2000_resel&p=1.
[253] Public Health and Disability Act 2000, Section 18 (7).
[254] For a sample confidentiality agreement see CYMRC Annual Report 2003, pp. 18 and 19.
[255] CYMRC Annual Report 2003 at p.19.

Data is collected, stored and linked to appropriate cases by the Mortality Review Data Group.[256] The flow of information to the Group, and from them to the Mortality Review Database is demonstrated in the following diagram:



The data is coded according to various themes, including age group, ethnicity, underlying cause of death, District Health Board of usual residence, place of death, and region that should review the death. Duplication of data is eliminated through regular review. The data is updated continuously, and all information is available to the local mortality review groups.[257]

With regard to availability of data for uses other than by the CYMRC or its agents, interested parties may apply for information gathered by the CYMRC using a standard form.[258] Information which identifies deceased children or youth cannot be released. A standard form for applying for access to data is distributed upon request.[259]

[256] CYMRC Annual Report 2008 at p. 7.
[257] CYMRC Annual Report 2008 Appendices at pp. 8 and 9.
[258] CYMRC Annual Report 2004 at p. 46.
[259] CYMRC Annual Report 2004 at pp. 48 and 49

Parental Involvement in Death Review

With regard to parental involvement in death review processes, the CYMRC has developed principles to enable two levels of involvement. Firstly, a brochure was developed describing the process of mortality review, and distributed by members of the Funeral Directors Association, GPs and paediatric departments. Secondly, since December 2006, parents have been given the opportunity to provide information directly to the Data Group using an online feedback form.[260] The CYMRC has consistently found that families express a need to try to prevent other families experiencing similar trauma and are very willing to be involved in the death review process.[261]

Monitoring Implementation of Recommendations

In terms of monitoring the implementation of recommendations delivered to the Minister of Health annually by the CYMRC, in recent years, the latter has published, in its annual report, a review of recommendations made in previous years and an assessment of whether or not they have been carried out.[262]

FAMILY VIOLENCE DEATH REVIEW COMMITTEE (FVDRC)

Overview

The FVDRC, an independent statutory body, was also founded on the basis of Sections 11 and 18 of the Public Health and Disability Act 2000. It is a recent venture, having been established in July 2008, holding its first meeting in October 2008 and releasing its first (and, to date, only) report in September 2009.

The FVDRC reviews and reports on deaths arising from family violence. It is particularly relevant to the review of deaths of children in the care of the state, as the definition of a 'family or extended family member' includes foster parents,[263] and death perpetrated by a 'caregiver' falls

[260] CYMRC Annual Report 2006 at p. 2.
[261] CYMRC Annual Report 2006 at p. 4.
[262] See CYMRC fourth Annual Report 2007 pp. 44 – 47, and fifth Annual Report 2008, Appendices pp. 46 – 51.
[263] FVDRC Annual Report 2009 http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 8.

within the definition of a family violence death.[264] A caregiver is defined as 'a person living in a domestic relationship with, and providing care for, the victim'.[265]

The FVDRC is concerned with the deaths of all who have died as a result of family violence, and therefore there is no applicable age range for the committee.[266] All family violence deaths will be reviewed by the Committee, which only started operating at the beginning of 2010.[267]

The Committee's overarching goal is to work towards the prevention of family violence and resulting deaths,[268] with working from a 'non-blaming' perspective being a high priority.[269]

The working details of the FVDRC are very similar to those of the CYMRC. The Committee reviews individual cases on a local and national level, but also aims to identify patterns and trends in family violence deaths over time.[270]

A family violence death review is defined as "a systematic analysis of the lives of victims, perpetrators and their families, and events leading up to and factors surrounding death(s), by a combination of agencies and disciplines in a confidential and culturally safe environment."[271]

The Committee is expected to liaise with other death review committees appointed under the 2000 Act.[272]

Function

The Committee's function is three-fold and consists of death reviewing with a view to future prevention of family violence and resulting death, development of strategic plans to reduce

[264] FVDRC Terms of Reference, Section 8(1) (see http://www.fvdrc.health.govt.nz/moh.nsf/indexcm/fvdrc-aboutus-tor?Open&m_id=2.2).
[265] FVDRC Annual Report 2009 http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 8.
[266] FVDRC Annual Report 2009 http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 8.
[267] FVDRC Annual Report 2009 http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 8.
[268] FVDRC Terms of Reference, Section 6.
[269] FVDRC Terms of Reference, Section 7.6.
[270] FVDRC Terms of Reference, Section 4.1.
[271] FVDRC Terms of Reference, Section 10.1.
[272] FVDRC Terms of Reference, Section 4.1.

family violence and morbidity and advising on any matters related to family deaths that the Minister for Health specifies.[273]

Committee Composition and Operation

The Committee is composed of a maximum of 8 members appointed by the Minister for Health, all of whom will have knowledge or expertise in the area of family violence.[274] The FVDRC's Terms of Reference list various areas in which the Committee members may have expertise – mortality review systems; social science and health research; social work or family violence case work; child abuse and protection; as health practitioners or as clinical psychologists; as lawyers with family violence law expertise; from a service user/ family perspective; as a Māori or other ethnic group member with knowledge of family violence issues or experience in working with such families affected by violence.[275]

Committee members are appointed for a term of up to three years and will be staggered, as with the CYMRC, to ensure continuity of membership.[276] There is a strong emphasis on members of the Committee being appointed as independent persons with a responsibility to mortality reviewing as a whole, rather than as representatives of professional organisations or particular Community bodies.[277] In the case of a conflict of interest, the Terms of Reference oblige Committee members to declare it and to withdraw from relevant discussion and activity.[278]

The Terms of Reference also makes provision for the Committee to be assisted by six Government advisors, who are not members of the Committee but will make available to it relevant information expertise and advice, and are drawn from the Chief Coroner's Office, the Ministry of Health, the Ministry of Social Development, the Ministry of Justice, the New Zealand Police, and the Office of the Children's Commissioner.[279]

[273] FVDRC Terms of Reference, Section 3.
[274] FVDRC Terms of Reference, Sections 12 and 13.
[275] FVDRC Terms of Reference, Sections 14.1 – 14.10.
[276] FVDRC Terms of Reference, Section 18.
[277] FVDRC Terms of Reference, Section 32.
[278] FVDRC Terms of Reference, Section 34.
[279] FVDRC Terms of Reference, Section 15.

The Committee meets approximately five times per year, either face to face or by teleconference.[280] The Committee and Terms of Reference will be reviewed three years from the date of establishment, with the aim being to ensure alignment between principles, purpose and processes of the Committee and to identify potential improvements.[281]

Confidentiality

Regarding confidentiality, the same broad privileges apply to the FVDRC as to the CYMRC, in accordance with section 18 and schedule 5 of the 2000 Act as discussed above under the heading of the CYMRC.[282]

Information Gathering

Establishment of working information systems is once again regarded as key. The FVDRC Annual Report 2009 lists this as one of its key recommendations to the Minister for Health.[283]

In its first annual report, the Committee reported on its first set of pilot reviews. Information gathering proved particularly problematic, taking longer than first indicated and 'involving several rounds of requests for information'.[284] Three months was the estimated time that it would take to gather necessary information for a review to take place.

On the basis of their pilot reviews, the Committee outlined the data collection steps as follows:

- The New Zealand Police notify the Committee of a family violence death
- The lead co-ordinator identifies all relevant agencies/ organisations that may hold information on the death and requests information
- Committee member is identified to attend each local review
- Agencies/organisations forward information to the lead co-ordinator
- A standard local review group identifies additional members for the local review group

[280] http://www.fvdrc.health.govt.nz/moh.nsf/indexcm/fvdrc-aboutus-meetings?Open&m_id=2.4.
[281] FVDRC Terms of Reference, Section 52.
[282] FVDRC Terms of Reference, Sections 35 and 36.
[283] FVDRC Annual Report 09 - http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 6
[284] FVDRC Annual Report 2009 http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p 12

- The lead co-ordinator invites local agencies and individuals to make a presentation to the review group
- The lead co-ordinator facilitates family violence death review meetings at the local level
- Local findings and recommendations are fed back to the Committee by the lead co-ordinator
- The Committee makes recommendations for system, policy and practice improvements to reduce and prevent family violence deaths

Reporting and Recommendations

The Committee is required to report to the Minister for Health annually, or as required by him/her. This report will then be tabled in the House of Representatives in accordance with section 18 (4) of the 2000 Act.[285] The Annual Report will contain the recommendations of the Committee.

Initial Goals

Very clear goals are outlined for the Committee's first year of operation. The vast importance of inter-agency communication and relationship is once again strongly recognised in these goals.

These include: development of mechanisms and protocols for family violence death reviews; determination of the availability, reliability and validity of existing data collection processes and what additional data could be collected; establishing functional relationships with various bodies including the National Health Epidemiology and Quality Assurance Advisory Committee, the CYMRC, local non-statutory mortality review committees, other agencies who conduct family violence mortality reviews and other key stakeholders in the family violence sector; establishing processes to ensure confidentiality; determining how to operate in a culturally sensitive, appropriate and responsive manner, and establishing processes to ensure Committee members will be well supported with regard to the potentially distressing nature of some of the material to be considered.[286]

[285] FVDRC Terms of Reference, Section 44.2.
[286] FVDRC Terms of Reference, Sections 51.1 – 51.8.

The Committee sets annual goals for its development, building on the foundation of what has been achieved in the past year.[287]

OFFICE OF THE CHILDREN'S COMMISSIONER

Overview

The OCC has powers of investigation pursuant to the Children's Commissioner Act 2003, under which it may investigate the deaths of children. It is relevant in the context of children in the care of the State as the Office of the Children's Commissioner is the body with responsibility for overseeing the work of the Department of Child, Youth and Family, who are primarily responsible for children in the care of the State. Two high profile reports have been carried out into the deaths of three such children – James Whakaruru in 2000 and Saliel and Olympia Aplin in 2003. It is quite a rare occurrence for the OCC to commission a report into the death of a child. None has been undertaken since the Aplin report.[288]

Section 12 (1)(a) of the 2003 Act states that one of the functions of the Children's Commissioner is "to investigate any decision or recommendation made, or any act done or omitted… in respect of any child in that child's personal capacity". Under section 12 (2), the Commissioner is required to act independently in exercising his statutory powers.

Remit

Under Sections 13 (1)(b) and (c) of the Children's Commissioner Act 2003, the Commissioner is required to monitor and assess the policies and practices of the Child, Youth and Family Department, which deals with children in the care of the State, as well as those of any other person, body, or organization that relate to the performance or exercise by the person, body, or organization of a function, duty or power under the Children, Young Persons, and Their Families Act 1989, and to encourage the development, within the department, of policies and services that are designed to promote the welfare of children and young persons. Under the 2003 Act, a

[287] FVDRC Annual Report 09 - http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf at p. 5.

[288] Email correspondence with Ms. Nic Johnstone, Senior Adviser, Office of the Children's Commissioner of New Zealand, 2nd June 2010.

child refers to a boy or girl under the age of fourteen.[289] The OCC will also base their investigations on the United Nations Convention on the Rights of the Child.[290]

On the basis of these provisions, the OCC may choose to review the deaths of children from time to time, but it is not obliged to do so. Cases are chosen for investigation at the discretion of the Commissioner, and there is no legislative or policy criteria by which this happens, but rather they tend to be chosen due to identified systemic gaps when looking at the lives of children and especially in the circumstances leading up to their deaths. Both the Whakaruru and Aplin cases identified gaps in communication and information-sharing between the various services involved with the families. In the Whakaruru case, there was a specific focus on the response of the Health System, whereas family violence and the role of the police and CYF were of interest in the Aplin case.[291]

Approach to Reviewing

When the OCC conducts a child death review, it is conducted by members of their office. In terms of death reviewing, the role of the Commissioner focuses on the actions and response of relevant agencies, rather than on revisiting trials of those who may have been convicted.[292] The purpose of an OCC review is not to assign blame to any agency or individual, but rather to determine how deaths can be prevented in future.[293]

Their approach in reviewing is to interview and request information from relevant agencies and professionals, to look at social issues which impacted on the children's' lives (including the role of the extended family, Government response to family violence, and community response to family violence), and to make recommendations as to future actions which could be taken by the agencies which had been involved to prevent deaths occurring in similar situations in future.[294] These recommendations will tend to be very detailed and focused. In the Aplin report,

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[289] Children's Commissioner Act 2003, Section 13(2) in accordance with Section 2(1) of the Children, Young Persons, and Their Families Act 1989.
[290] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 2 at http://www.occ.org.nz/__data/assets/pdf_file/0013/3307/OCC_Saliel_and_Olympia_Aplin_Invesitgation.pdf.
[291] Email correspondence with Ms. Nic Johnstone, Senior Adviser, Office of the Children's Commissioner of New Zealand, 2nd June 2010.
[292] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 17.
[293] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 3.
[294] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 3.

the OCC directed recommendations to the Minister of Social Development, the Chief Executive of the Department of Child, Youth and Family Services, the Commissioner for Police, the Director-General of Health, the Secretary of Education and various media regulating bodies.[295] The reports will typically focus in much depth on the responses of the Department of Child, Youth and Family Services, the New Zealand Police and the Education Sector. There are no specific guidelines by which cases are reviewed.[296]

Standard Review

The report into the Aplin sisters' deaths outlines Terms of Reference apparently standard to an OCC report.[297] The overall objective is stated as 'determining whether the agencies and schools involved with the relevant children responded appropriately to their circumstances'.

