Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of death of a child known to the child protection system: Harry

Executive Summary

July 2016

Introduction and background

Baby Harry had older half siblings and was seven months old when he died from Sudden Unexpected Death in Infancy (SUDI). He was born prematurely and was initially slow to gain weight but made good progress as the months passed. His development was closely monitored by the public health nursing (PHN) service. Harry's mother normally lived on her own with her children and was considered to be a capable parent who also had the support of her extended family. However, she had allegedly been a victim of domestic violence from Harry's father including an assault on the day prior to his birth. Harry and the other children were referred to the social work department (SWD) when he was two months old by the Gardaí following an alleged assault on Harry's mother by his father. Some preliminary inquiries were made by the SWD and the case was designated as 'welfare' i.e. not considered to be high risk.

Approximately two months after the first report was made to the SWD, Harry's family was referred to a community agency for assessment. However, the community agency was, under its contractual agreement with The Child & Family Agency, unable to undertake an assessment without the consent of Harry's father. His mother was unwilling to share his contact details for fear of reprisals and despite efforts made to contact her by the community agency, she did not engage with the assessment and after a further five weeks, the case was referred back to the SWD. By this time, the PHN was also having difficulty contacting Harry's mother and was aware that she had suffered an injury and had been evicted, but ultimately tracked her down by enquiring with family members. She and the children were staying with relatives at the time of Harry's death. The case was allocated in the SWD after it was referred back by the community agency but the social worker had only managed to make brief contact with the family before Harry died.

Findings and conclusions

The review found that the response to concerns about Harry and his family was slow with none of the services communicating interactively, despite telephone calls to the SWD from the PHN. Apart from the PHN service, there was only limited face to face contact between the family and professionals. No full assessment was conducted. The review has noted that Harry's mother, who had previously opened up to different professionals about domestic violence, became reluctant to engage in an assessment when it was made clear to her that Harry's father would have to give his consent. In the opinion of the reviewers, it would not be unreasonable for a person who had experienced domestic violence and was fearful of repercussions to be put off by the requirement for

both parents to consent to an assessment. Requiring two parental consents implies that both parents are on a 'level playing pitch' and it was evident that Harry's mother did not believe this to be the case. It is also noted that communication of information from the SWD to the PHN, who was actively involved from the outset, was very poor; for example the PHN service was never informed about the referral to the community organisation for assessment. This would be regarded as a significant deficit in any case, but particularly here where the PHN had a central role and a trusting relationship with Harry's mother.

Harry died from SUDI, and the review did not find any connection between his death and any action or inaction on the part of The Child & Family Agency. However, it found that the designation of 'welfare' in this case where significant domestic violence had been alleged had implications for the way that the case was managed. Finally, the review found that the PHN service played a key positive role in this case, both in monitoring Harry's developmental progress and offering support to his mother and concludes that the SWD should have worked more collaboratively and constructively with the this service.

Key Learning

The review identified a number of key learning points which are summarised below:

- Designating a referral as child welfare where domestic violence exists requires a lot of careful forethought particularly if it has implications for how or by whom further assessment will be conducted.

- Addressing domestic violence requires a multi-disciplinary approach. Although the PHNs who were interviewed were familiar with Children First, they had not heard of the HSE Practice Guide on Domestic, Sexual and Gender Based Violence. It would be very beneficial if local The Child & Family Agency managers were to draw the attention of relevant disciplines to useful and easily accessible materials such as this.

- The literature has established strong links between domestic violence, homelessness and child welfare difficulties. These additional vulnerabilities need to be taken into account when responding to reports about children exposed to domestic violence.

- The separation of The Child & Family Agency from mainstream health services as well as a general expansion in the number and size of organisations involved in children's services

creates extra challenges and it is all the more important to set up and maintain good channels for the exchange of information.

Recommendations

- This review recommends that local areas promote, as far as possible, collaborative responses to domestic violence which utilises the combined and individual skills of all relevant services.
- It is also recommended that formal channels for communication between the Child and Family Agency and the public health nursing service are established and maintained.

Dr. Helen Buckley
Chair, National Review Panel