Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of death of a young person known to the child protection system: Alan

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Introduction and background

Alan was a member of the Traveller community when he died at 16 years of age in an accident. He was described as a pleasant young man who was easily led by others. He had been brought up by his mother, his father having left the family home when he was young. He and his siblings lived in different accommodations in various areas during his childhood and experienced periodic homelessness. Reports were made about Alan and his siblings to the social work department (SWD) from the time he was seven years old, detailing neglect of the children, parental alcohol misuse, mental health problems and domestic violence. Although social workers visited the family sporadically, there is no evidence of action being taken in response to referrals up to the time Alan was 14, with one area noting that the family was vulnerable but did not present with child protection concerns.

More substantive SWD involvement with the family began when Alan was 14, though the focus was initially on older and younger siblings. By this time, Alan was not attending school and there were emerging concerns regarding his involvement in potentially serious offending. A HSE (now Tusla) social worker and family support worker from a voluntary service for Travellers were both allocated to work with the family, and when the family moved, another social worker was allocated and worked with them for the following two years. When Alan was 15, he moved away from his mother and siblings for a while and and stayed with relatives, a pattern that was repeated from time to time. He was under the supervision of a juvenile liaison officer at this point, but was associating with people who had known involvement in offending. He moved to a city in another jurisdiction for a period and, on his return, was offered a place on a diversion programme. He was eventually offered a place at Youthreach but did not take it up. He began to accumulate charges for burglary and trespassing and despite her best efforts, his mother had difficulty managing him. Her own mental health was poor and she suffered from stress. Numerous services were involved with the family at this point and the SWD had regular contact. Child protection conferences took place and made plans in relation to all the children.

When Alan was 16, he was remanded in custody in another jurisdiction. He died in an accident a few months after his return.

Review findings

Alan died in a tragic accident, associated with what appears to have been risk taking behaviour. The review found that the responses made to Alan and his family following initial reports was inadequate

and there were a number of shortcomings in management and practice up to the time he was in his early teens. Neither his needs, nor those of his siblings, were assessed adequately and the family did not receive the degree of intervention they needed when the children were young. Overall, a low standard was applied to evaluating their situation following the first referrals made about the family.

From time that Alan was 14, there was ample evidence of the involvement of frontline staff and management with the family, child protection conferences were held, plans were followed up and positive interagency collaboration took place. In addition to the SWD, Alan received services from education and youth justice services as well as a voluntary agency. The review noted, however, that there was a certain lack of child centeredness in the approach taken by the SWD, with the children being treated as a family unit rather than as individuals.

Key Learning

This review highlights a number of learning points including the following:

Assessment: While it is acknowledged here that the standard business processes later introduced into social work services were not operational at the time this case was first referred, it is notable that the children's needs were never assessed individually. This meant that there was no clear understanding of the potential damage to them of living with the number of adversities that they experienced. It also meant that information was not collated in a meaningful way, and the decision to close the case at an early stage was not made in full knowledge of the children's situation. Assessing the needs of children from the Traveller community requires consideration of needs that may be additional to those of children in the settled population. These can include suitability of accommodation, impact on children of frequent moves, availability of areas for safe play, inter-familial structures, gender roles, barriers to the use of services and cultural norms around discipline and child rearing generally[1]. It is also important to understand practices and norms in the Travelling community in relation to extended family support systems, hygiene rules, attitude to education, religious rituals and attitude to services[2]. Assessments that fail to attend to all these matters will be incomplete.

[1] Cemlyn, S. (2008) 'Human Rights and Gypsies and Travellers: An Exploration of the Application of a Human Rights Perspective to Social Work with a Minority Community in Britain.' *British Journal of Social Work,* 38,1: 153-173.

[2] Buckley, H., Horwath, J. and Whelan, S. (2006) *Framework for the Assessment of Vulnerable Children and their Families,* Trinity College

Child protection or child welfare: As noted above a serious weakness in social work provision was the failure to provide early intervention when Alan was very young. The criteria for case closure at an early stage was the absence of child protection reports, which essentially implied that welfare or vulnerability issues were not the business of a SWD. Currently, the majority of reports made to Tusla are classified as 'welfare'. It is important that the use of this classification does not preclude a full consideration of the vulnerabilities to which children are subject which, may have more serious implications for their safety than might be initially assumed. The fact that child protection concerns had not been reported may mean that professionals who made reports were either unaware of the impact of certain factors, or had no confidence that services would respond. Issues such as domestic violence, mental illness and substance misuse can have varying effects on a child, some serious and others less so. It may not be the task of the SWD to assess these, but it should ensure that they are addressed by an appropriate service.

Services specific to members of the Traveller Community: A number of issues were raised by interviewees that met with the review team, regarding deficits in services specific to the members of the Traveller community. These matters are outside the remit of the Child and Family Agency, but are of relevance to the case. While Tusla cannot resolve these issues, understanding of them and advocacy for particular services could be utilised when opportunities arise.

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