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

August 2014

1. Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious incidents including Deaths of Children in Care' issued in 2010. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the Health Service Executive in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the Health Service executive or a Health Service Executive funded service
- Serious incidents involving a child in care or known to the child protection service

2. National Review Panel

A National Review Panel was established by the Health Service Executive and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the Child and Family Agency. When a death or serious incident fitting the criteria above occurs, it is notified through the Child and Family Agency to the CEO's Office and from there to the National Review Panel. The CEO and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents, families and children, and site visits. A report will be produced which will contain a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions and recommendations. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

Major review: to be held where contact with the Health Service Executive services prior to the incident has been long in direction (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.

Comprehensive review: to be held where involvement of Health Service Executive services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interview with staff and family members. The output should be a report with conclusions and recommendations.

Concise review: to be held where the involvement of Health service Executive services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.

Desktop review: to be held where involvement of Health Service Executive services has been brief or the facts of the case, including the circumstances leading up to the death or serious incident, are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no

suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

Recommendation for internal local review to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

4. Death of young person here referred to as Cal

This review is concerned with a toddler who died following a domestic accident. His autopsy attributed his death to asphyxiation as a result of 'imprudent restraint in a mobile car seat'. Cal was a member of the travelling community and lived on an established traveller site in a dwelling which was part mobile home and part permanent structure. His family had been known to the Social Work Department (SWD) in his area for a number of years. Cal was described by the crèche staff as an affectionate little boy who responded better in a one to one situation than a group.

5. Level and Process of Review

This was conducted as a concise review by Ceili O'Callaghan, Independent Child Care Consultant and Jean Forbes, Independent Child Care Consultant. The review was chaired by Dr. Helen Buckley. The methodology adopted was a review of social work records, public health nursing records, submissions from staff and interviews with key staff. The family were offered an opportunity to meet with the review team but declined.

6. Terms of Reference

The review adopted the following terms of reference:

- To review the services provided to Cal and his family for the duration of his short life.
- To determine whether compliance with relevant procedures, standards and regulations was satisfactory
- To examine inter-agency and inter-professional relationships
- To provide an objective report to the Child and Family Agency including an executive summary, conclusions and recommendations.

7. Background and reason for contact with Children and Family Services

Cal had older and younger siblings. The family had been receiving intensive support from a number of services over the years, some of which were delivered through the Traveller Health Strategy. They were referred to the SWD because of concerns about physical neglect of the children, including safety issues and low attendance at necessary health services. There were also concerns about the standard of accommodation in which they were residing.

8. Services involved with Cal and his family

There were a number of services involved with the family, including the following::

- Children and Family Social Work,
- Local Authority (housing) Social Work Team
- Specialist Public Health Nurse,(SPHN)[1]
- Public Health Nursing,
- Community Welfare Officer
- Community Psychology
- Speech and language Therapy
- The Crèche, schools and after school facility
- General Practitioner,

- Area Medical Officer
- Hospital Paediatrician.
- Physiotherapy.

The key professionals working with the family were the SPHN the SWD and various medical professionals. The role of the SPHN involved working with traveller families, and advising the Traveller Health Unit about their general needs. She had an additional responsibility which was to advise the Traveller Health Unit on the identified needs of traveller families, and she was expected to participate in the implementation of the HSE Traveller Health Strategy. In this particular case, she visited the family frequently and advised both parents in relation to suitable diet and nutrition for the children and appropriate play and safety issues within the home. She linked with all of the professionals involved with them, linked the family with all supports available, reminded the family of appointments, conducted joint home visits with the social workers and advocated for the family. The community public health nurse was responsible for children's health and developmental checks. Full developmental assessments were completed. Both public health nurses were active in linking with the community welfare officer on behalf of the family.

The SWD provided support to the family through regular and frequent home visits once the case had been allocated. The allocated social worker worked closely with the SPHN and availed of her specialist knowledge of the community.

The GP, hospital paediatrician and area medical officer worked closely together to coordinate the health care of the family.

9. Summary of Cal's needs during his involvement with the Children and Family Services

Cal had specific health needs. His weight was at or often below the 2nd centile and was monitored regularly. He had a tendency to suffer from chest problems, his immunisations were not kept up to date and he had some motor development delays requiring physiotherapy. He also had some skin problems. His speech was slightly delayed and he required speech and language assessment.

