Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death experienced by a young child whose family was known to the Child and Family Agency

Jane

Executive Summary

June 2017

Introduction

This review concerns a two year old child, here called Jane, who died as a result of an incurable medical condition which had been diagnosed when she was a few months old. Jane was one of a number of siblings born to her parents, here called Jim and Carol. The review focuses on the period prior to Jane's birth as well as afterwards because of concerns that existed in the years before she was born.

The first report was made about the family prior to Jane's birth when an older child, who was then an infant, presented in hospital with a head injury. Her parents claimed it was caused by another child throwing an object. However, the consultant paediatrician felt that this explanation did not satisfactorily explain the injury. A child protection conference was held at which it emerged that the family had a number of welfare concerns and were experiencing difficulty managing routines and boundaries with their large young family. The child's name was listed on the Child Protection Notification System (CPNS) and a child protection plan developed. The family were offered and availed of parenting sessions and were subsequently visited regularly by family support, social work and public health nursing professionals. A review child protection conference nine months later noted that the baby was thriving and that Jim and Carol were very cooperative and a decision was made to de-activate the child's status on the CPNS. It was decided that a family welfare conference would be a more appropriate means of reviewing the case as no child protection concerns were apparent after a period of months. The parenting course was completed by Jim and Carol, and welfare services were then provided by a local community based organisation. Over the following six months, two reports were made to the SWD about the family, one concerning alleged domestic violence and another regarding an injury to a different child which was deemed to be accidental. Although responded to, these reports were not fully investigated.

A family welfare conference was held just after the birth of Jane, which resulted in a detailed plan in relation to family routines, meeting the needs of the children, immediate medical attention for any accidents, supervision of the children and family support. Some concerns about supervision remained. The case was subsequently closed to the SWD. The review was unable to ascertain whether the community organisation continued to provide services at this time.

Jane was diagnosed with a serious medical condition when she was six months old, which involved frequent medical appointments and hospital attendances. A referral was made to the SWD by the hospital when Jane was around one and a half, with some concerns about supervision of an older child and about Jane's own welfare. The SWD planned to carry out an initial assessment and the case was put on a waiting list for allocation, where it remained until Jane's death four months later.

Findings

The review notes that Jane's death was from an incurable illness and was not related in any way to the level of service provided. Jane's family received very regular and consistent services during the period following the referral about the older child's injury. The interventions are well recorded. There were examples of good collaborative work, of plans being carried out, and of good relationships being formed with the family. Some practice weaknesses were identified, including the fact that the assessment conducted following the alleged NAI was not sufficiently focused on the risk it implied for that child and other children in the family. Regardless of the fact that no other NAI's appear to have occurred to the children during the period under review, and the family did engage well with professionals and were deemed to make progress, the failure of the SWD to properly investigate and assess the risks to the child concerned and any other children in the same environment reflects a lack of appreciation at that time of the significance of an unexplained head injury to a vulnerable child.

It is also notable that while the Gardaí were informed, they were not formally notified nor included in a joint investigation. The plan that was made at the first and second child protection conferences were detailed, very clear and relevant to many of the general parenting concerns observed, and the methods proposed for monitoring those matters were sound, but in the absence of an investigatory focus on the cause of the injury and potential for further injuries, the plans were incomplete.

While the family support interventions following the earlier reports were well detailed and the parenting course that was proposed was carried out, there was a lack of clarity about the level of progress that was being made by Jim and Carol in their ability to keep their children safe. The family welfare conference was well managed, the ensuing plan was clear, and the supportive interventions suggested were appropriate. However, there was evidence over the following months that some of the previous parenting difficulties still endured, and the history of the case should have led to a rapid transfer back to the child protection social work services once further reports were made. The need for an initial assessment was recognised by the SWD but the case was waitlisted until after Jane's death several months later. The NRP is aware from other reviews that this area was under serious pressure at the time due to a high volume of referrals and unfilled vacancies which may explain the delay in allocation. However, the history of this case and the risks inherent from the outset should have led to prioritisation.

Key Learning

- The review has highlighted a number of learning points, the principal of which is the need for comprehensive assessment when serious concerns present to social work services. As the review has highlighted, it is vital to be vigilant in response to suspected non accidental injury (NAI). This means assessing the current level of risk, identifying indicators of risk and being specific about not only the methods to be used to effect change but the means of identifying that change has taken place. Consideration must be given to the vulnerability of the children, the possibility that injury may re-occur and the likely impact on the children if that happened. It is acknowledged that investigation of suspected physical abuse is complicated. Research[1] demonstrates that what are called SIDE (serious injury – discrepant explanation) present significant challenges to child protection practitioners in relation to assessment for future risks. It also demonstrates that denial is normal, as parents will fear repercussions and have little incentive to acknowledge a NAI. A study in the UK[2] found that child protection workers can become confused by the multiplicity of factors that emerge from assessment, which can lead to conflicting decisions particularly where a high number of welfare needs become apparent and parents are judged as doing their best in difficult circumstances or, where an absence of 'traditional' child abuse indictors is taken as supportive of a non-abuse explanation. Assessments in such circumstances need to be probing, focused and rigorous in terms of detail and should consider a range of alternative hypotheses, each of which should be thoroughly considered. Assessment of suspected NAI is, inevitably, a multidisciplinary endeavour and one area where child protection practitioners cannot work alone. Inquiries have shown that practitioners may see a reduction in the number of incidents over a given period as reducing the risk to the child when this may not in fact be the case[3].
- It should also be recognised that where physical abuse has occurred, domestic violence is often an associated factor. This implies that reports of suspected domestic violence must be followed up especially where suspected NAI has been the subject of investigation[4].

[1] Buckley, H. Horwath, J. and Whelan, S. (2006) *Framework for the assessment of vulnerable children and their families.* Children's Research Centre, Trinity College Dublin.
[2] Dale, P., Green, R. and Fellows, R. (2002) *What Really Happened? Child protection case management of infants with serious injuries and discrepant explanations.* NSPCC Practice Series.
[3] Fitzgerald, J. (1999) Policy and Practice in Child Protection: Its Relationship to Dangerousness in R. Dent (ed) *Dangerous Care*, London: The Bridge Child Care Development Service.

[4] Radford, L. Corral, S. Bradley, C. Fisher, H, Collishaw, S. Bassett, C. and Howat, N. (2011*) Child Abuse and Neglect in the UK Today*, London: NSPCC

- While accounts of the family support interventions at the early stages of this case are clear, it is suggested that clearer evidence could be demonstrated of how the parenting difficulties initially identified are being addressed, and whether improvements are sustainable. It appears that in this case, family support services ceased at some point although this is not recorded. Research has shown that while evidence based programmes are effective, the improvements may 'wash out' unless they are repeated. For this reason, a clear forward plan which includes re-visiting the main issues would result in a longer lasting and more positive effect.

Recommendation

The review team is aware that considerable reform has occurred in the area where the case that is the subject of this review has taken place. It makes one recommendation which is of national relevance and should be addressed by the intended adoption of the Signs of Safety programme by the Child and Family Agency. The recommendation is that the evaluation of risk should become a standard element of any national assessment framework.

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