The review included an analysis of the Department of Child, Youth and Family's involvement and their response, of the schools involved, of any other agency or professional involvement with the family and of family dynamics which contributed to creating an unsafe environment for the children, and the extent to which social workers and other professionals were aware of and responded to these dynamics.[298]

The findings in the Aplin case reveal some foundational failings, a commonly reported failing encountered with child death reviewing. First, it was reported that "many opportunities for appropriate interventions were lost because no single agency had the whole picture or a complete understanding of the risks present" in the relevant children's' lives.[299] Inter-agency information appears to be crucial in both the death review process and in terms of protecting children prior to death occurring. A lack of proper documentation by social workers also proved a source of difficulty for the investigation.[300] The investigation concluded that agencies and the community failed to adequately recognise the risks that family violence places on children.[301]

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[295] See 'OCC Saliel and Olympia Aplin Investigation Report' pp. 53 – 56.
[296] Email correspondence with Ms. Nic Johnstone, Senior Adviser, Office of the Children's Commissioner of New Zealand, 2nd June 2010.
[297] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 63.
[298] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 63.
[299] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 1.
[300] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 3.
[301] See 'OCC Saliel and Olympia Aplin Investigation Report' p. 5

As part of its monitoring of CYF in accordance with Section 13 of the Children's Commissioner Act 2003, the Chief Executive of CYF is required to advise the Commissioner of deaths of those children and young people known to the service within a year of their death. CYF may conduct their own death reviews and if they do copies of these reports are provided to the OCC. The Children's Commissioner can raise concerns about a case that falls outside the regular parameters for CYF review and may request that the Chief Executive of CYF seek a review by the Chief Social Worker. Following the receipt of such reports, the OCC sometimes makes further enquiries. If a report indicates systemic practice issues, this information will be kept on record as part of information gathering for some of the other monitoring duties undertaken by the OCC, such as visiting CYF offices around the country.[302]

CHILD YOUTH AND FAMILY (CYF)

As noted above, the CYF falls within the umbrella of the Office of the Children's Commissioner. The CYF have the main responsibility for children in care in New Zealand. They occasionally carry out reviews of children who die in care, but are not obliged to do so in every circumstance. The manner in which such a review is undertaken is much less structured than in the case of the CYMRC or FVDRC, and reviews are carried out internally. There is little information available publicly regarding CYF's death review procedure, and the following information has been gathered through email correspondence with members of CYF staff.[303]

There is nothing in legislation that requires CYF to carry out a review following a child's death, but there is an understanding with the OCC to undertake reviews in certain circumstances – where a child is considered 'known to' CYF.

A child is considered known to CYF if they have had involvement with them in the 12 months prior to their death – specifically if there is a current investigation/ assessment or a current intervention with them. Some children for whom, for example, one notification has been received and no action has been taken, will not necessarily have a review of their death undertaken, and it will depend on the cause of death.

[302] See generally email correspondence with Ms. Nic Johnstone, Senior Adviser, Office of the Children's Commissioner of New Zealand, 2nd June 2010.
[303] See generally email correspondence with Ms. Kelly Anderson, CYF Department, 13th June 2010.

Where the cause of death is either suicide or homicide the CYF undertake a review as standard. There is, however, another category of deaths where reviews may be undertaken, which is 'where the Chief Executive determines there is a need for a review to be undertaken'. This may be in the case of serious neglect where CYF were involved. The OCC can also request that CYF undertake a review in exceptional circumstances.

Two levels of review will be undertaken. On the first, a data and file analysis will be conducted, when the death is not an abuse death and the nature of CYF's involvement does not warrant a further review. On the second level, a full review will take place involving interviews with CYF staff, management and other professionals in the community and family members. This type of review is typically the higher profile child homicide cases, or suicide cases where CYF practice appears to be significantly lacking.

Reviews are carried out by advisors in the Office of the Chief Social Worker. They are lead by CYF and are signed off by the Chief Social Worker. The reports are seldom made public for confidentiality reasons.

SUMMARY OF INTERNATIONAL MODELS

Below is a general overview of the approaches of different mechanisms to the areas outlined at the beginning of this chapter.

- **Should there be an individual case review or an approach which examines broader trends at a demographic level?**

In most cases, both individual cases and broader trends at a demographic level are assessed, and both feed into each other. One approach has been for local review groups to conduct individual child death reviews and to send their findings to a national death review team, who collate and examine data at a broader level. Most mechanisms seem to regard the assessment of broader trends as essential to develop strategies to reduce preventable deaths.

- **What ages should the mechanism cover?**

As is seen above, the age for a reviewable death can range from birth to 24 years. The most typical age range is from birth to 18 years.

- **Should all deaths be investigated, or only those resulting from abuse, neglect, or other child protection concerns? Should there be flexibility about selecting certain cases for more in-depth review?**

At this point in time, most Western regions have developed a child death review mechanism through which all deaths are screened. In most cases, there is flexibility as to whether an in-depth review or merely a brief review of the file should take place, depending on whether or not the death was expected, and the severity of circumstances surrounding it.

Many mechanisms allow the flexibility for sub-committees to be formed to look specifically at certain categories of deaths which it is believed a special focus on is required at a particular point in time.

- **Is it worth having an independent child death review mechanism, if there are already review processes examining specific groups of children?**

Most regions have answered this question in the affirmative. The rationale for doing so lies in the need for accountability to the public, and for independence of the review mechanism for an unbiased review to take place.

- **Should the review mechanism be in a position to examine serious incidents which do not end in death?**

In the majority of well-developed death review mechanisms, only deaths are reviewed, and the issue of examining serious incidents is left to other bodies. Some exceptions to this are found in the UK and British Columbia, where the rationale behind reviewing serious incidents as well as deaths is that it will enhance the chances of reducing preventable deaths.

- **What should the composition of the review mechanism team be?**

Again this question has been answered in different ways, all of which are detailed earlier in this chapter. In general, the team members will be a range of professionals involved in working with children in various capacities, and will often include a Chief of Police and a representative of the Attorney General's office or equivalent.

- **Should it be a standing body or an ad-hoc group?**

In most cases, a standing body has been created. The rationale behind this appears to be that experience with death reviewing will enable more efficient reviewing of deaths and assist in gaining a picture of a trend in child deaths.

An alternative approach has been for Departments responsible for the review of child deaths to conduct their own internal reviews without creating a group at all.

The approach of a standing child death review group appears to be the best structured and most sustainable.

- **How do you guarantee independence of the mechanism, and at the same time maintain links with state agencies and service providers?**

One way in which this question has been specifically addressed has been to require all team members to sign an agreement prior to their starting with the team, acknowledging that should

they find themselves in a position where a conflict of interest arises, they will immediately remove themselves from relevant situations.[304]

Many mechanisms have been developed as independent statutory bodies, whose members are not drawn from State departments.

- **What should the remit of the child death review body be?**

This question has been answered in different ways by different regions. Most bodies now review the deaths of all who fall within the 0 – 18 age category with the option to focus in more depth on some cases than on others. Some focus solely on those children who received care from Child Protection services in the months prior to their death.

It has also been seen as vital that child death review mechanisms are never involved in determinations of culpability, but rather focus on prevention of deaths in future, and development of strategies to do so.

- **Would the body have the power to compel information?**

Many review mechanisms have statutorily enshrined powers to compel information from those from whom it is required, and this would seem to be the only manner by which to guarantee availability of necessary information. In practice, some mechanisms have found that at the time shortly following their creation many agencies are reluctant to divulge information to them. It has been found to be most successful to work alongside the agencies to develop trust rather than compelling information from the outset.

- **What level of confidentiality should be guaranteed to those providing information?**

Most review processes insist that before a report is made public, the information must be made unidentifiable of any individual.

[304] See the approach of the CYMRC and FVDRC in New Zealand.

- **How would a child death review team interact with other agencies investigating particular aspects of a child's death?**

Inter-agency information sharing has been consistently acknowledged as one of the great obstacles to successful death review structures. One means of encouraging information sharing has been to invite relevant agencies to a local death review meeting where information can be shared. Another has been to assign a designated person to each case, whose responsibility it is to contact all agencies involved to request information from them.

- **What principles should underpin the involvement of family members in the process of child death review?**

It is widely agreed that the involvement of family members in the death review process is vital, and that most families are eager to contribute. The UK system appears to have looked most thoroughly at how the death review process should be explained to family members, and how family members should be dealt with during the review process. It appears standard that family members do not take part in the actual death review meetings, but contribute information through a designated person.

- **Where should recommendations made by the child death review body be sent? How should implementation be monitored?**

Again, responses to this have varied. Recommendations will generally be published in annual reports, and sent to relevant government and non-government agencies, and to the most relevant government Minister.

Often implementation is monitored by a board which oversees the child death review mechanism (see for example the system in the UK). In other cases implementation is tracked by the child death review team themselves, who follow up the agencies involved, and publish progress, or lack of it, on implementation of the recommendations in their annual reports.

- **What sort of dataset should be sought? (e.g. social circumstances, previous medical history etc)**

Again, the approach to this area varies from mechanism to mechanism but data that appears to be universally acknowledged as fundamental includes: a child's age, the classification of their

death, risk factors of deaths and whether or not there had been previous involvement with Child Protection services.

- **What should the sources of that information be?**

The role of the Coroner in relation to the child death review mechanism has been widely acknowledged as vital. In many cases, it is the responsibility of the Coroner to provide notification of death to the child death review team. Births, Marriages and Deaths departments also play an important role.

Agencies who have worked with the child and schools which the child has attended are also seen as key, as well as input from the members of the families of the deceased child.

- **How accessible is that information? If there are gaps in it, how should they be addressed?**

Many mechanisms are structured in such a way as to place a legislative obligation on relevant parties to provide a report to the child death review team on the death of the child and their involvement with them. Other mechanisms have developed specific forms to be sent to agencies and families on the commencement of a child death review or investigation. A key element in the success of information gathering appears to be having an individual designated to collect all relevant information regarding a particular case.

5.2.1 Health (Amendment) Act 2010

When the Review Group was initially set up, the HSE expressed concern that it did not have the authority to pass the relevant files to the ICDRG. It stated that as the files contained information relating to Court proceedings which were held *in camera*, such files could not legally be disclosed. While this interpretation of the *in camera* rule is a matter of continued debate, the Oireachtas intervened and passed the Health (Amendment) Act 2010. This Act amended the Health Act 2004 and provides that the HSE shall furnish information to the Minister for Health which the Minister is likely to consider significant for the performance of his or her functions or any information of public interest or concern that has been specified in writing by the Minister. Essentially this creates an ongoing obligation on the HSE to furnish such information to the Minister. Furthermore, the Act provides that the Minister may require that the HSE furnish information or documents where he or she considers it necessary in the public interest. The HSE is entitled and obliged to furnish this information whether or not it has the consent of any person to furnish this information and regardless of the rules of non-disclosure, confidentiality and the *in camera* rule.

The 2010 Act also allows the Minister to pass this information/documentation to any person that the Minister has appointed to examine or inquire into any matter. Again, the passing of this information/documentation by the Minister is not bound by the rules of consent, non-disclosure, confidentiality or the *in camera* rule. This section obviously allowed the Minister to pass the files to be reviewed to the ICDRG.

Interestingly, section 40E allows the Minister to use the information and documentation in the performance of her functions but does not permit publication of the information or documentation if it would not otherwise be lawful, i.e. there is no saver in respect of the rules of consent, non-disclosure, confidentiality or the *in camera* rule.

In light of the difficulties which the Review Group experienced in accessing the files to be reviewed, it is important to consider the rules in existence which the HSE cited for withholding

the files and whether or not these rules need to be amended in light of the recommendations made in this Report.

5.2.2 The *In Camera* Rule

It is stated in Article 34 of Bunreacht na hÉireann that justice shall be administered in public save in special and limited cases as may be prescribed by law. It is commonly said that justice must not only be done, it must also be seen to be done and while Article 34 upholds the general rule of public justice, it also allows for exceptions to be created to this rule. These exceptions will arise where the interests in protecting the privacy of the parties involved in a dispute override the general interest in public justice. The *in camera* rule operates to prevent the general public and the media from being present in the court when certain proceedings are ongoing.

One particular area where these interests in privacy are protected from public scrutiny is in the child care area and the family law area in general.

Statutory Provisions

Section 45(1) of the Courts (Supplemental Provisions) Act 1961 states that in cases of *inter alia* "matrimonial causes or matters" and "minor matters", justice may be administered otherwise than in public. This provision does not impose a requirement of a private hearing; it merely gives discretion to the judge in question. "Otherwise than in public" does not necessarily imply a prohibition on the publication of the judgment and such information as is necessary to explain it. Section 34 of the Judicial Separation and Family Law Reform Act 1989 and section 38(5) of the Family Law (Divorce) Act 1996 go somewhat further by stating that proceedings under those Acts shall be heard otherwise than in public. These provisions remove the discretion of the judge.

It is clearly very important for the protection of minors' interests that their anonymity be maintained. This should be approached on two fronts; first, statutory provisions, similar to those outlined above must provide for hearings involving minors to be held otherwise than in public; secondly, there needs to be effective penalties for those who breach the rules on anonymity. It should be pointed out however that the existence of rules which protect the anonymity of

minors and their families should not be taken to mean that the operation and actions of the court in relation to such matters should be secret. By allowing a veil of secrecy to cover the work of the court in these types of issues, public confidence in the system is damaged and it prevents the recognition of good work and, in equal measures, the recognition of areas in need of reform.

This secrecy surrounding the courts operation in such matters has been ameliorated somewhat by the introduction of section 40 of the Civil Liability and Courts Act 2004. While this provision does not allow full range of access to the media, it gives access to a limited range of parties such as *bona fide* researchers and persons appointed by the Courts Service. The persons allowed to access the family courts can publish reports on the proceeding so long as the anonymity of the parties is maintained. The pioneering work of Dr Carol Coulter in reporting on family law matters provides an excellent template as to how to balance the right to privacy with the right to a fair, transparent and accountable system of justice.

The introduction of section 40 of the 2004 Act has been criticised as not going far enough. Other proceedings, such as a prosecution for rape (which is arguably more traumatic and personal), can be viewed by "officers of the court, persons directly concerned in the proceedings, *bona fide* representatives of the press and any such persons (if any) as the judge... may in his...discretion permit to remain." This provision has operated very successfully and consideration should be given to the extension of this system to child care cases.