10. Chronology of Contact between Cal, his family and the Health Service Executive

Before Cal's birth

Over the two years prior to Cal's birth, the SPHN had become concerned about safety in the family home, where the cramped circumstances created some risks for the children. After she had twice drawn the parents' attention to the safety issues, she made a child protection notification to the SWD. According to her notes, a social worker visited with her in response and had a 'long chat' following which the parents said that the safety issues would be addressed.

Cal's early life

When Cal was five months old, the SPHN became concerned about his delayed motor development including poor head control for his age, his below average growth and weight gain and the fact that he had not had his recommended vaccinations. She referred him to the Area Medical Officer (AMO), who subsequently became very active in his care. Cal received his BCG shot at this point, and was referred for physiotherapy. A paediatric referral was not considered necessary at this time; however, Cal was hospitalised six months later for a chest infection and the paediatrician then became involved in his care. Medical appointments were not consistently attended by Cal and his parents and the supervision of his development became quite challenging. Over the following months, the SPHN, AMO, GP and paediatrician were required to collaborate closely. Between them, they attentively monitored Cal's progress and ensured that he received the required medical examinations and procedures. There were on-going concerns about his growth and general development. Physiotherapy and speech and language appointments were offered but not regularly attended.

Child Protection Notifications

Another child protection notification was made to the SWD concerning the children when Cal was eighteen months old, this time by An Garda Síochána who had found two of Cal's older siblings out on the road unsupervised and inadequately dressed, without their parents' knowledge. The review team could find no contemporaneous record of this notification and it is not known what response was made by the SWD at the time.

The next notification was made two months later by the SPHN, outlining concern with regard to both parents' capacity to meet their children's needs, and reporting neglect of the children. It

described a situation where the SPHN had called to the home one morning and found the parents in bed while the smaller children were up, hungry, unsupervised and inadequately dressed with very wet and dirty nappies. The notification stated that Cal's physiotherapy appointments had not been kept, despite reminders and the fact that the family had their own transport. The notification also described the reluctance of the parents to engage with local family support services despite encouragement and home visits by the staff. There was no contemporaneous record of this notification on the social work file but a letter on file from the Principal Social Worker which confirmed the referral was on a waiting list for response.

When Cal was twenty two months old, reports were made by the older children's school in respect of their neglected and unhygienic presentation, their poor attendance and lack of proper lunches. The notification reported that one of the children had started to make a disclosure of violent behaviour by his father and had been discouraged from talking about it by the other child. The notification went on to describe how, when the teacher subsequently asked their father about cuts and bruises on one of the children, he attributed them to an accident.

The SPHN's notes record that she telephoned the crèche at that time to ask staff there to encourage the family to use the crèche for support. Shortly afterwards the SPHN phoned the SWD to request a date for a Professionals Meeting. She mentioned concerns about Cal's health. There was a record on file of notes in relation to a professionals meeting made by the AMO. However, there is no record on the social work file to indicate whether or not a meeting took place or if the SWD was involved.

A letter on the social work file, dated some weeks later, from the SPHN outlined a number of shortcomings in respect of the family's accommodation. The letter described how the children were sleeping on the floor in a space with leaking windows, that the floor was frequently wet and the room very cold. This letter also noted a number of the children were being seen by the AMO because of suspected failure to thrive, as the parents refused to attend hospital for investigations of this problem.

The principal social worker (PSW) responded to the letter by consulting the case records on the family, following which she asked a duty social worker to visit.

A social worker from the duty team accompanied the SPHN on a home visit nine days later. It appears from the social work record of this visit that all the child welfare issues that had been previously noted were discussed openly with Cal's parents, including the necessity for supervision of

the children, the importance of routines and the need to keep them safe and warm. The main focus of the conversation however, was the urgent need for re-housing as the accommodation was totally unsuitable for the needs of a large family. After this visit the duty social worker discussed the situation with the social work team leader (SWTL) and PSW and sought approval from the SWTL to visit again one week later.

