Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

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

**February 2017**

## Introduction and background

Joey was a member of the travelling community and was only three months old when he was tragically killed in an accident. Although Joey had not been seen by any staff from the Child and Family Agency, his parents and older sibling had been the subject of assessment eighteen months prior to his birth. A total of four referrals about the family were made to the social work department (SWD), the third one a few weeks prior to Joey's birth and the fourth one a few days before he died.

The principal concerns about Joey and his sibling stemmed from his mother's previous drug and alcohol use while caring for her older child, her low mood the week before Joey died and allegations made at different times that she was a victim of domestic violence.

The SWD had responded to earlier reports by referring the case on to a partner voluntary child and family service for a 'child welfare' assessment. On the basis of this assessment, the family were considered to be somewhat isolated, but capable of caring for their children and as Joey's mother had committed to avoiding alcohol for the sake of her children, the case was closed to the SWD. Eighteen months later, Joey was born between the third and fourth referrals about the family to the SWD, both of which concerned alleged domestic violence between Joey's parents. Although the SWD had responded to the third referral with a home visit, further planned contact with the family and an initial assessment were delayed and in fact did not take place prior to Joey's death three months later. This delay was partially explained by the fact that the duty system was overloaded. In addition, some frontline management in the SWD had changed and it had taken the new social work duty team leader a number of weeks to familiarise herself with the cases held on duty. In the meantime, significant information concerning Joey's family was received in the area manager's office from social services in a different jurisdiction but was not passed on to the SWD for six weeks, until the day that Joey died, as the connection had not been made between this report and information on record about Joey's family.

## Findings

Joey died in a tragic accident and there was no evident link between his death and any action or inaction on the part of the Child and Family Agency. The review has, however, identified a number of practice weaknesses in the SWD at the time, as follows:

- The response of the SWD, in particular to the third referral, should have been made in a timelier manner. It appears that the case drifted at that point in an overloaded duty system with a change of team leader. Some aspects of the management of the intake system also contributed to the delay and these have already been addressed locally.
- The case was initially categorised as 'child welfare' even though there was evidence of domestic violence and substance misuse which had, in the past, been considered serious. This and previous reviews highlight that the process of categorising cases as 'protection' or 'welfare' often has implications for how they are managed.
- The partner agency's welfare assessment did not adequately address such issues as the combined impact of addiction, social isolation and domestic violence. The significance of multiple adverse factors was not given the recognition warranted.
- A significant piece of information was not passed from the area manager's office to the SWD and this, combined with the fact that not all services were in possession of all relevant pieces of information meant that a full picture of the concerns did not emerge for some time.

## Key Learning points

Cleaver et al 2011 (*Children's Needs – Parenting Capacity,* London TSO) wrote about the impact of multiple problems and are of the view that it is the 'multiplicative' impact of combined factors that have been found to increase the risk of harm to children. Further, they point out that 'although there is substantial evidence showing that a combination of parental mental illness, learning disability and problem substance misuse increases the risk to children's safety and welfare, the best prediction of adverse long term effects on children is the co-existence with family disharmony and violence' This they continue, is reinforced by the findings from serious case reviews 'domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds and it is the combination of these factors which is particularly "toxic" (Brandon et al 2010).

The Child Protection and Welfare Practice Handbook, HSE 2011 (page 63) poses the question of whether professionals may over-optimistic in their assessment of a situation, resulting in a minimising of the abuse/risk. It points out the need to consider interlinking risk factors that may be affecting parenting capacity e.g. adult mental health issues, substance misuse, social isolation, adult intellectual disability and child disability. It also notes that pregnancy and after the birth of a child

are higher risk periods for domestic violence as research has shown that a woman is at higher risk when she is pregnant. Of women experiencing domestic violence 28% are assaulted for the first time during pregnancy. (Royal College of Midwives 1997). One in eight women attending the Rotunda Hospital suffered abuse during pregnancy (O'Donnell 2000).

The HSE Practice Guide on Domestic, Sexual and Gender Based Violence (page 13 2.3.) gives the following guidance; 'Intimate partner violence is often a hidden aspect and not the presenting problem. It should always be considered as a possibility from referral through to assessment and closure in all cases' and further 'The adult survivor's ability to adequately parent or protect the children may be affected by their experience of violence. It is essential that initial and ongoing assessment tools are used to measure the risk of all forms of abuse that the children are exposed to whilst in the home and who they are at risk from.' It also points out (page 13) that the degree of isolation and vulnerability of the adult survivor needs to be taken into account. Under Myths About Intimate Partner Violence (page 6) the practice guide includes 'If there were no visible injuries then the assault cannot have been that bad'.

The practice guide makes reference to the 'Stella Project'. This project is part of Action Against Violence and Abuse in London. It focuses on the "development of inclusive and responsive services for people affected by drugs, alcohol and domestic violence". The project provides a toolkit for workers with sample documents including a domestic abuse risk indicator checklist and a drug and alcohol risk assessment form. Details are available on their website:www.avaproject.co.uk.

## Recommendation

The internal review made the point that some of the delays in responding to this case were associated with a change of team leader. While this is understandable, it needs to be acknowledged that staff turnover is an inevitable occurrence in the Child and Family Agency at present and is likely to continue. It should therefore be identified as a potential obstacle to good practice in the forthcoming Child and Family Agency Child Protection and Welfare Practice Handbook, with pointers as to how disruption or delays in service could be minimised.

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