The Group notes, with approval, the recent decision of Mr. Justice Birmingham in the case of *Health Service Executive v. McAnaspie*. This case centred on the disclosure of the guardian ad litem reports concerning a child who died whilst in the care of the HSE, and the restrictions, if any, on the disclosure of such reports and reporting thereof. Nine questions in all were referred by the District Court to the High Court by way of consultative case stated. In a comprehensive and analytical judgment Birmingham J. ruled that for the purposes of the Child Care Act 1991 a child who has died whilst in the care of the HSE no longer falls within the definition of "child" under the Child Care Act 1991. However, following the death of a child in the care of the HSE another person may bring an application seeking relief under the Child Care Act 1991, and the court may, if it sees fit, order the release of documents or information prepared for the purposes of proceedings under Parts III, IV or V of the Child Care Act 1991.

The position in Irish law in respect of the *in camera* rule now appears to be that there is no absolute prohibition on the release of information in respect of proceedings heard otherwise than in public, but that in considering whether to lift the *in camera* rule the court should give due and proper weight to both the interests of the administration of justice and the interests of those persons who may be specifically affected by such a decision. To hold otherwise may in fact render such a legislative provision incompatible with the European Convention on Human Rights. As stated by Birmingham J. at paragraph 36 of his judgment:

> *"A total prohibition on access by family members to material generated during proceedings heard in camera sits ill with the State's procedural or investigative duty."*

Although a child that has died whilst in the care of the HSE is no longer deemed to be a child for the purposes of the Child Care Act 1991, the courts still have a function which includes disclosing information pertaining to that child.

The *In Camera* Rule in Europe

The *in camera* rule has various incarnations across Europe. In Denmark, Portugal and Spain family proceedings take place *in camera*. While family proceedings in Belgium are not held in private, there is a prohibition on publicity while the case is ongoing. In both France and Scotland, discretion exists as to the hearing of such matters. In France the judge can exclude any or all members of the public where their presence would affect the privacy of the parties or disrupt the judicial atmosphere or where the parties request a private hearing. In Italy, the initial hearing of a contentious divorce case will be heard *in camera* however subsequent hearings will be held in public.

It should be noted that while the above restrictions exist to protect the anonymity and privacy of the parties to these types of hearings, the judgment itself will be made public in most European countries.

The *In Camera* Rule Internationally

The law on this area has changed over the past 30 - 40 years in Australia. Initially when the Family Court of Australia was established by the Family Law Act 1975, it was a closed court. The Family Law Act 1975 was amended subsequently to allow for public hearings of matters in the Family Court. Currently, there is provision for proceedings concerning children to be held in

Chambers however the general practice is for open hearings with no restrictions on members of the general public or press attending. Indeed, section 121 of the Family Law Act 1975 as amended expressly allows for publication of the proceedings by newspaper, radio and/or television with the only limitation being that the parties, their relations or witnesses must have their identity protected.

In Canada, the Law Reform Commission has recommended that in family law proceedings, the identities of the parties should remain anonymous but the media should be permitted to attend and report on any family law proceedings.

Reform of the *In Camera* Rule in England and Wales

In 2005, a Constitutional Affairs Committee in England recommended that the Family Court system be reformed to make it more transparent. It suggested that the rules that persisted in the court system were too restrictive. The Report suggested allowing the media into the family courts subject to certain restrictions and the discretion of the judge to exclude the media in appropriate situations. This Report was followed by a number of others which recognised the need for reform of the system.

In 2007, the Government published a paper which contained proposals for allowing the media to attend family proceedings. These proposals were brought into force under the Family Proceedings Courts (Miscellaneous Amendments) Rules 2009 and the Family Proceedings (Amendment) (No. 2) Rules.

The new rules allow for members of the media to attend family cases in all courts. Some discretion remains with the judge however and he/she is entitled to exclude the media in certain circumstances. Certain parties can also apply to the court to have the media and/or others excluded from the proceedings. Where children are involved in the proceedings, there is a prohibition on the media identifying them and publicising the proceedings themselves. However, there have been some instances where the parents seek to have information enter the public domain and this has been permitted. The main issue is that there is a broad consensus that the total closure of the family courts, and in particular courts dealing with child welfare matters, is unjustifiable and that the public interest is best served by transparency.

The new rules have proved difficult to implement for both the judiciary and the media, and there have been a number of discussions between their representatives, culminating in an agreed protocol for the reporting of both private family law proceedings and public child care proceedings. The latter have been the main focus of attention, as successive judgments of the higher courts of England and Wales have stressed the importance of accountability in the child welfare system.

The *In Camera* Rule and the European Convention on Human Rights (ECHR)

Under Article 6 of the ECHR the right to a fair trial is guaranteed. One aspect of this right is the hearing of the case in public. While there are limitations on the right of a person to have their case heard in public, the Court is generally slow to interfere with this element of the right.

In *Werner v Austria* the Court emphasised the importance of public hearings for the protection of the right arising under Article 6. The Court held that where there was no judicial decision pronounced publicly and that publicity was not sufficiently ensured by other means, a breach of Article 6 would occur. This case allows for the situation which prevails in Ireland where the proceedings dealing with minors/family are dealt with in private but the judicial decision is made public. A similar approach to that in *Werner* was followed in *B. v United Kingdom*.

Conclusion

The operation of the *in camera* rule in Ireland is currently very restrictive. While the rationale for its presence is the protection of minors and families in sensitive legal situations, it is clear from other jurisdictions that such interests can still be protected while allowing for greater transparency in such proceedings. The maintenance of a shroud of secrecy around child care cases does not necessarily mean that the interests of minors are always protected as well as they can be as practices which may need overhauling are shielded from scrutiny. A complete review of the operation of this rule in child care cases is now necessary. This matter should be given priority to ensure confidence is maintained in the child protection system.

5.2.3 Data Protection

The Data Protection Acts 1988 - 2003 contain rules relating to the protection of personal data. "Personal data" is defined in section 1 of the Data Protection Act 1988 as amended by the Data Protection Act 2003 as data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is, or is likely to come into, the possession of the data controller. "Sensitive personal data" is defined as personal data as to:

- the racial or ethnic origin, the political opinions or the religious or philosophical beliefs of the data subject
- whether the data subject is a member of a trade union
- the physical or mental health or condition or sexual life of a data subject
- the commission or alleged commission of any offence by the data subject or
- any proceedings for an offence committed or alleged to have been committed by the data subject, the disposal of such proceedings or the sentence of any court in such proceedings

The data subject refers to the individual who is the subject of personal data.

Pursuant to section 2 of the 1988 Act as amended, the data controller must, *inter alia*, take appropriate security measures against unauthorised access, alteration, disclosure or destruction of personal data. Section 2A states that personal data shall not be processed (the definition of which includes disclosure) until section 2 is complied with and one of the conditions within section 2A is met. The conditions under section 2A are:

- The consent of the data subject or person acting on his or her behalf (only in certain circumstances) is obtained
- The processing is necessary for the performance of a contract, to take steps at the request of the data subject prior to entering a contract or for compliance with a legal obligation which the data controller is subject to (other than a contractual obligation)
- To prevent injury or damage to the health of the data subject or serious loss of or damage to the property of the data subject
- The processing is necessary for the administration of justice, for the performance of a legislative function conferred on a person, for the performance of a function of the

Government or a Government Minister or for the performance of any other function of a public nature performed in the public interest by a person or

- The processing is necessary for the legitimate interests pursued by the data controller or a third party to whom the data is disclosed except where the processing is unwarranted in any particular case by reason of prejudice to the fundamental rights and freedoms or legitimate interests of the data subject.

For sensitive data to be legally processed, section 2 must be complied with, one of the conditions within section 2A must be met and, furthermore, at least one of the conditions within section 2B must be met. Such conditions include (but are not limited to) processing with explicit consent, the processing is necessary for the administration of justice or the performance of a function conferred under an enactment.

In relation to reviewing the death of a child or young person, the Data Protection Acts do not cover information regarding the child or young person as he or she is not a living individual. The files could however disclose personal data or sensitive personal data on other family members. In such circumstances it is suggested that the disclosure/processing of such data would fall within a number of the exemptions under sections 2A and 2B.

5.2.4 Recommendations Relating to the *In* Camera Rule and Data Protection

The operation of the *in camera* rule must be reviewed to allow for transparency and accountability in child care cases, in the reporting of child care cases and in the use of information relating to proceedings in child care cases. It is accepted that the rule provides protection for the child; however the identity of a child can be protected while also ensuring that there is oversight of the system - both the court system and the child protection system.

Furthermore, it is essential that agencies under the umbrella of the child protection services can share information relating to vulnerable children and their families. Such free flow of communication is imperative to the proper functioning of the services. It is certainly not clear to the Review Group that the Health (Amendment) Act 2010 was at all necessary. However, given that it is now in existence, it may be necessary to amend it statutorily to allow for the passing of

information between agencies involved in child protection without the intervention of the Minister for Health.

The Child Death Review Unit (CDRU) (as proposed at section 5.4.1 below) must be statutory in its foundation and as part of its statutory foundation it must be given the appropriate powers to compel the production of information and to publish the information.

PART 3: DEATHS OF CHILDREN IN CARE V DEATHS OF CHILDREN IN THE GENERAL POPULATION

The figures below show a comparison between the number of deaths and mortality rate of children in care[305] who have died in the last 10 years compared with the number of deaths and the mortality rate of children[306] in the general population who have died[307] between 2000 and 2009.[308]

Table 1: Age-specific mortality rate for persons aged 0-19, Ireland, 2000-2010

Year	Population aged 0-19 (000s) – CSO population estimates*	Deaths in 0-19 age group - CSO Annual Report on Vital Statistics 2008, Table 3.1	Age-specific mortality rates per 10,000 population aged 0-19	Deaths among children in care– ICDRG report	Mortality rates per 10,000 for children in care
2000	1,157.4	672	5.8	2	4.5
2001	1,148.0	657	5.7	3	5.4
2002	1,140.6	606	5.3	3	6.1
2003	1,139.4	567	5.0	3	6.0
2004	1,142.2	544	4.8	4	7.9
2005	1,146.2	510	4.4	2	3.8
2006	1,155.9	508	4.4	4	7.6
2007	1,169.8	500	4.3	2	3.8
2008	1,196.1	535	4.5	3	5.6
2009	1,216.4			8	14.1
2010	1,232.4			2	3.4

[305] These figures do not contain young persons who died in aftercare or children or young persons who died and were known to the HSE.

[306] The figures are taken from the CSO Births, Death and Marriages Statistics and comprise children and young persons between the ages of 0 and 19. Statistics are available at http://www.cso.ie/statistics/deaths_by_age_sex.htm

[307] The cause of death of these children and young persons is not detailed so it must be assumed that it would include both natural and unnatural deaths.

[308] Up to date figures for 2010 are not yet available.

* See http://www.cso.ie/px/pxeirestat/Statire/SelectVarVal/Define.asp?maintable=PEA11&PLanguage=0 Population estimates for 2007-2010 are preliminary and will be revised following the publication of the Census 2011 results.

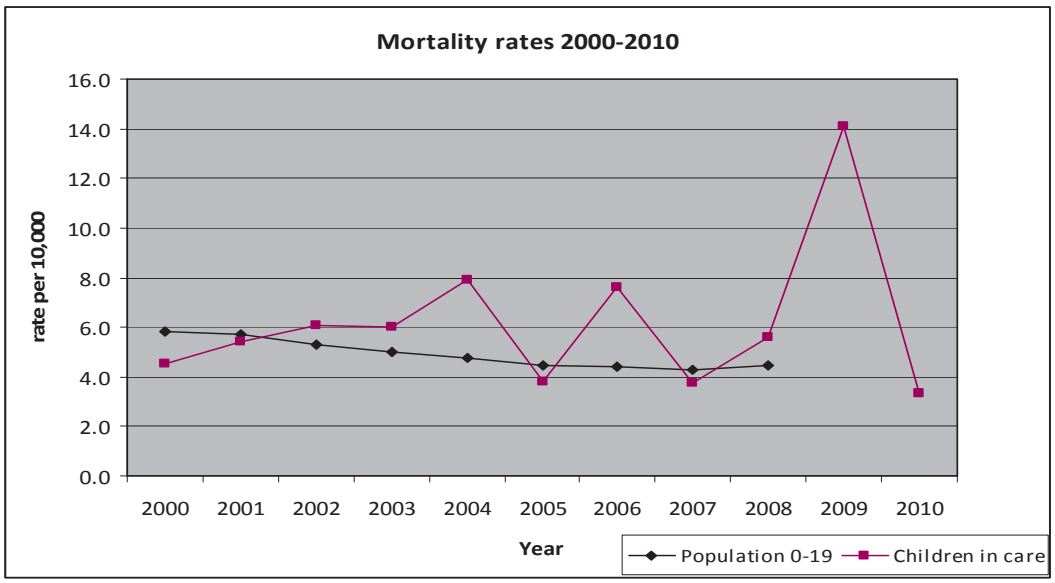
Making National and International Comparisons

In terms of international comparisons, there is much variation in concepts of “in care” across geographic and legal boundaries. Different jurisdictions have different definitions of "in care". Some have national systems while some have State/regional systems. The geographic and demographic areas covered vary greatly as do the rules under which the systems operate. And, as is the case for Ireland, while not seeking to minimise the gravity of the issue of deaths of children in care, in statistical terms the numbers will be small. Therefore any generalisation based on these numbers, or even comparisons with the general population is likely to be unreliable.

Also, with regard to the mortality data, the data for the general population is collected under well-established procedures and internationally agreed methodologies for recording and categorising deaths by cause and calculating relevant rates. This may not necessarily be the case for data on deaths of children in care which further complicates comparisons either between children in care and the general population at national level or among different cohorts internationally.

When mortality rates for the general population and the children in care populations for Ireland are examined graphically, the instability of the latter series becomes more evident (Figure 1).