At the suggestion of the PSW the team leader asked the SPHN if she believed that there was need for immediate action to be taken in respect of the children, i.e. whether they required to be placed in care. The SPHN responded that while the situation was 'very bad' but that immediate action was not yet required. In her assessment, the family's primary needs were for housing and 'close monitoring' from the SWD and herself.

The social worker from the council housing department subsequently became involved at the request of the SWD and SPHN and the family's housing needs were conveyed to the local council. They were given a larger home within a short time, though their new situation was still considered to be hazardous. The SPHN told the review team that the children were often forced to play inside the home as there were concerns in respect of vermin surrounding the home.

The next note of contact in the social work file was dated two months later. While there is evidence that the SPHN continued to visit the family during this period, the case remained on the waiting list for allocation to a social worker.

Allocation of Social Worker 1

The case was allocated to a social worker two months later and the same worker remained involved with the family during the time span covered by this review. The social worker, here known as Social Worker 1, had met the family whilst on duty and she was allocated to the case because she had managed to establish a relationship with them. It was known that the family were reluctant to engage with social workers; they had told SPHN that they would not allow the children to attend the after school centre or crèche as they blamed these services for getting social work involved.

Soon after the social worker became involved, Cal's mother and his siblings moved out of the area following an incident of alleged domestic violence. Social Worker 1 and her SWTL visited her in her temporary accommodation and found the children well and cared for. The social work notes record that the family returned home within a few weeks; the incident was subsequently referred to as a 'once off' episode by the parents.

During this time, concerns remained about Cal's growth and development and health staff remained involved. The social worker linked closely with the SPHN once she was allocated to the family and she also reminded the family when appointments were coming up.

Over the following months, Social Worker 1 and the SPHN visited the family regularly, at least every ten days and sometimes more frequently. The concerns that were recorded about the family at the time include:

- Parents' failure to consistently accept professional concerns about safety and child care
- Parent's failure to take consistent action.
- The fact that the children were sometimes found in very wet and dirty nappies. All of the children had nappy rash for long periods of time.
- Problem with the children's attendance and punctuality at school,
- Cal's sporadic attendance at crèche.
- Concern about the behaviour problems of the older children at school, which led to a referral to the psychology service. The children's parents resisted referral to the psychology service despite a lot of encouragement by the social worker who tried to get them to understand that the children's behaviour might be a symptom of stress.

The records indicate that the problems were addressed by the parents at times, and improvements were noted in the social work file on a number of occasions. The review team notes the large number of services involved with the family at this time, and the efforts and encouragement made by them to engage the parents and children in services. It also notes the resistance displayed particularly by the children's father, to the services offered.

Events leading to Case Conference

Three months later, the SPHN notified the SWD about an occasion where she had, one a home visit, found the children unsupervised and inappropriately dressed with wet and dirty nappies. Cal was noted to have excrement coming down his legs. The children were eating dried complan out of a cup, and adult medication was visible within their reach. One of the older children was tied into a car seat. The special public health nurse also reported that the children's weight tended to fluctuate erratically. She considered that they were suffering 'gross neglect' and requested an urgent child protection conference.

Social Worker 1 and the SWTL responded by visiting the family the following day. They found Cal strapped into a car seat on the sofa. The social worker went into considerable detail with his mother about the dangers associated with this and she took him out of it. The review team were told that this was only one of a number of issues raised during a fraught home visit where the family showed considerable hostility to the social workers and threatened to leave the area because of their involvement. The records indicate that despite the threats, the social worker and SWTL spoke frankly to the parents and pointed out the necessity to feed the children properly, supervise them at all times, provide adequate clothing and ensure that they attended school and crèche. Their father once again objected to the psychology appointments. On the positive side, the social workers noted that on this particular occasion, the children looked well cared for. They were playing happily, though the workers noted that risky interactions between the children at play were unnoticed by the parents. The SWTL informed the family that the role of the SWD was to ensure that the children were protected and that they would continue to monitor whether by agreement or under a supervision order. The review team notes that this was the first recorded occasion on which legal action was mentioned to the parents. The SWTL told the parents that a child protection conference was being planned.

