# Review undertaken in respect of the death of Cal, a child known to the child protection system

## Executive Summary

**August 2014**

## Review undertaken in respect of Cal

This review is concerned with a young child who died of strangulation whilst strapped into a car seat in his family home. It was conducted as a concise review and the team consisted of Dr. Helen Buckley (chair), Ceili O'Callaghan and Jean Forbes. The review was based on the records provided by the HSE social work department, public health nursing records, submissions from staff and interviews with staff. The family were offered an opportunity to meet with the review team but declined.

## Background

Cal was a member of the travelling community. He lived with his parents and siblings on a traveller site. He had specific health needs and he and his siblings were referred to the social work department (SWD) because of concerns about physical neglect, including safety issues and a low attendance at necessary health services. There were also concerns about the accommodation in which the family was residing and safety issues in the home. A number of health professionals were involved with the family from early in Cal's life including a specialist PHN (SPHN) for travellers, who was linked with the Traveller Health Unit and was involved in the implementation of the Traveller Health Strategy. She visited the family frequently. A community PHN was also involved, as was the Area Medical Officer and later, a hospital paediatrician and other community health services. The children had places in a community crèche, though their attendance was irregular.

Notifications about Cal and his siblings were made to the SWD when Cal was 18 months, 20 months and 22 months. There is no record of a SWD response to the first two referrals though there is evidence that the case was put on a waiting list to be dealt with by the duty social work service. A social worker visited with the SPHN after the third referral, and the case was allocated a short time later. The same social worker remained involved with the family over the timeframe of this review. Despite the parents' hostile attitude to her, the social worker visited them regularly and frequently and ultimately developed a working relationship with them. She was sometimes accompanied by her team leader and/or the SPHN. There is evidence of concern about safety and health issues and these were consistently and firmly addressed by each of the visiting professionals. The SPHN took specific steps to educate families on the site about the risks involved in using car seats inappropriately.

Following an episode where the children were found in a neglected state, a child protection conference was called, and took place almost three months later. The professionals regarded this as a turning point for the family, standards of child care got observably better and attendance and cooperation with services improved. Tragically, Cal died in a domestic accident involving a car seat a few months later.

## Findings

- The review acknowledges that Cal's death was an accident. It also acknowledges the concern held by staff about the safety issues associated with the accident, and the considerable efforts made by them to reduce the risks.

- The fact that this family were members of the traveller community and living in a halting site which, according to the evidence provided, was of a standard that posed health risks to the families living there, has to underpin the conclusions reached by this review. The fact that the parents continued to put their toddler inappropriately into a car seat in which he ultimately died has to be seen in the context where this was common practice within their community.

- The question has to be asked whether the standards applied by the professionals in this case were relativistic, in other words, whether they applied lower standards in this case because the family was from the travelling community. This is an extremely difficult question to address. The professionals were working in a context where it was deemed acceptable by the authorities for families to live in circumstances that were cramped, unsafe and unhygienic. The work pressures being experienced by the professionals must also be taken into consideration. It was very clear that mainstream service delivery would find it very difficult to cater for the needs of such a hard to reach family.

- The review concludes that the professionals involved were alert to the balance of the very particular risks involved in this case, and did as much as they could in the circumstances to address them. Their methods and actual interventions were clearly documented.

- It is sad to note that the death of a young child in this family is in keeping with the mortality rate in this community generally. The child protection issues in this case cannot be entirely

separated from the broader public health issues known to present challenges to traveller children's safety and welfare.

## Key learning from the review

- The All Ireland Traveller Health Study published in 2010 has recognised the challenges in engaging travellers with health services and has identified mistrust particularly as a key issue. The problems identified in that research were also reflected in this case. The review team acknowledges the efforts made by statutory staff to find solutions that would work for the family, including linking them with the less formal elements of the service which they were more likely to trust. However, despite the interventions of the SPHN and the flexibility displayed by staff in different settings, the family's uptake of health, education and support services was low. This indicates that many challenges remain in respect of working with travellers, not least of which are the sort of safety issues that commonly occur in communities where housing is substandard and the accommodation is cramped. The inappropriate use of car seats is an example of one of these issues that had a tragic outcome in this case. It is beyond the scope of this review to outline methods for the successful engagement of traveller families, but there have been a number of reports, including the above mentioned study, published over the past decade which may provide a useful source of learning.

- The review has also indicated that notifications of serious child neglect did not receive the priority that was warranted when they were first made, and that the SPHN was left carrying full responsibility during a period when she made several attempts to involve the SWD. Notwithstanding the pressure that the SWD may have been under at the time which may have meant that the case could not be allocated, the review has noted the absence of coordinated record keeping by the duty system, and the lack of evidence in this case of a system for monitoring cases on the waiting list or prioritising them for allocation.

- While the later record keeping in the case was of a good standard, the review team found it difficult to discern how decisions were made. For example, prior to the child protection conference, legal action was being considered. The rationale for this consideration was clear to the review team, but the reason for discarding it was not clear until it was explained to

them at interview. The act of recording can be an aid to reflective practice, so it is important to record the reason for decisions as clearly as possible.

- Whilst acknowledging the very sad event of Cal's death, the review has noted many examples of good practice in this case. The allocated social worker displayed skill and diligence in her approach to the family, and the review team were able to pick this up from her contemporaneous case records. She managed to maintain a positive relationship despite the family's resistance to social work, while at the same time managing to be direct and honest in her approach. The SWTL, who was already carrying a caseload and supervising staff, showed commitment and support by accompanying the social worker on visits to the site and providing regular supervision.

- The SPHN provided an excellent service to this family, and it may be assumed that many other traveller families benefited from her involvement with them. She is no longer in post, and told the review team that her post has not been filled in the area. This review, which has documented the importance of her role, demonstrates the importance of maintaining the position of Specialist PHN with travellers.

## Recommendations

- It is essentially beyond the scope of the review to make recommendations for social change, as it is confined to an examination of child protection services. However, it would be disingenuous of the review team to ignore the social context in which Cal died, where the rates of accidents and child mortality are higher than the norm for the rest of the population. Therefore the review is compelled to make a recommendation for national attention to be paid to the conditions in which travellers live and to urge the government to make further efforts to improve the general health and wellbeing of this group. Continued development of the specialist Primary Care Teams for travellers, of which the SPHN was a member, is a core component of this endeavour.

- The review is obliged to step outside its immediate remit for a second time, to recommend to the relevant government departments that a public health message about the dangers of using infant car seats in settings other than cars is reiterated through as many media as possible. The message should be affirmed by child protection and welfare staff.

- It will be important for the Child and Family Agency to firstly, take account in its proposed service delivery of the particular issues involved in promoting the safety and welfare of travellers, and to build bridges with existing specialist services.

**Dr. Helen Buckley,**

**Chair, National Review Panel**

**Date: 20th August 2014**