Figure 1: Mortality rates 2000-2010, General population aged 0-19 and children in care



Of the sources identified internationally, data from the work of the Victorian Child Death Review Committee would appear to most closely mirror the process being undertaken by the the ICDRG. A recent report of that Committee provides time series data for deaths of children known to the child protection system over the period 1996 to 2009, and profiles these children by a number of key characteristics. The report notes *that "VCDRC, after 15 years of monitoring child deaths in the Child Protection population, has not observed any meaningful trends in the numbers of deaths. The child death review process looks beyond numbers and endeavours to build a comprehensive picture of the individual, family, community and service system issues that are relevant in each child's case*. *The significance and interpretation of death rates is impacted by the small volatile numbers from year to year as well as the shift over time in the definition of children known to Child Protection*".

Other International Sources

Data collection and reviews relating to deaths of children (although not necessarily children in care) have been conducted in a number of other jurisdictions. Links are provided below to some relevant sites where information is available in English-speaking jurisdictions. There are difficulties in accessing and assessing the quality of data on deaths of children in care, especially in terms of coverage and definitions used. There are a range of practices in place internationally.

Country/State	**Link to review / report**
Australia	http://www.aifs.gov.au/nch/pubs/sheets/rs4/rs4.pdf
Australia – State of Victoria	http://www.kids.vic.gov.au/downloads/vcdrc/ar_vcdrc_2010.pdf
England	http://www.education.gov.uk/rsgateway/DB/STR/d001015/OSR11_2011.pdf
Scotland	http://www.nspcc.org.uk/Inform/resourcesforprofessionals/looked_after_children_statistics_wda79691.html
USA	http://www.childdeathreview.org/home.htm
European	http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database
International	http://www.who.int/healthinfo/morttables/en/index.html

While the review of files furnished to the ICDRG by the HSE revealed some good work in relation to practice in the area of child welfare and protection the Review Group is very concerned that overall there remains a high level of problems within the child protection system. Along with a lack of adherence to the legislation and regulations currently in place, there is evidence of serious problems with resources, facilities and the general ethos of the care system. There is evidence that vulnerable children are being let down by the very system which is supposed to protect them, ensure their safety and put their needs first. The ICDRG recommends therefore that the following measures be taken:

5.4.1 Creation of a Child Death Review Unit (CDRU)

As noted above, Ireland is trailing behind other jurisdictions in terms of reviewing the deaths of children in care. The jurisdictions discussed above all have one, if not numerous, agencies which have the power to investigate the death of a child in care. The ICDRG believe that reviewing the deaths of children in care should not be a function of the HSE or of the new Child and Family Support Agency. It is essential that the Agency responsible for child protection should not be involved in a review into possible failures by the child protection system. It is therefore recommended that a Unit be established within the new Department of Children which would have responsibility for reviewing the deaths of any children in the care of the HSE.

Remit

It is recommended that that the CDRU would automatically investigate the deaths of children or young people in the care of the HSE (which would comprise of children up to the age of 18) and in the aftercare of the HSE (which would comprise of young persons above the age of 18). The CDRU should also have the power to investigate the deaths of children/young persons who were known to the HSE.

Functions

It is recommended that the CDRU would have the following functions:

- Review the provision of care/aftercare to the child/young person who has died

- Where the child/young person was known to the HSE, review the circumstances in which the child/young person came into contact with the HSE and the interventions provided by the HSE
- Investigate the circumstances of the death of the child/young person
- Make specific recommendations to the Oireachtas/State agencies regarding the death of an individual child/young person
- Report annually to the Oireachtas on the deaths of children/young persons in the care/aftercare of the HSE identifying any trends/patterns relating to the deaths of children/young persons
- Make general recommendations arising from the annual review of the deaths of children/young persons in the care/aftercare of the HSE
- Maintain a register of the deaths of children/young persons in the care/aftercare of the HSE

Composition

This Unit should be a permanent one which is answerable and accountable to the Oireachtas. The Unit should comprise of a Social Worker, a Coroner, a Psychiatrist/Psychologist and a member of the legal profession. The ICDRG do not believe that cases where a child has died of natural causes and where that is certified should be reviewed unless concerns have been expressed surrounding the care of the child/young person prior to his/her death.

Confidentiality

The creation of a Unit of this kind will naturally engender concerns regarding the protection of the anonymity of the children/young persons. It is acknowledged that the protection of the identities of children/young persons who die in the care/aftercare of the HSE is a valid and important concern and measures must be taken to address these concerns. However, in the interests of transparency and accountability it is imperative that all and any reports created by the CDRU are published. Information which might identify the children/young people who are the subjects of the report can be redacted or the report written in such a way as to prevent identification.

Alternatively, the Review Group recommends that consideration be given by the Minister to providing for a Child Death Review Mechanism in the Office of the Ombudsman for Children or as a function to be discharged by the Coroners. Both of these options, with the appropriate legislative framework and resources, could discharge the duties outlined above.

5.4.2 Change of Ethos

An essential change which must occur throughout the child protection system is a change in the culture. Each and every person working within the system must take responsibility for their own role in promoting the welfare of children and in ensuring their protection. It appears to the ICDRG that available resources are not always utilised in an effective manner to promote the welfare of children and young people who come to the attention of the system. There are considerable financial resources invested in these services and it is clear that the public are not getting a proper child protection system at this time. There is a lack of audit of what Social Workers, Psychiatrists and other professionals within the system do, and more so, there is even a lack of basic information regarding the work done. Professional meetings held to discuss and plan a service response for a child/young person appear in many instances not to have a clear focus and often no clear conclusion or plan. The implementation of any plans that are recorded often goes unmonitored.

5.4.3 Risk/Mental Health Assessment

The ICDRG notes that in many of the cases they reviewed the psychological and mental heath needs of children and young people did not appear to form part of the risk assessment, where one had been carried out. When a child/young person is referred to the HSE, an assessment of that child/young person's needs must be carried out. This assessment must include a comprehensive review of the child/young person's physical, psychological and mental health. The purpose of this assessment is to provide a road map for the care of the child/young person and to ensure that there is a plan in place to tackle and resolve any problems that the child/young person may encounter. It is essential that this assessment take place as soon as possible after the child/young person comes into contact with the HSE as an early diagnostic profile is critical to proper planning for the care and/or supervision of the child/young person.

In terms of a risk assessment, it is accepted that there are certain behaviours that are clear and strong indicators that the child/young person may be at risk or vulnerable: Among those are alcohol, drug, and solvent abuse; and fire setting. Escalating patterns of at risk behaviour and poor impulse control should raise a red flag for all professionals involved and should designate the child/young person as being in need of urgent intervention.

5.4.4 Early intervention

Where concerns or referrals are made to the HSE with regard to a child/young person, it is essential that the HSE respond appropriately to such concerns immediately. The vast majority of such reports are likely to be genuine and require to be considered within an agreed national assessment framework.

Such early intervention is necessary to ensure that the safety, protection and well-being of the child/young person are paramount. There were a number of files received by the ICDRG where it was clear that, even after numerous referrals to the HSE, there was no meaningful intervention. It is critical that the system actually intervene on behalf of the child and does not become preoccupied with the problems of the parents to the exclusion of the needs of the child.

Following assessment and where it is clear that there is concern regarding a child in the family, it is crucial that the protection and welfare of any other children in the family are also considered and investigated.

5.4.5 Care Plans

It is essential that a plan is in place with respect to the care being provided to a child/young person by the HSE. The care plan will arise from the Risk Assessment and will ensure that work is carried out proactively in respect of the care of the child/young person in a planned and responsive way rather than as it appears at present where the system reacts to each individual event and new crisis.

5.4.6 Supervision Orders

It was noted by the ICDRG during the Review that the Supervision Order as provided for by Section 19 of the Child Care Act 1991 was not utilised as often as it could be. The Supervision

Order is a very useful tool for the HSE where there are child protection concerns but the investigation of those concerns is at an early stage or the concerns do not warrant the child being taken into the voluntary, emergency, interim or full care of the HSE. It is suggested by the ICDRG that this legislative provision should be considered more proactively in the future. In particular, the Child Care Act 1991 should be amended to permit the granting of a Supervision Order in cases where the threshold for the granting of an Interim Care Order has not been satisfied.

Furthermore, where a Supervision Order is granted, there must be evidence of a clear change in behaviour before it is allowed to lapse and the case is closed. Prematurely closing a case is detrimental to a vulnerable child/young person. The reasons for closing a case must be carefully written up and signed off by a designated manager.

5.4.7 Assigning of Social Workers and Consistency of Social Workers

When a child/young person comes into the care of the HSE, that child/young person must be assigned a specific Social Worker. This assignment is an essential part of the care of the child/ young person as it ensures consistency, the building of a relationship, and responsibility for ensuring that the care provided for the child/young person is appropriate, amongst other key functions.

The constant changing of Social Workers on a given case is a significant problem and was clearly evident on the files reviewed by the ICDRG. It is, however, unclear why there is such a high turnover of Social Workers. Is it due to burn out? Are Social Workers being rotated between centres? Is it because newly qualified Social workers do not receive adequate supervision, support and mentoring? This lack of continuity is a significant issue. Unfortunately it appears to be ongoing and can have devastating effects on children and their families.

5.4.8 Appropriate Placements

The Risk Assessment and resulting care plan must identify appropriate placements which are linked to the needs of the child/young person. This must be also considered in light of the length of time the child or young person is likely to spend there. In a number of cases reviewed by the ICDRG, there was evidence that placements were merely a stop-gap measure and there was little

evidence of long-term or permanency planning for the child/young person. The Care Plan should seek to identify appropriate long-term and permanent placements that offer security to the child/young person. Furthermore, placements for specific groups of vulnerable children/young persons must be considered. For example, suitable emergency accommodation for mothers and children must be provided. Where the child/young person being accommodated has alcohol or substance abuse problems, this has to be considered to ensure that the child/ young person is protected from those risk factors insofar as is possible.

5.4.9 Appropriate Referrals

The HSE must utilise relevant specialist agencies and bodies where the needs of the child/ young person dictate. As such, greater links and improved interagency cooperation need to be in place to ensure that referrals of a child or young person to such an agency or body are timely and effective. This includes targeted family support services, addiction services and the CAMHS service.

5.4.10 Regular Care Reviews

The care plan and the carrying out of the plan must be regularly reviewed to ensure that it is continuing to meet the needs of the child/young person. Where it is not, the care plan must be amended to fit the circumstances and needs of the child/young person.

5.4.11 Professional Supervision and Support

Each Social Worker should be professionally supervised and supported by a Social Work Team Leader. This supervision and support ensures quality of the case work in respect of each child/young person and allows for discussions regarding the options to be pursued. Furthermore, it is essential that there is clarity regarding the areas of responsibility of each staff member and such clarity must come from the top of the organisation.

It is critical that Senior Managers carry out their responsibilities in an active manner and ensure that regulations, protocols and recommendations are implemented throughout the country. Senior Managers must take a *proactive* role here. The files reviewed by the ICDRG show that in many cases management was passive and inactive. Such weak and passive management structures percolate down to those on the front line of child protection work. It can create a lack

of urgency, a sense of helplessness and a lack of a sense of responsibility. It is critical that all disciplines, i.e. Social Work, Child Psychiatry/Psychology, Gardaí, General Practitioners, Hospital Personnel, Paediatricians, Addiction Specialists and Adult Mental Health Practitioners play their part. Communication between all of these groups is absolutely critical and in the current era of instant communication there is no reason for a failure to communicate.

5.4.12 Legislation and Regulations

It was clear from some of the files received by the ICDRG that the provisions laid down in the Child Care Act 1991, the Child Care Regulations and the *Children First Guidelines* were not being adhered to. The purpose of these legislative and policy documents is to ensure a consistent high standard of care for every child/young person and to provide a checklist for the HSE in dealing with such cases. It is essential that the provisions be followed. The revised *Children First Guidance*[309] and the *Child Protection and Welfare Practice Handbook*[310] provide much needed clarity and assistance, but only if they are utilised.

5.4.13 Critical Incident Reports

Where a critical incident occurs while a child/young person is in care, this must be reported and assessed in terms of the needs and issues of the child/young person. This report has to feed into the care plan for the child/young person and any review of care. Nothing predicts like the past; those who are not aware of history are bound to repeat it and there appears to be a failure to learn from past mistakes. Significantly, where there are concerns surrounding one child in a family, it is critical that the safety and welfare of any other children in the family are considered and investigated. It is also essential that systems are in place to ensure that the learning from each report is acted upon and informs the management of other cases.

5.4.14 Record Keeping

There were serious problems evident with record keeping in the files furnished to the ICDRG and significant improvement in this area is required. In December 2009, the Children Acts Advisory

[309] Children First: National Guidance for the Protection and Welfare of Children (2011) available at: http://hse.ie/eng/services/Publications/services/Children/cf2011.pdf

[310] Child Protection and Welfare Practice Handbook (2011), available at: http://www.hse.ie/go/childrenfirst

Board produced a document, Guidelines on Recording in Children's Residential Care.[311] This document provides broad guidelines for recording and maintaining files in relation to children in residential care and it is recommended that these guidelines be expanded to include the recording and maintenance by the HSE of all files on children that are in the care of the HSE or who are known to the HSE. Some files were presented in a very professional manner so it is clear the necessary information on best practice is within the system.

Electronic forms of communication and record-keeping must be looked at. Information can be transmitted through email to all stakeholders and gathered together within the relevant file to ensure that it is legible, safe and appropriately recorded.

At minimum, each file should have a summary section at the front of the file, containing basic demographic data, the legal status of the child/young person, a list of risk factors and plans in place to assist in mitigating those risks and finally, where appropriate, a note of any medication being taken. The file should be presented in further sections (there is evidence of this good practice in some HSE areas) that make it easy to access key information. It is recommended that every member of the family involved with the Social Services have their own individual file. The lack of an individual file can lead to confusion between the various members of a family and can result in children getting lost and/or forgotten. On a practical level, each individual file could be contained in a ring folder which could house all of the family files.

5.4.15 Information Management System

A system for managing information in relation to each child/young person who comes into contact with the HSE must be created. The need for this system was highlighted by the poor state of the files received by the ICDRG. This system should be accessible by the Social Work team and any other specialist agencies who are involved in the particular case. It should ensure that families moving accommodation can be tracked where there are ongoing child welfare and protection concerns.

