Review undertaken in respect of the death of

Christy

A young person known to the then HSE

Child Protection System

Executive Summary

October 2014

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This review was assisted by the completion of a review conducted at area level shortly after Christy's death.

Introduction

This review was carried out in respect of a young person here named Christy, who was a settled member of the travelling community and died accidentally at 17 years of age. The review was conducted because Christy and his family had been known to HSE child protection services over a period of nearly five years. It was conducted as a desktop review by Deirdre McTeigue and Helen Buckley. The terms of reference were:

- To examine the services provided to Christy and his family by the HSE and HSE funded services prior to his death.
- To identify opportunities for learning from the findings of the review.
- To provide a report to the Child and Family Agency with conclusions and recommendations

Background

Christy and his siblings had been living in the same area for six years prior to his death, having moved there from another jurisdiction. The main carer was Christy's father, here called Martin. His mother lived with the family intermittently. The child protection services were involved because of concerns about Martin's ability to care for the children which was impacted by mental health and alcohol problems. Over the period under review, numerous reports were made by Gardai, health and educational staff to the SWD. A major concern was the poor school attendance of the children; there were also concerns about familial and inter-family violence on different occasions. The case was open to the SWD for three years

at the outset. It was dealt with on duty initially and then allocated to a social worker for eighteen months, closed for a year because the child neglect was considered low level, and then allocated again thirteen months before Christy died. Different workers were also involved as incidents arose. During the period in which it was closed, incidents were responded to by members of the duty social work team. A large number of professionals were involved at different times, including school and educational welfare staff, services for travellers, health services, the Gardaí, the housing department, addiction services and Youthreach. Interventions centred mostly on Martin and on Christy's siblings; there is comparatively little mention of Christy in the records. Around the time that Christy turned 16, he took up a place at Youthreach and reportedly did very well there. The situation at home had, according to the records, improved at this point. Tragically, one month after his 17th birthday, Christy died in an accident which was associated with risk taking behaviour.

Findings

Christy died in a tragic accident and the review has found no direct link between this accident and the quality of services provided to the family. It notes the efforts made by the two allocated social workers to effect improvements. Nonetheless, it has identified a number of weaknesses in practice as follows:

- A failure to comprehensively assess the individual needs of the children despite reports of child neglect. While there is evidence of the active involvement of the two allocated social workers and serious efforts on their part to effect change in the parents' behaviour, the absence of a comprehensive assessment meant that the children's individual needs were not consistently understood or met.
- There was a lack of coordination and follow through of interventions to address the different issues or systematically review progress
- Supervision was not provided to the required standard at the earlier stages of this case. It is noted that a national supervision policy has been introduced and this review assumes that it has now been implemented in the area.
- The case reflects a failure at the point of first closure to take seriously the cumulative impact of neglect on children's safety and welfare

Key learning points

- A number of key reforms have taken place since the time of Christy's death, including the establishment of the Child and Family Agency and the development of

a new model of service delivery which is in the process of implementation. Under the new model, a case such as this, where children were considered vulnerable but not at risk of significant harm should receive services in the community via the local area partnerships. There was no indication in this case that the family were unwilling to engage or accept services, therefore they may have responded well if such a coordinated approach were available to them at the time. However, weaknesses such as those identified here (inadequate assessment, lack of coordination, failure to evaluate or review) could persist even in the context of recent reforms so it is important to recognise that unless vigilance in respect of practice standards is consistently applied, the effectiveness of area based partnerships will be undermined.

- This case was closed at one point in the knowledge that the children were experiencing 'low level neglect'. This action reflects a trend, reflected in research whereby 'low-level care' may be tolerated when there is no evidence of sustained improvement in standards of care over the long term. However, it should be noted that Miller (2007)[1] and Miller and Bromfield (2010)[2] have looked at the negative impact of cumulative harm which includes patterns of circumstances and events in a child's life that diminish a child's sense of safety, stability and well-being and ultimately undermine their capacity to develop necessary coping skills. They caution practitioners not to underestimate the long term damage to a child and point out that a focus on cumulative harm requires each notification to be assessed as bringing new information which needs to be integrated into the history of previous assessments. In order to pre-empt further deterioration, goals and clearly articulated responsibilities need to be set and to be monitored. The review team considered whether the fact that this family were members of the travelling community meant that lower standards, indeed 'low level neglect' was tolerated. Without comparison of this SWD's practice in other cases it is not possible to make such a judgement. However, it is a point worth considering in light of research which shows that differential assessments and cultural relativism may be applied to

[1] Miller, R. (2007) *cumulative harm: a conceptual overview.* Victorian Government http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf

[2] Bromfield, L. And Miller, R. (2012) *Cumulative Harm: Best Interests case practice model specialist practice resource.* Victorian Government. http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/665902/cumulative-harm-specialist-practice-resource-2012.pdf

minority groups. In that regard, SWDs must take great care to ensure that they are alive to this concept and its potential to permit the continuance of unacceptable risks and substandard practice.

- As well as living with a parent whose mental health and addiction problems impeded his parenting capacity, Christy and his siblings were regularly exposed periodically to domestic violence. Research shows the detrimental impact of each of these social factors on child development, but importantly, it also demonstrates that more than one adversity in a child's life has a 'multiplicative' effect. Practitioners and managers should be aware of, and apply, formal knowledge (e.g. empirical research) that is relevant to the families who come into contact with the service. The best way to achieve this is to firstly, commit to evidence informed practice and utilise available resources such as the North South Child Protection Hub (NSPCH.com) or the NSPCC inform website (NSPCC.com) and, secondly, use an approved assessment framework to ensure a comprehensive approach.

Recommendations

A review of this case was carried out by the Child and Family Agency at local level, and it made specific recommendations for implementation in the area. This review notes that the Child and Family Agency is in the process of implementing a service delivery model which incorporates many of the issues highlighted in this report in respect of the assessment of welfare cases and partnership responses on the part of community services. This review endorses that model and recommends dissemination of the above key learning points to staff in the Child & Family Agency and funded agencies.

Dr. Helen Buckley

Chairperson, National Review Panel