While awaiting the child protection conference, which was held just under three months later, the SWD established an interim plan, including

- CPN1 Notification
- Complete Individual Assessments for each child
- Follow up Psychology referral
- Weekly Home Visits

Over the next few months, improvements were noted on file with regard to attendance, presentation and behaviour at crèche. The crèche staff advised the social worker that the children's clothing was clean and often new. The children were noted to be eating well when at crèche.

There is evidence on file that the weekly joint home visits took place as planned, with current issues being addressed at each visit. These issues included once again finding one of the children in the car seat on the sofa. At one point, bruises on some of the children were noted, attributed to rough play. The social work record indicates that these issues were raised by the social worker with the family.

The school reported a disclosure by the children of a violent encounter between their father and a sibling. This was investigated by the social worker, who arranged for the child concerned to be medically examined. The outcome of the medical examination was inconclusive but the parents' account was not consistent with the doctor's view. In the meantime, it was noted that the children's mother was pregnant and was tired and unwell at times.

Child protection conference

The Child Protection Conference was held three months later. The review team saw the reports prepared by the social worker, the SPHN, the AMO and the crèche.

- The social worker noted that a lot of services were engaged with the family. She further noted the inconsistent level of cooperation shown by the parents, which meant that concerns were sometimes taken on board with positive action following. However, she noted that their parental capacity fluctuated, improvements were not always sustained, and that they showed a lot of resistance to intervention with low motivation to change.
- The SPHN reported on the situation of each individual child. She noted that their mother suffered from depression, and would only accept treatment from her GP. She identified the recent problems, but also specified the positive changes that had taken place, including a move to more suitable accommodation, use of the crèche, after school care, and attendance at appointments with the AMO. However, she also identified sporadic attendance at other medical appointments, inconsistent supervision, and problems with nutrition and physical care of the children.
- The AMO furnished a report detailing the medical issues of each child, which noted that Cal had dropped again in weight from 2nd centile to under the 2nd centile and that his immunisations were incomplete. He further noted that Cal had been referred to speech and language therapy where he had his assessment and the speech and language therapist had given a programme to support his language development to the crèche. Cal was referred to physiotherapy for mild gross motor delay but had been discharged from the latter due to poor attendance.
- The report from the crèche expressed general concerns about the children's basic needs for nutrition, hygiene, affection and the importance of their regular attendance at the crèche where they would have an opportunity to play, learn and develop socially. The report also noted that they were lovely children who had the ability to reach their potential in development. They recommended the appointment of a support worker to work in the family home and indicated their willingness to provide this service.

The child protection conference, which was attended by the children's father but not their mother, reached a decision to place all the children on the Child Protection Notification System because of neglect, specifically poor nutrition and hygiene, supervision and safety, developmental delays and poor opportunities to play. It identified a number of conditions for the parents which included their acceptance of a support worker in the home, provision of supervision at all times, attendance at appointments, crèche and school. The child protection conference also recommended the continued coordinated involvement of the social worker and SPHN.

Post Case Conference

Social Worker 1 and the SWTL told the review team that the child protection conference was a turning point for the family, that they took the plan seriously and made efforts to comply with it. Over the following six months, announced and unannounced home visits by the social worker and SPHN continued as before, at least weekly. They struggled to keep the children attending appointments, which included important health checks for Cal. The crèche continued to provide support, and plans were made for a family support worker to commence within two months. It was noted that Cal's mother gave birth to another baby, which impacted on her general capacity to care for the children in a challenging environment.

The records convey evidence of some general improvement; the children were attending crèche and were noted to be thriving. Over the next few months, there were reports of what might be described as generally 'good-enough' care noted in the social work file with the odd incident requiring exploration e.g. a bruise on one of the children.

Tragically, Cal died shortly afterwards in an incident related to his being strapped into a car seat in the family home.

11. Analysis of involvement of Health Service Executive Children and Family Service

It must be acknowledged that the professionals working on this case were delivering services in a context that was shaped by two very significant factors. The first one is that, from the description in the files and the accounts of the workers involved, the family was living in an environment that was cramped and damp although the new accommodation provided was a big improvement. The external area was unsafe for the children because of the presence of vermin. This undoubtedly

affected the parents' ability to keep their children healthy, and their capacity to conform to normal child care standards. The second factor was that the family were hostile to the intervention of services, particularly social work, and were disinclined to attend appointments outside their home. These two factors posed considerable challenges to the professionals involved, and in the opinion of the review team, resulted in high thresholds being applied in respect of the acceptability of the children's situation at home.