[311] Guidelines on Recording in Children's Residential Care (2009), available at: http://www.caab.ie/getdoc/3184eb9e-03bd-4c4e-8b56-0a5600d73457/Guidelines-Recording-Child-Res-Care.aspx

5.4.16 Drug and Alcohol Abuse

In a significant number of cases, it was evident that drug and/or alcohol abuse by parents was having a very damaging effect on their ability to consistently parent their child. Indeed, in some cases, drug and/or alcohol abuse was the key factor in the child/young person being referred to the HSE or being taken into care. This is a problem which has to be tackled. When a Social Worker comes into contact with a family where drug/alcohol abuse is significantly disrupting familial life, it is essential that such abuse is addressed in a robust manner. The effect on the children has to be recognised and the parents must be made aware of the support and treatment options that are available. Parents must be encouraged and enabled to take up those supports.

Furthermore, drug and alcohol services must be actively integrated into the child protection system. These services have the capacity to alert Social Workers to potentially devastating events happening between parents with drug and/or alcohol problems and their children often before the children are ever referred to the HSE. There must be open channels of communication between drug and alcohol services and the child protection system so that where these services become aware of child protection concerns, this information is quickly conveyed to the child protection system. The planning around these children and families must actively engage each part of the system.

5.4.17 Mental Health Issues

A common problem which emerged from the review of files received by the ICDRG was the difficulties facing children/young persons who were experiencing psychological or mental health difficulties or indeed children/young persons whose parents were experiencing mental health difficulties. In many cases where mental health difficulties were evident, Adult Psychiatry and Child Psychiatry services were simply not involved or the nature of their involvement was not known to the Child Protection system because of reluctance to share appropriate information or expertise.

Families which are experiencing such difficulties are often referred to as dysfunctional. However, it may simply be that one member of the family, either a child or parent, requires targeted support and/or treatment by the mental health services. There are a number of recommendations which flow from this:

- While it is clear from this Report that the HSE has clearly failed many of the children/young people referred to, there are specific failures which have arisen in relation to the mental health services. It is important that this Report be actioned not only by the Minister for Children and Youth Affairs, Ms. Frances Fitzgerald, T.D., but also the Minister of State with responsibility for mental health, Ms. Kathleen Lynch, T.D.
- It is important and essential to integrate the CAMHS service with child welfare and protection work in the community. There is a need for all those working in child welfare and protection to be aware of and trained in the recognition of mental health problems. There is also a need to utilise appropriate professional psychological and psychiatric support where warranted. From many of the files reviewed there would appear to be an inability to recognise emerging mental health issues. Warning signs were not treated with sufficient seriousness. Indeed, it would appear from these files that that child psychiatry professionals seem to be involved with the less severe cases while inexperienced social workers are working unsupported with the most serious cases. The most complex and disturbed families/parents/children are not being dealt with by appropriately qualified professionals. Furthermore, it is unfair to allow a newly qualified Social Worker or indeed any other newly qualified professional to bear the responsibility for very complex cases.
- It is recommended that a clear link between the adult and child psychiatric services is created. Such a link would be beneficial where, for example, a parent was experiencing mental health difficulties that were impacting on the mental wellbeing of the child. In many of the files received by the ICDRG where these issues arose, the deference in the Constitution to parental rights seriously impeded the State in intervening. Intervention, when it arrived, was too late to vindicate the right of the child to have his or her welfare secured.
- This Report and its recommendations should be considered and reviewed by the Royal College of Psychiatrists with a view to providing advice to its members.

5.4.18 Working Group on the Needs of Disturbed Children

It was evident from the files reviewed by the ICDRG that the HSE and its agencies were and are unable to cope in a proactive way with the needs of disturbed children and young persons. These children/young persons are those with extreme behavioural problems and heightened vulnerability. Many of them are moving between the care system and the justice system. There is evidence that existing child protection systems are not equipped to provide the support and care which these children/young persons require. While interventions were made, outcomes were not identified and/or met. It is recommended that a working group be set up to consider how the needs of such children/young persons can be met. The working group might usefully consider any legislative or administrative change necessary to ensure the resources in each area are effectively harnessed to meet the needs of these young people. The working group should report to the Minister for Children and Youth Affairs.

5.4.19 Foster Family Support

Where a child/young person is placed with a foster family, consistent and on-going support must be provided to the foster carers to ensure that the placement, if it is working, continues. In some cases reviewed, children in foster families were not regularly visited by Social Workers and the emergence of placement difficulties was not responded to in a timely manner.

5.4.20 Interagency Communication and Cooperation

As noted above, the HSE must ensure that the appropriate specialist bodies or agencies are utilised to address the needs of the child/young person in care. Community Care Social Workers, General Practitioners, Adult and Child Psychiatrists, Public Health Nurses, Hospital Care Staff and Gardaí must work as a unit. It is essential that channels of communication are open between the various agencies that work with children and young people in care. As noted above, the existence of text messages, emails, conference calls etc., means that communicating with colleagues in other agencies is not difficult. Confidentiality of child and family information will require to be observed.

There must also be protocols in place to deal with interagency cooperation to ensure that the appropriate care is provided to the child/young person. This is particularly pertinent where a family or child/young person moves between HSE areas. It was clear from the files reviewed that any protocols which are in place to deal with the transfer of information regarding a vulnerable

family or child between HSE areas were not necessarily adhered to. These must be put in place to ensure that these families or children do not slip through the net and get lost.

Specific reference was made above to the needs of those with mental health difficulties. Reference must also be made to children or young people who come into contact with the criminal justice system and the Gardaí. Juvenile Liaison Officers and Community Gardaí played a positive role in many of the cases received by the ICDRG. They are an excellent resource and it is critical that they are fully involved, where appropriate.

Furthermore, where concerns or referrals with regard to a child/young person are made to a body or agency other than the HSE, that body or agency must communicate those concerns to the HSE immediately. Again, this immediate response is necessary to ensure the safety, protection and well-being of the child/young person.

It would be helpful if, at some point in the future, all agencies involved in child protection were grouped together on the same campus.

5.4.21 Education and Training

There appears to be a significant issue in relation to the Third Level Education and Training of Social Workers. The level of mental health and child psychiatric training received by Social Workers appears to be inadequate and to not prepare them adequately for recognition of the major stresses in these areas that they will meet working in the community. This needs to be addressed with third level institutions training Social Workers.

5.4.22 Consistency of Care and Practice

It is recommended that the annual review of the adequacy of child care and family support services which is provided for under Section 8 of the Child Care Act 1991 be treated as an annual audit for each region of the HSE. To ensure the effectiveness of such a move, appropriate quality assurance mechanisms must be put in place to have a yardstick against which to measure the level and consistency of the care being provided. It is also suggested that the placement of the *Children First Guidance* on a statutory footing will go some way to ensuring greater consistency of practice. Likewise the adoption and utilisation of the *Child Protection and Welfare Practice*

Handbook can be a significant support to frontline staff charged with the very demanding task of protecting children/young people.

5.4.23 Communication between Social Workers and Family

In one specific case reviewed by the ICDRG where a baby had died, there was a very thorough process undertaken to determine the exact cause of death. This process took some time and it would appear that there was insufficient communication given by the Social Work team to the family regarding the process. It is recommended that the Social Work department would, in future, outline to families in these type of situations exactly what the nature and frequency of contact will be and why. It can be very difficult for families going through a traumatic experience to understand the timelines and processes involved, so time must be available for frequent provision of information and checking back that the information is fully understood.

5.4.24 Emerging Child Protection Concerns

As professionals within the HSE and the Voluntary and Community sector have contact with society's most vulnerable children on a daily basis, they are ideally placed to identify emerging issues affecting such children. It is recommended that a permanent taskforce within the Department of Children and Youth Affairs be given the responsibility of addressing these issues and identifying means of tackling them.

5.4.25 Aftercare Provision

The ICDRG notes in particular that for many young people who had been in the care of the HSE the years immediately following their care experience were particularly vulnerable ones. The files reviewed do not show consistent provision for that group of young people and the ICDRG urges the Minister to consider placing a statutory responsibility on the HSE/Child and Family Support Services Agency to ensure adequate supports are in place for these young people.

5.4.26 Conclusion

The ICDRG reviewed the case files of 196 children and young people. The files related to the deaths of children and young people involved with the care system between 2000 and 2010. The recommendations made in this report arise from the evidence garnered from those files. The ICDRG are heartened by the new energy in the area of child welfare and protection that is

evidenced by the establishment of a Government Department of Children and Youth Affairs, the appointment for the first time of a National Director for Children and Family Services within the HSE. It is hoped that the establishment of a Child and Family Support Services Agency will further greatly enhance the chances that each child/young person whose wellbeing is under threat will receive a service that meets their needs, protects their rights, and enhances their life chances. The system must be accountable, it must be consistent and it must strive always to minimise the risk of the death of any child where that death is preventable.

APPENDIX 1

Independent Review Group on Child Deaths

Final Terms of Reference

The Independent Review Group on Child Deaths will examine existing information in respect of deaths of children over the period of 1 January 2000 to 30 April 2010 who were:

- in care within the meaning of the Child Care Act, 1991 at the time of their death;
- in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death;
- known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 at the time of their death.

The Group will, as an initial step, seek to validate within the above categorisation the cause of death as being from natural causes or otherwise. The Group may seek to obtain additional information which, in the opinion of the Group, will assist it in the performance of this function.

In relation to children other than those who died from natural causes (and where the cause of death was so validated), the Group will examine existing reviews/reports completed by the HSE (or by others on behalf of the HSE) and, based upon this information, provide an overall report to the Minister for Children and Youth Affairs for publication which:

- provides on an anonymised basis key summary information regarding each child and the circumstances leading up to their death;
- focuses, in particular, on the relevant involvement of State services with the child and his/her family;
- examines the strengths and weaknesses of such involvement;
- in so far as lessons were or can be identified from these reports/reviews, including common issues presenting, make recommendations as to how child protection responses can be strengthened; and
- if considered useful, comment on the nature of the reports/reviews available for its consideration.

The Group is also required, following completion of the task set out above and as a separate function, to make itself available to interview families of the deceased who may wish to have the opportunity to air their views and following such interviews to present to the Minister an anonymised synopsis of such interviews.

The Review Group is to report to the Minister for Children and Youth Affairs by year end 2010.

16 July 2010

APPENDIX 2

Independent Child Death Review Group

Floor 2, St Stephen's Green House, Earlsfort Terrace, Dublin 2. Telephone: 01 6679002

23rd June 2010

Mr Barry Andrews, TD
Minister for Children
Office of the Minister for Children and Youth Affairs
Hawkins House
Dublin 2

Re: Independent Review into the Deaths of Children in Care

Dear Minister,

We write in relation to the above matter and, in particular, with regard to our Terms of Reference.

Given the recent and ongoing public debate around the Group's work, it may be helpful to outline the limitations of our review, having regard to the Terms of Reference and the procedures which we intend to adopt for the investigation. The purpose of this letter is therefore to provide a brief overview of the potential issues which occur to us in relation to the Terms of Reference so that same can be addressed by your office.

Temporal limits on investigation

The first issue to note is the lack of any temporal limitations on the scope of our investigation. The OMCYA website launching the Group on 8th March 2010 states that it is *"to examine the results of completed reviews of deaths of children in care since 2000".* This limitation is not reflected in the Terms of Reference.

This ambiguity is a matter that perhaps should be reflected in the Terms of Reference. If a temporal limitation is to be imposed on our retrospective investigation, it may be necessary for us to seek further

clarification on this issue. Further, or in the alternative, we may be required to consider the Terms of Reference and come to a reasoned decision about the temporal restrictions, if any, which we propose to apply to our investigation.

Furthermore, it is also not clear whether we are required to look only at completed reviews in the past or whether we are also required to review files or cases which arise going forward. Accordingly, it is likely that we may be confined to reviewing cases which were in existence at the date of the establishment of the Independent Group.

Categories of children in the terms of reference

We note that the terms of reference currently refer only to children in care. This appears to cover only those children in care within the meaning of the Child Care Act 1991 and does not cover children in receipt of aftercare or children known to child protection services. The HIQA Guidance to the HSE includes both of these categories and the Group is of the view that, given the recent reporting by the HSE of a number of deaths of children in those categories, the terms of reference of the Group should be expanded to cover those categories also.

We also note that the Terms of Reference should make it clear that the children concerned must have been in one of the categories at the time of their deaths.

Content of investigation

The Terms of Reference appear to envisage a two stage process. Furthermore, the Terms of Reference differentiate between:

(a) the focus of the investigation at each stage, and

(b) the information which may be taken into account in respect of each stage.

The latter distinction seems to us to be likely to raise considerable practical difficulties and these are discussed below.

Stage 1: Validation of cause of death

As regards the first stage, the Terms of Reference describe our purpose as being to validate the categorisation of those children who died from natural causes. This suggests that we will have to consider, as a preliminary matter, what constitutes a death from natural causes. It may be, in this regard, that we will adhere to other legal definitions of natural causes that may exist. Alternatively, we may adopt a different definition of death from natural causes for the purposes of this validation.

In terms of the content of the first stage, it should be observed that the validation of the cause of death is a limited objective which appears primarily factual in character. This strongly indicates that we may be limited at this stage to considering only evidence which goes to the factual question of whether the child in question died from natural causes.

This view is supported by the fact that the Terms of Reference confine us to an examination of "existing information". This suggests that our function is not inquisitorial but is limited to reviewing existing information. It does not appear that we have been asked to "*investigate*". It is notable that the verb "examine" is used repeatedly in the Terms of Reference in relation to our work. The extent to which we may gather information seems to be limited in accordance with this restriction.

It is also arguable that the "*existing information"* to which we are entitled to have regard is confined to data which has already been compiled in some organised fashion at the date upon which the Independent Group was established.

Furthermore, the requirement that the material be in existence may indicate that we can only refer to documentary evidence which could be said to exist on the relevant date. The argument could be made that oral evidence given at a later date, even if based on recollections about prior events, would not constitute "*existing information"* and may be, as a result, material to which we cannot refer.

Having regard to this, it seems that the taking of oral evidence from third parties such as, for example, family members could exceed our Terms of Reference.

Stage 2: Provision of a report for publication

The Terms of Reference seem to permit us to examine only cases of children who can definitively be categorised as having died otherwise than of natural causes. Again, for this reason, some working definition of death from natural causes such as the findings of the coroner will be required.

As regards the second stage, the focus of our investigation is considerably broader but the material to which we may have regard is considerably narrower. The information to which we may have regard during this second stage of the examination is limited to *"existing reviews/reports completed by the HSE (or by others on behalf of the HSE*)". This limitation applies to both the examination process and the publication of a report. This confines the potential operation of the Independent Group in a number of ways.

The reference to these reviews/reports being "completed" could give rise to potential difficulties where files have not been closed or where a review/report has not been *"completed"* in some formal sense. This may limit considerably the cases which will fall within this aspect of our work.

Furthermore, this limitation suggests that it would be impermissible for us to take account of any other sources of information during this stage of our investigation. This again suggests that, for example, the taking of oral evidence from family members or other parties with knowledge of the child would go beyond our Terms of Reference. Furthermore, it also suggests that it would be impermissible for us, in the course of exercising our second stage functions, to have regard to material which was available to us during the first stage but would not otherwise have been available to us during the second stage.

This seems to raise some significant practical difficulties for the carrying out of the Group's work as material which may have useful in the context of the first stage and which is relevant to the second stage would have to be discounted post-validation and excluded from any Report. We are of the view that it would be preferable to amend the Terms of Reference so as to include the same material at both the first and second stages of the Group's work.

Interviews

We note that under the current draft of the Terms of Reference, the Group does not appear to be entitled to conduct interviews at the second stage (as it is limited to HSE reports). It also seems to be limited at the first stage as the reference to "existing information" does not seem broad enough to include interviews. If it is intended that the Group should be entitled to conduct interviews this will have to be made explicit in the Terms of Reference.

In this context, we note that the Group's limited timeframe does not seem to us to be adequate for comprehensive interviews. The Group, if it is to conduct interviews, will need to develop a policy on inviting parties for interview. Some difficulties are likely to arise with any system under which oral evidence is received on a partial and limited basis.

The requirements of natural and constitutional justice in the context of receiving oral input into the Group's work significantly increases the prospects of a challenge to the taking of particular oral evidence by the Group being brought. The fact that the Group's report will be anonymised and that it is not making findings means that the requirements of constitutional justice may be less than would be the case for other investigative bodies. These principles are still, however, likely to require the adoption of additional procedures by the Group once any additional evidence is obtained. Furthermore, the prospect of a challenge being brought on this basis will also substantially increase once such limited procedures for adopting evidence is adopted.

For example, if the Group intended to receive oral evidence on a partial and limited basis, it would be necessary for it to devise criteria for determining when such evidence would be received. It would also have to ensure that the opportunity to provide evidence, or to apply to provide evidence, was equally available to all interested parties. In terms of the taking of such evidence, this is also likely to give rise to significant issues in relation to ensuring that the rights of other parties with an interest in the evidence given to natural and constitutional justice are adequately vindicated. Again, what this would involve cannot be determined in the abstract as it would depend on the evidence given. However, it would be likely in many cases to require that family members, individual social workers, other individuals involved in, or aware of, the care of the relevant child or the HSE itself be given the opportunity to challenge the evidence given, and to provide their own evidence as to what occurred. As the decision in *Murray v. Commission to Inquire into Child Abuse* [2004] 2 I.R. 222 indicates, individuals or groups of individuals who are not named in a report may nonetheless be entitled to an input into the process once that process might lead to an outcome which may have some adverse consequences for them, or for their reputations.

Taking oral evidence is thus likely to create a greatly increased workload for the Group, to require the adoption of significantly more complicated procedures than would otherwise be required, and to substantially increase the likelihood of legal challenges being brought. If it is the Minister's intention that the Group is to conduct interviews, it is the Group's view that a stenographer would be required to record any such interviews so as to protect the Group's work in the event of a legal challenge.

The fact that (under the current Terms of Reference) such evidence could only be taken in order to validate the categorisation of the cause of death of the child in question seems additionally problematic.

Other limitations on material available to the Group

As the Group has not been established on statutory basis, it will presumably have to rely on the voluntary co-operation of any third parties from whom it wishes to obtain information.

The Group has been established by the Minister pursuant to his executive powers. Unlike statutory forms of inquiry established under the Commission of Investigations Act 2004 or the Tribunals of Inquiry Act 1921, the Group does not enjoy a general statutory power to compel third parties to furnish it with documentation. The limitations on the powers of an inquiry without statutory underpinning were referred to by Costello J. in *Goodman International v. Mr. Justice Hamilton* [1992] 2 I.R. 542. Discussing the Beef Tribunal, he stated (at page 554) that:

There is no statutory provision which empowers the establishment of this Tribunal either by the two Houses or the Minister. It is established by an administrative act, that is by the order of the Minister of the 31st May, 1991. The Government or any Minister can inquire into matters of public interest as part of the exercise of its executive powers, but if this done without reference to parliament then the inquiry will not have statutory powers which are to be found in the Tribunals of Inquiry (Evidence) Act, 1921, and the Tribunals of Inquiry (Evidence) (Amendment) Act, 1979.

As noted by Finlay Geoghegan J. in *Gama Endustri Tesisleri Imalat Montag A.S v Minister for Enterprise Trade and Employment* (14th June 2005) Costello J.'s judgment:

envisages two distinct types of tribunals of inquiry which may be established by a Minister as part of the exercise of executive power. First, a tribunal of inquiry in respect of which there is a resolution passed by both Houses of the Oireachtas and which can then invoke for its conduct the statutory provisions of the Tribunals of Inquiry (Evidence) Act, 1921, and the Tribunals of Inquiry (Evidence) (Amendment) Act, 1979. Second, a commission or tribunal of inquiry which is established in exercise of the executive power of the State but which does not invoke any statutory power. In such instances, the conduct of the commission or tribunal of inquiry would appear to continue to be an exercise of the executive power of the State. Such commissions or tribunals of inquiry depend upon the voluntary co-operation of all concerned and have no powers of compulsion.

Finlay Geoghegan J. went on to refer to Casey *Constitutional Law in Ireland*, 3rd Ed. (Dublin, 2000) where it states as follows:

In certain circumstances the constitutional grant of the executive power may enable the Government to act without statutory authority in domestic affairs. It seems clear, however, that it could not, without

statutory warrant, take action imposing obligations or burdens on any citizen. The absence of any Irish judicial authority on this point doubtless reflects consistent legal advice to Governments that statutory authority is essential for such action. .....

It *is presumably under its executive power that the Government establishes commissions and committees to inquire into some subject (e.g. industrial relations, itinerancy, taxation) and report thereon. Such bodies, of course, function on the basis of evidence voluntarily tendered: and it would not be possible to clothe them with authority to compel the attendance of witnesses or the production of documents. (pages 235 and 236)*

In Gama, Finlay Geoghegan J. considered a challenge to the publication of a report of an investigation the legal basis for which was an issue in the case. The Minister for Enterprise had directed the Labour Inspectorate of his Department to carry out an urgent investigation into a matter. There was no formal instrument setting out the terms of the direction. Both Finlay Geoghegan J. and the Supreme Court found that the investigation was limited by virtue of the statutory context in which it was directed (albeit with differing views on the implications of this finding for the publication of the report).

Kearns J., giving the judgment of the Supreme Court, (30 April 2009) noted that:

While extensive written submissions, many of them addressed to the theme of the powers of the Executive, were lodged on behalf of the respondents for the purpose of this appeal, the fact that the investigation was so clearly and exclusively premised on specific statutory powers renders it unnecessary in my view to enquire as to whether some inherent (though never invoked) Executive power provided an alternative basis for this investigation. Nor do I consider it necessary to consider further whether such power, undefined and apparently limitless in nature, may be said to overlap or run in tandem with statutory powers in this case.

This reservation on the part of the Court underlines the fact that the Group, in the absence of express statutory authority or powers, will be limited in the exercise of its functions to the material which is voluntarily provided to it or to which it may entitled under some other statutory provision e.g. s. 29(1) of the Coroner's Act 1962.

The Group welcomes the introduction of the Health (Amendment) Bill 2010 which clarifies the power of the Minister to obtain information from the HSE and to pass it on to the Group. As far as other third

parties are concerned, however, the Group notes that it may not be possible to obtain all the information it may wish to use in the absence of co-operation from such parties.

The Group also notes that some relevant sources of information may raise issues under the Data Protection Acts 1988 and 2003. HSE files and reports, Garda files, hospital records, school files and Coroner's reports all seem to raise potential issues as some of the material contained therein may fall within the concept of "sensitive personal data" under s.1 of the Data Protection Act 1988 as being data concerning the physical or mental health or condition of the subject. The exempting provisions of s.8 (e) for processing of data (which includes disclosure) where this is required by or under any enactment or by a rule of law or order of a court do not appear to apply to the processing of sensitive personal data so that the mere provision for this in statute may not be sufficient to address our data protection concerns.

Sensitive personal data may be processed by a data controller only where the requirements of s.2A and 2.B are met. Under s.2A, for example, the processing would be legitimate where it was necessary for compliance with a legal obligation to which the data controller was subject. One of the requirements of s.2B would also have to be met e.g. the processing is authorised by Ministerial regulations made "for substantial reasons of public interest".

In this regard, we note that the Health (Amendment) Bill 2010 may address these issues as far as HSE documents are concerned. The issue may arise, however, in respect of other sources.
Further issues regarding the Terms of Reference may arise as our work progresses but these preliminary points seem to us to raise issues which your office should be aware of at this relatively early stage of the process.

We trust that the above is of assistance and look forward to hearing from you.

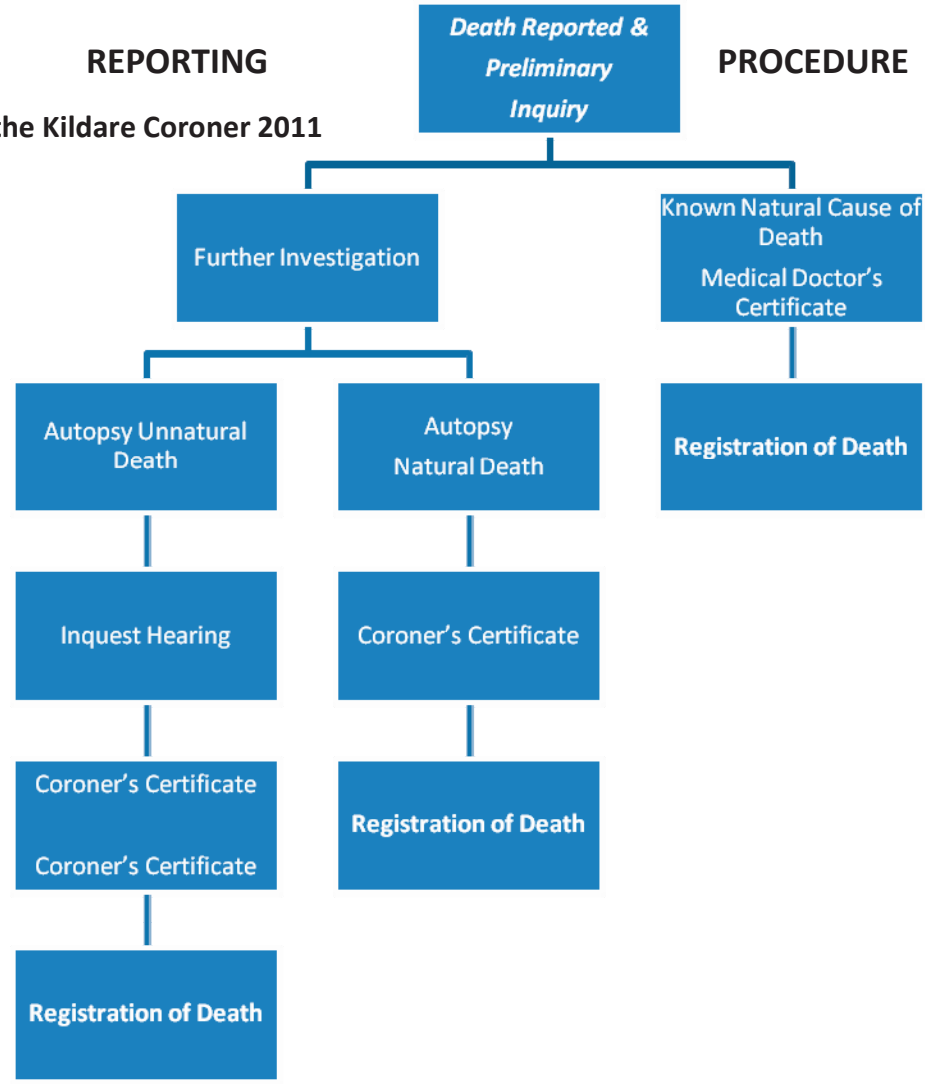
Yours sincerely,

_____

Geoffrey Shannon and Norah Gibbons

APPENDIX 3: REPORTING PROCEDURE

Adapted from the Kildare Coroner 2011



Verdicts

- Natural causes
- Accident
- Misadventure (risk factors)
- Suicide
- Open
- Unlawful Killing
- In accordance with the verdict of a criminal court
- Narrative

Riders/ Recommendations

- Must accord with the totality of the evidence
- Relating to safety and/or health issues
- Arising from risk factors identified in evidence
- To prevent death occurring in similar circumstances
- Must not blame, censure, exonerate
- Addressed to Government Department/Local Authority/Public Bodies/Road Safety Authority/HSE/Vehicle, machine manufacturer etc.

APPENDIX 4: SUMMARY OF KEY DATA

The ICDRG reviewed the child and family files of 196 children and young people involved with the care system who died between 2000 and 2010.