11.1 Initial Response of services to concerns about the family

During the years prior to the formal engagement of the SWD with this family, a number of health and support services had been actively involved with the parents and children. The SPHN records indicate a number of attempts to engage the SWD from the two years prior to Cal's birth, but the social work record shows no contemporaneous evidence of these notifications. For six months before the case was allocated to a specific social worker, it was dealt with by the intake team, which meant that no one social worker had overall responsibility for it. It was on a waiting list for allocation for three months, indicating that it had not met the threshold for allocation earlier, and that when it was considered eligible the SWD was unable to take it on right away. In the experience of the National Review Panel, this pattern of engagement would not be unusual but indicates that children suffering from neglect, including serious incidents of neglect, have not been receiving the full range of services. The fact that earlier notifications were not recorded on the social work record later opened by the SWD suggests that inefficient record keeping, may have implications for the way that reports are prioritised for allocation.

11.2 Assessment

The social work file shows an initial assessment which largely reflects the referral made by the PHN. While the file does not contain a specific assessment in respect of individual children or their needs, a report for the child protection conference contains evidence that the parents' capacity and motivation to change was given detailed consideration.

In general, the files and child protection conference reports indicate that the SPHN, social worker, other health staff and support services had a fairly clear sense of the needs of the children and the relevant safety issues. However, the lack of a structured assessment format meant that it was not possible to identify from the record how decisions were made in respect of thresholds of neglect. Further information was provided to the review team by the professionals who came to meet them, but in the absence of this it would have been difficult to form a complete picture. In keeping with

standards of good practice outlined in Children First and other documents, a separate assessment should have been completed, using a standard framework, which looked at the needs of each child separately, the capacity of the parents to meet each of the needs, any special circumstances and any obstacles being experienced by them which may undermine that. It should also have indicated how any progress in respect of desired goals would have been tracked and demonstrated.

11.3 Compliance with regulations

Notwithstanding the delay in allocation of the case, there is evidence of general compliance with Children First by all the professionals and services involved, including the family's referral to the CPNS and the holding of a child protection conference. The standard of assessment did not comply with the requirements of Children First, nor did the quality of record keeping in respect of some of the core group and professionals' meetings. The almost three month delay was described as 'not untypical'. However the review team considered that it was too long given the nature of concerns that precipitated the conference.

11.4 Quality of Practice

11.4.1 Interaction with the child and family

The social worker and SPHN had the most consistent contact with the family, visiting frequently; at least one of them visited once a week, often both. Social Worker 1 was accompanied by the SWTL, when the SPHN was not available, or when there were serious issues to be discussed. The SWTL also visited at times when the social worker was not available.

The review team was impressed by the efforts made by all the professionals and agencies involved, each of which showed considerable flexibility and willingness to offer services over and over again despite persistent non- attendance. The family were described to the review team as suspicious of intervention and threatened by professionals. The records indicate that social worker and specialist public health nurse worked hard to overcome these challenges and did not let up in their regular and frequent surveillance of the quality of child care.

Despite the aforementioned difficulties, the records indicate that Social Worker 1 managed to develop a good relationship with the family and appears to have gained a certain level of respect within a very tense context. Despite not being welcome at times, she maintained regular and frequent contact with them. She did not refrain from confronting the children's parents about the

shortcomings when it was necessary to do so and her interactions with them appear to have been both firm and warm.

Although the SPHN had a specialist post working with traveller families, the degree to which she could become involved in any particular case was limited by the large caseload she carried and the extensive area that she covered. Nonetheless, she provided an attentive service in this case and showed considerable creativity and cultural sensitivity in respect of her work. For example, she was very concerned about the inappropriate use of car seats in the traveller community, and brought a representative from a motor accessories firm to the site to speak to parents about the risks of mis-using infant car seats. She did as much as she possibly could to facilitate the children's attendance at medical appointments by reminding them on the day. She showed insight into other specific issues related to the traveller community and encouraged the children's mother to attend a women's group. Her dedication to her work was obvious in both her written records and the evidence she presented at interview.