- 36 Children and Young People died while in the care of the HSE
    - 19 deaths were of natural causes
    - 17 deaths were of unnatural causes
    - The average age of death of a child in care was 11 years and 4 months
- 32 Young People died while receiving Aftercare Services from the HSE
    - 5 deaths were of natural causes
    - 27 deaths were of unnatural causes
    - The average age of death of a young person in receipt of aftercare was 18 years and 11 months
- 128 Children and Young People died while known to the HSE
    - 60 deaths were of natural causes
    - 68 deaths were of unnatural causes
    - The age-range of children and young people who died while known to the HSE was hugely diverse; ranging from a child who was stillborn to a young man of 19 years

A number of further statistics are notable:

- 23 children and young people died from complications arising from developmental delay
- 29 children died from Sudden Child Death Syndrome
- 30 children and young people died drug related deaths
- 28 children and young people died by suicide (22 by hanging, 5 by drowning, 1 by shooting)
- 17 children and young people died of injuries sustained in road traffic accidents
- 16 children and young people were unlawfully killed
- The ICDRG reviewed the files of 11 sets of siblings. Of these:
    - Two sets of siblings died of drug related deaths, in separate incidents
    - Two sets of siblings were unlawfully killed by a parent

- One set of siblings died of Sudden Child Death Syndrome, in separate incidents
- One set of siblings died from injuries received in a road traffic accident
- One set of siblings died in a house fire

The chart below sets out information on the causes of death of all of the children whose files were reviewed by the ICDRG. Case summaries are not included in the report for children who and young people who died of natural causes.

Natural Deaths		**Unnatural Deaths**	
In Care		***In Care***	
Asthma	1	Asphyxia (accidental)	1
Cancer	6	Drowning (accidental)	1
Complications from Developmental Delay	11	Drug Related	5
Sudden Child Death Syndrome	1	Hanging	5
		Injuries resulting from a Road Traffic Accident	3
		Unlawful killing	2
Subtotal	*19*	*Subtotal*	*17*
Aftercare		***Aftercare***	
Cancer	1	Asphyxia (accidental)	1
Complications from Developmental Delay	2	Drowning (suicide)	3
Miscellaneous	2	Drug Related	14
		Hanging	4
		Injuries resulting from a Road Traffic Accident	3
		Unlawful killing	1
		Unknown	1
Subtotal	*5*	*Subtotal*	*27*
Known to the HSE		***Known to the HSE***	
Asthma	1	Accidental Fall	2
Cancer	1	Asphyxia (accidental)	3
Complications from Cystic Fibrosis	2	Drowning (accidental)	3
Complications from Developmental Delay	10	Drowning (suicide)	2
Complications from Diabetes	1	Drug Related	11
Heart Problems	2	Hanging	13
Genetic neurological condition	3	Head Injuries (Cause unknown)	2
Stillborn	1	Injuries resulting from a Road Traffic Accident	11
Sudden Child Death Syndrome	28	Injuries sustained in House Fire	5
Undetermined/Unknown	2	Shooting (suicide)	1
Miscellaneous	9	Unlawful killing	13
		Unknown	2
Subtotal	*60*	*Subtotal*	*68*
Total	**84**	**Total**	**112**

Fig. A4.1

APPENDIX 5: CHARTS REPRESENTING ALL INFORMATION RECEIVED BY ICDRG

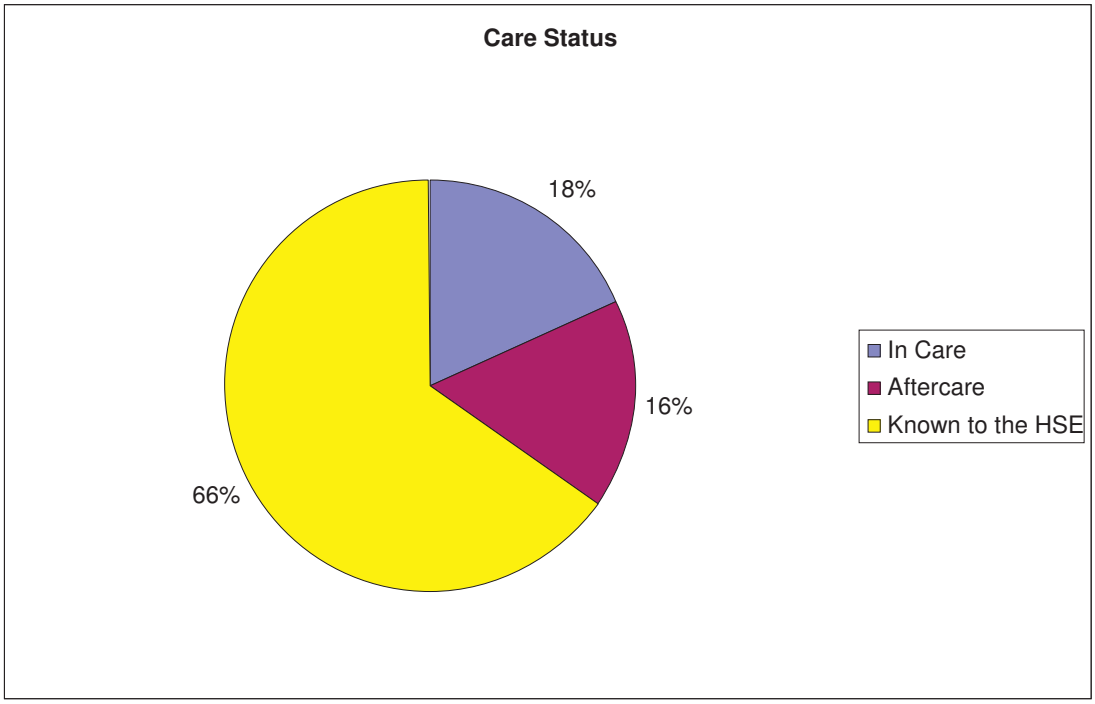


Fig A5.1 – Care Status

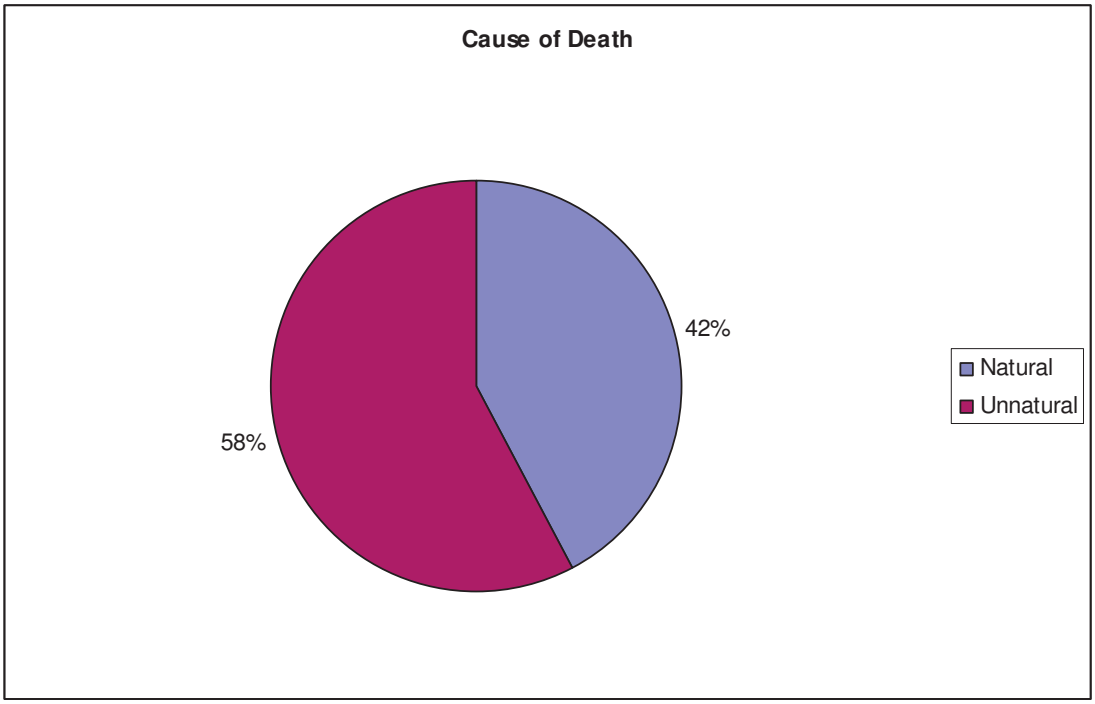


Fig A5.2 – Cause of Death

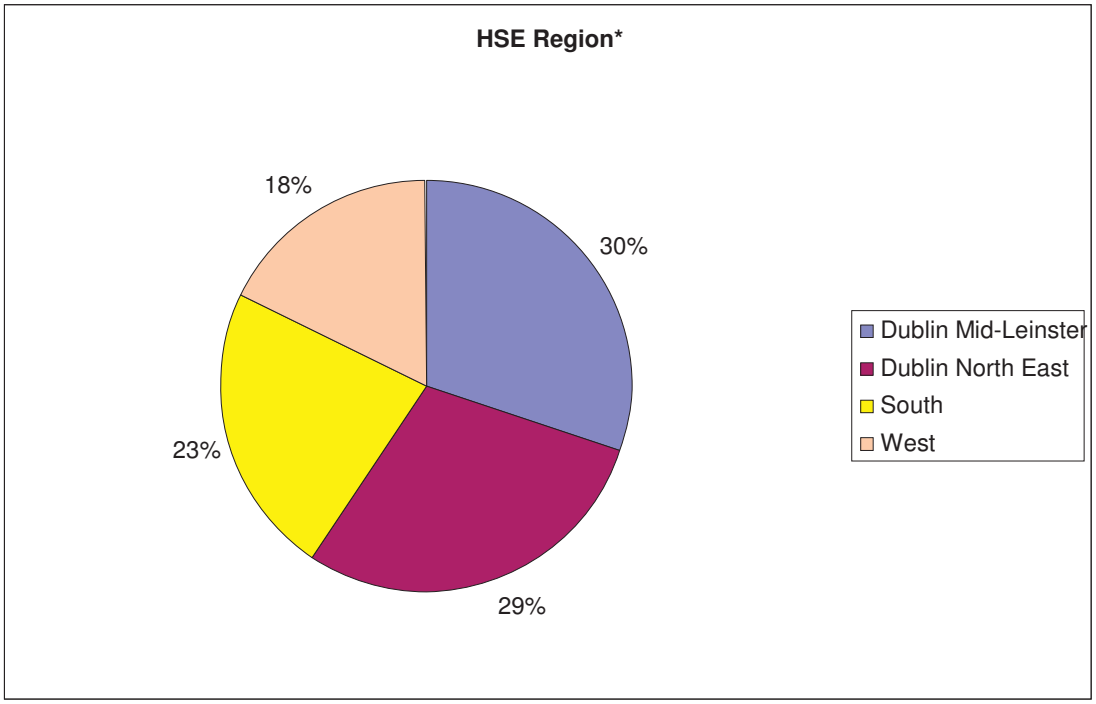


Fig A4.3 – HSE Region

*Child Known to the HSE 088 was known to HSE Areas Dublin Mid-Leinster and West.

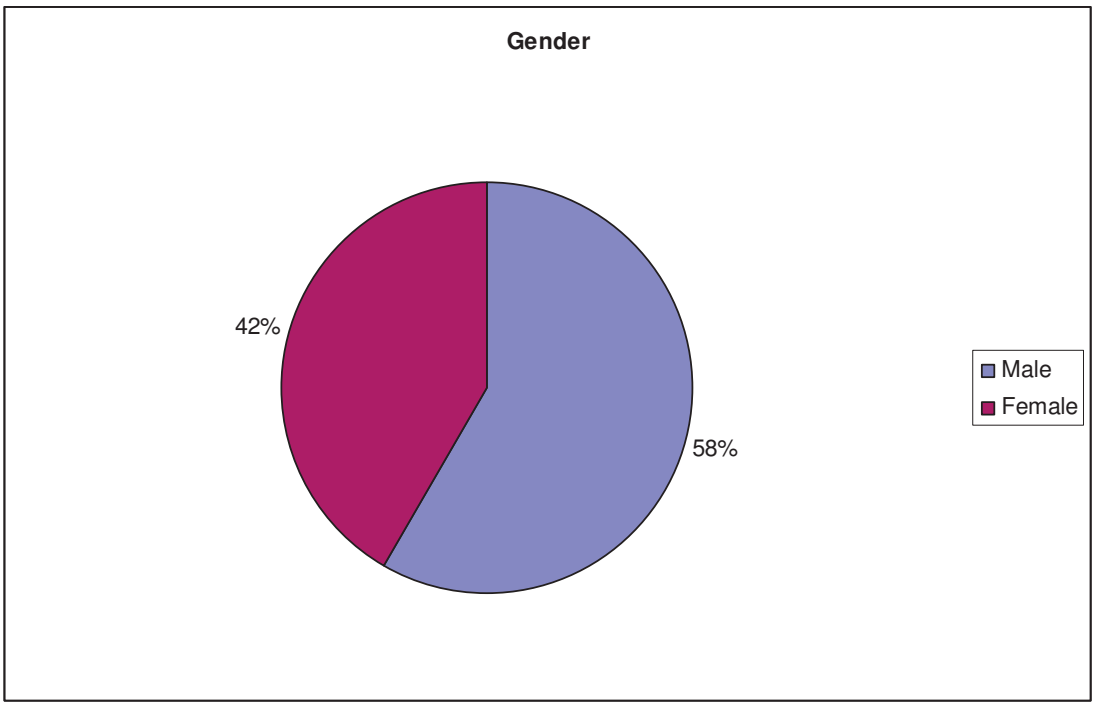


Fig A5.4 - Gender

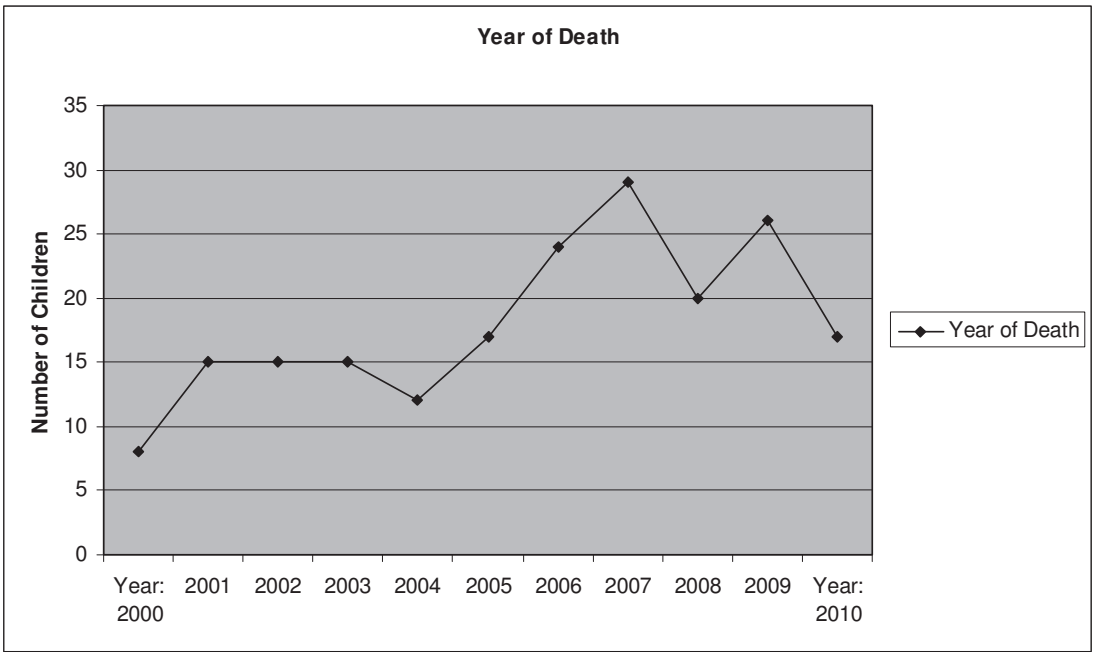


Fig A5.5 – Year of Death

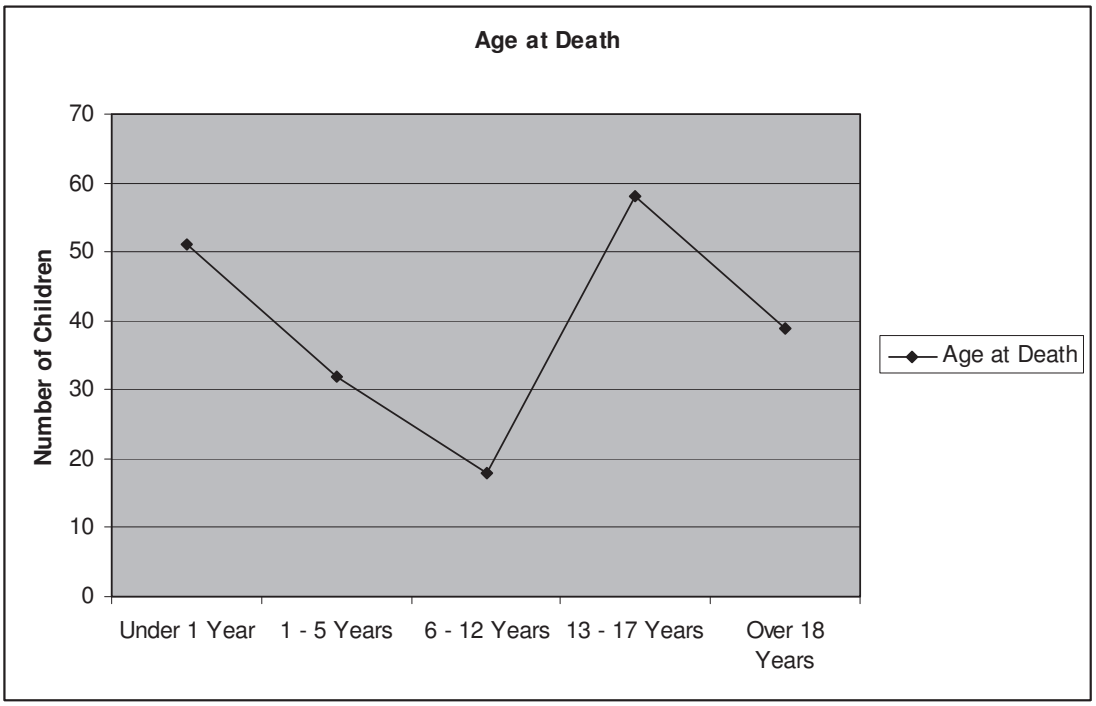


Fig A5.6 – Age at Death

APPENDIX 6: REFERENCES USED IN REVIEW OF INTERNATIONAL MODELS

UNITED KINGDOM

- *Working Together to Safeguard Children* – available at http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010
- *Department of Education website* – http://www.education.gov.uk/
- *The Children Act 2004* – available at http://www.legislation.gov.uk/ukpga/2004/31/contents
- *The Children Act 1989* – available at http://www.legislation.gov.uk/ukpga/1989/41/contents

VICTORIA

- *VCDRC Annual Report 2010* – available at http://www.ocsc.vic.gov.au/vcdrc/publications.htm
- Child Safety & Wellbeing Act 2005 – available at http://www.austlii.edu.au/au/legis/vic/consol_act/cwasa2005218/
- Office of the Child Safety Commissioner Website – www.ocsc.vic.gov.au
- Victorian Child Death Review Committee Website - http://www.ocsc.vic.gov.au/vcdrc/index.htm

NEW SOUTH WALES

- Children Legislation Amendment (Wood Inquiry recommendations) Act 2009 – available at http://www.legislation.nsw.gov.au/maintop/view/inforce/act+13+2009+cd+0+N
- Commission for Children and Young People Act 1998 – available at http://www.legislation.nsw.gov.au/xref/inforce/?xref=Type%3Dact%20AND%20Year%3D1998%20AND%20no%3D146&nohits=y
- Community Services (Complaints, Reviews and Monitoring) Act 1993 – available at http://www.austlii.edu.au/au/legis/nsw/consol_act/csrama1993583/
- Ombudsman Act 1974 – available at http://www.austlii.edu.au/au/legis/nsw/consol_act/oa1974114/

- New South Wales Child Death Review Team website - http://kids.nsw.gov.au/kids/about/who/childdeathreviewteam.cfm
- NSW Child Death Review Team Annual Report 2008 – available at http://www.austlii.edu.au/au/legis/nsw/consol_act/csrama1993583/s4.html#child_in_care
- NSW Factsheet on Reviewable Deaths – available at http://www.ombo.nsw.gov.au/publication/PDF/factsheets/CSD%20Fact%20Sheet%203_Reviewable%20Deaths.pdf
- Ombudsman Report 2007 – 2009 – available at http://www.ombo.nsw.gov.au/show.asp?id=566

MICHIGAN

- The Michigan Child Protection Law Act, (Public Act 238 of 1975) as amended by the Michigan Child Protection Act, (Public Act 167 of 1997)– available at http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-238-of-1975.pdf
- Keeping Kids Alive Website - http://www.keepingkidsalive.org/Tools_for_Teams/The_process/General_Process/purpose.htm
- Fourth Annual Report – available at http://www.michigan.gov/documents/FIA-Child-Death-Report-Fourth-Annual_109561_7.pdf

CONNECTICUT

- www.childdeathreview.org/spotlightCT.htm
- Connecticut Fatality Review Panel Website - http://www.ct.gov/oca/cwp/view.asp?a=1303&Q=254872&ocaNav=|
- CFRP Annual Report 2000, - http://www.childdeathreview.org/reports/CT_CDR_2000_3425k.pdf
- Connecticut Statute § 46A-131 (1995) – available at http://www.childdeathreview.org/Legislation/CTleg.pdf

BRITISH COLUMBIA

- Child Death Review Unit Web Page - http://www.pssg.gov.bc.ca/coroners/child-death-review/index.htm
- CDRU Annual Report 2005 – available at http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-2005annualreport.pdf
- Aboriginal Youth Report - See http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/death-review-panel-aboriginal-youth.pdf
- CDRU Annual Report 2008 – available at http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-2008annualreport.pdf
- The Coroner's Act 2007 – available at http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_07015_01
- Representative for Children and Youth Website - http://www.rcybc.ca
- RCY Representative's Report, July 7, 2010 – available at http://www.rcybc.ca/Images/PDFs/Reports/CID%20Update%209%20-%20July%207%2010%20FINAL.pdf
- Child, Family and Community Service Act 1996 - http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96046_01#section13
- Representative for Children and Youth Act 2006 – available at http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_06029_01#part4
- Ministry for Children and Families Website - http://www.mcf.gov.bc.ca/about_us/accountability.htm
- MCFD Death Report at - http://www.mcf.gov.bc.ca/about_us/directors_case/2010/BY_FOI_2009-00881_Executive_Summary.pdf
- MCFD Serious Incident Report - http://www.mcf.gov.bc.ca/about_us/directors_case/2010/MJ_FOI_2009-00999_Executive_Summary.pdf.

NEW ZEALAND

- CYMRC website – www.cymrc.health.govt.nz

- FVDRC website – www.fvdrc.health.govt.nz
- Office of the Children's Commissioner Website – www.occ.org.nz
- Child, Youth and Family Department Website – www.cyf.govt.nz
- CYMRC Annual Reports – available at http://www.cymrc.health.govt.nz/moh.nsf/indexcm/cymrc-resources-publications
- FVDRC Annual Report 2009 - http://www.fvdrc.health.govt.nz/moh.nsf/pagescm/7637/$File/fvdrc-annualreport-09.pdf
- New Zealand Public Health and Disability Act 2000 – available at http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html?search=ts_act_disability+2000_resel&p=1
- 'OCC Saliel and Olympia Aplin Investigation Report' – available at http://www.occ.org.nz/publications/reports_documents/reports__and__publications
- 'OCC James Whakaruru Investigation Report' – available at http://www.occ.org.nz/publications/reports_documents/reports__and__publications

APPENDIX 7:

Meetings with Interested Parties relevant to Children and Young People whose deaths fell within the remit of the ICDRG

Requests were received from twelve interested parties to meet the members of the ICDRG. Appointments were offered to all those who requested a meeting and nine such meetings were held. At the outset of each meeting it was fully explained that the meetings were an opportunity for the ICDRG team to listen to the experiences of the attendees and to hear information of relevance to the terms of reference of the ICDRG. It was fully explained that the case report of the ICDRG in relation to the child or young person they wished to discuss was already completed. It was further explained that the ICDRG would not identify any individual they spoke of whether positively or negatively. The ICDRG is reporting on these meetings in a manner that does not allow any child or young person to be identified in line with the terms of reference of the Review.

The ICDRG wishes to express its thanks to everyone who spoke with them. The ICDRG notes that all those who attended these meetings were very upset by the loss of the child or young person they knew very well and hoped that in coming forward they would assist in avoiding similar experiences for families or professionals in the future. The ICDRG in addition wishes to commend and thank the various professionals, many from the HSE, who attended with and supported some of the families and others who wished to speak with the ICDRG.
The ICDRG met with a range of family members, foster carers and care professionals who knew the children or young people they wished to speak about. Some attendees came alone, others were supported by family members or by professionals who were working with them or had done so in the past.

This short report outlines the main themes that interested parties brought to the notice of the ICDRG.

1) **A lack of early intervention in the lives of children/young people**: There was a consistent view expressed that when a child or young person was brought to the attention of the HSE there was very little appropriate support provided. The situation was often left to deteriorate until a serious crisis arose and at that point the intervention was perceived as being too late. Families felt disempowered and felt some staff did not listen to the knowledge they had of the young person's behaviour or feelings.

2) **Exclusion from School:** The exclusion of children or young people from school was described as a major trigger for deterioration in their life experiences. Some young people were out of school for long periods and the families were perplexed by the apparent inability of the HSE to influence the Department of Education or local schools to admit the child to an educational establishment. Isolation of the young person from their peer group was a key factor noted during periods of school exclusion.

3) **Lack of Information:** All three groups who met with the ICDRG recounted that they did not have key information relevant to their young person relayed to them in a timely manner. There was anger expressed that they were excluded from information that they should have had. The types of information not provided included information on admission to hospital when seriously ill, information on past behaviour that would have affected decisions regarding placement suitability and notification that the young person had absconded.

4) **Lack of Coordination:** This aspect was most often commented on**.** Families spoke of too many people being involved with them, having to repeat the same information on numerous occasions and new workers appearing without any apparent understanding of the past history. This was also reflected in the many changes of personnel they could experience. Families spoke warmly of HSE Social Workers who had supported them through very difficult times and of their sense of loss when those key personnel who they had experienced as warm and respectful, notwithstanding the difficulties, had moved on. The very large numbers of people attending at meetings with them was also seen as a negative experience.

5) **Large number of placements:** Some of the families and professionals spoke of the amount of times the child/young person had moved placement and how difficult that was for both the child/young person and for them. They found it difficult to understand why there were so many moves particularly when the young person had settled well in a placement. The frequent moves often left family members with no idea of where the young person was being cared for at times and at best having to try to establish a relationship with new staff in relation to the welfare of the young person.

6) **Funeral Expenses:** In a small number of cases where the child/young person had a long involvement with the HSE and indeed with agencies offering placements to the HSE it was felt very keenly that the funeral arrangements and the payment for reasonable funeral expenses were poorly handled at official level. The view was expressed to the ICDRG that this compounded the distress of professionals who knew and cared for the young person who then covered the expenses in some cases.

7) **Lack of adequate and full explanation:** Views were expressed in some situations that there was a lack of full and adequate explanations provided when matters were disputed. This was experienced as very unsatisfactory by both professionals and family members.

8) **Concern over future negative consequences:** In three situations the person speaking with the ICDRG expressed some concern that they were not free to be in any way critical of service provision or professional responses as they feared there could be negative consequences for them in relation to future dealings. This could include sensitive matters such as ongoing access to children/young people or employment.

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