There were some occasions where the state of the children raised acute concern. However there were numerous other occasions where the SPHN and the social worker noted a level of improvement in the children's care, particularly following the child protection conference. The review team was impressed with the way that records reflected the doggedness of both the SPHN and the social worker in reiterating safety concerns, and dealing firmly with the resistance, particularly of the children's father, to their interventions.

11.4.2 Child and family focus.

The files reflect frequent interaction between the professionals and the parents of the children. Research has been critical of child protection practitioners in the past for focusing only on mothers, but in this case it is clear that both the SPHN and the social workers were successful in engaging the children's father regularly and clearly made efforts to do so. Both Social Worker 1 and the SPHN reported having witnessed warmth and affection between the children and their parents, family meals and the children playing contently. The children were also described by the social workers and the SPHN as bright and able. While the files also record interaction and play between the professionals and the children, there is not much information on file in respect of the children as individuals. For example, it is not possible to gain a picture of Cal as a child from the social work records. It is acknowledged, however, that this was a very large family and while the social worker appears, from the records, to have been primarily focused on the parents, the crèche and the PHN were closely engaged with the children, as was the school, and there is evidence that the different

members of the network communicated frequently with each other through the key working of the social worker. In that respect, the work was child focused and the work with the parents was intended to improve their capacity as parents as well as their own welfare.

11.4.3 Quality of Record Keeping

The records later kept by Social Worker 1 and all the records kept by the SPHN were contemporaneous and reflect the circumstances of the family at the time of visiting, and the level of interaction between them and the professionals. The social worker's notes specified which children were seen by her on each occasion.

However, certain aspects of the social work record lacked analysis. With the exception of case conference reports and minutes, it is not possible to identify from the file how the SWD assessed and concluded that the parenting was good enough and that alternative care was not warranted. Evidence provided at interview to the review team clarified that the social worker and SPHN had both given extensive consideration to the capacity of the parents in the course of their contact with them. This was key to their view that the children should remain at home.

11.5 Management

11.5.1. Allocation

It appears that the input from the duty team was sporadic prior to the allocation of the case despite the nature of the notification, which described a very neglectful situation. The case was put on a waiting list at some point, but there is no indication of how the reported concerns were assessed in terms of their priority for allocation. The review notes that once the case was allocated, it was held by the same worker, and that it was allocated to her because her earlier contact with them had been constructive.

11.5.2. Inter-Agency Meetings

While a number of meetings both formal and informal took place in respect of the case, there was only one child protection conference. The SWTL told the review team that this had been convened because despite social work involvement over a period, the same concerns were being reported by

the SPHN. According to the SWTL, the child protection conference was a turning point in the case, after which the family become less defensive and more cooperative. The child protection conference took place almost three months after it was requested and the review team were told that this type of time lapse is normal for the area. Given its significance in the case, the review panel considers it reasonable to judge the delay as unacceptable, albeit that it was outside of the control of the SWD.

The child protection conference was attended by the relevant professionals; reports were provided and a clear plan emerged.

11.5.3. Supervision

Evidence of supervision was provided to the review team. It was consistent and regular. In addition the file refers to informal case discussions on a weekly basis. The review team note that the SWTL carried a case load of her own and supervised a high number of staff. Within this pressurised context she provided good support to Social Worker 1.

11.5.4. Inter-agency collaboration

The review team found outstanding examples of multi-disciplinary and inter-agency working and information sharing in this case. It appears from the record and from interviews with staff that communication and collaboration worked well, with all services showing flexibility and a shared commitment to promoting the welfare of the children. The evidence presented pointed to close and efficient working relationships between the medical staff. It appeared that they kept in close contact and appointments were accessed without any difficulty when requested. It was also noted that the AMO would make himself available at short notice if requested to do so. There was an understanding that the family found it difficult to keep appointments. They had a large number of children with complex needs. It was noted that they found long waits in the paediatric out -patient department particularly difficult

12. Conclusions

- The review acknowledges that Cal's death was a tragic 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.

13. Key Learning Points

- 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, 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. Social Worker 1 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 Social Worker 1 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.

14. Recommendations

The review makes the following 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

20th August 2014