National Review Panel

Review undertaken in respect of the death of a child known to the child protection system: Baby G

May 2011

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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 HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare 6, 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 HSE or a HSE 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 HSE 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 HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the Assistant National Director's Office and from there to the National Review Panel. The Assistant National Director 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 or carers, families and children, and site visits. A report will be produced which contained a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. 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 HSE services prior to the incident has been long in duration (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
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- **Comprehensive review:** to be held where involvement of HSE 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 interviews with staff and family members. The output should be a report with conclusions and recommendations.

- **Concise review:** to be held where the involvement of HSE 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 HSE 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.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death: Baby G

This review is concerned with the death of a four month old baby, here called G, who was in the care of her mother, here called J. The review has been held as J and G, as well as J's parents and siblings, were known to the HSE Child and Family Services. The timescale principally covers the period from December 2009 up to G's death on 14th July 2010, but the review also examines the services offered to J and her family following a referral in December 2006.

5. Level and process of review

This was conducted as a desktop review. A post-mortem, the report of which is included in the records, had concluded that G died of Sudden Unexpected Death in Infancy, with no signs of injury or neglect. The post mortem also noted that she was a well nourished baby.

The methodology adopted was a review of HSE records only, with the option of consultation with staff for the purposes of clarification. The review was conducted by the chair of the NRP, Helen Buckley. The records consisted of one folder containing 161 pages containing copies of correspondence, case notes and reports including the post-mortem and a report from the family support service. The public health nursing notes were also requested and received; these consisted of brief notes of domiciliary visits and nurse's observations. A request for a specific piece of information was made to the area and a written response received which was incorporated into the review report. Extracts of the report were sent to relevant key staff and their responses were considered in finalising the report.

6. Terms of reference

- to examine events leading up to G's death and determine whether action or inaction on the part of HSE Children and Family Social Services had been a contributory factor
- to examine the quality of service provided to G, J and J's family by HSE Children and Families Services and the level of compliance with procedures, protocols and standards of good practice
- to provide an objective report to the HSE

7. Baby G and her parents J and F

Baby G was J's only child and was just under four months old when she died. She had been born three weeks prematurely, at home and was then admitted to the maternity hospital where she remained for two and a half weeks. J was just seventeen at the time of G's birth and is the fourth of seven children. Prior to G's birth, she lived in her family home with her parents, three of her siblings and her nephew.

J left secondary school at the end of 2nd year, and had attended a Youthreach programme for approximately four months in the two years prior to G's birth, though her attendance was described as erratic. She is described in the records as a vulnerable young person, prone to unhappiness and depression, and reluctant to engage with services. She did not get on well with her parents and constantly rowed with them.

G's father was F and he was twenty years old at the time of G's birth. There is very little information on file about him, other than that J and F had been in a relationship for two years and F had been serving a prison sentence during J's pregnancy. The records indicate that the couple separated shortly after G's birth but that his family were interested in keeping in contact with her.

8. Background and reason for referral to HSE Children and Family Services

J's family had been referred to HSE social work services first in 1998, again in 2003 and again in 2004. The referrals mainly concerned J's mother's mental health, alleged neglect and alleged drug use by members of the family. Each of these referrals received a response at the time, and the outcome on each occasion was a decision to take no further action.

A further referral was made in late 2006 by a Garda who notified domestic violence by J's father and from then onwards, the case was open to the duty social work service, though contact with the family was intermittent until late 2009, when J's pregnancy became known and another referral was made by the maternity hospital social worker. Throughout the period from late 2006 to 2010, J's mother, i.e. baby G's grandmother, had made at least two disclosures of domestic violence to a Garda in the area, saying that her husband drank a lot and beat her constantly. The garda stated that he was 'shocked' by the situation in the home and said that J's mother was kept prisoner by her husband. When asked about it by the two social workers who were involved, J's mother denied that domestic violence was a current problem. Her daughters also denied it, as did her husband.

J was sixteen and a half years old when Social Worker B met her. She was offered a considerable amount of social work support by the HSE during her pregnancy. She engaged with the social worker to a certain extent, but she was reluctant to accept other services offered to her. G was born in March 2010, and no concerns were noted about her safety or welfare, though there was not a lot of contact with the baby by the professionals involved (public health nurse, Social Worker B, Family support worker). G and J had been nominally living in J's family home, but because of tensions there, J had tended to stay with friends on occasions and particularly after G's birth. J had spent the night with a friend when baby G was found lifeless in her cot by the person in whose home they were staying. G was taken by ambulance to hospital and pronounced dead on arrival. A post-mortem report included in the records provided to the review found no evidence of child abuse or neglect and concluded that her death was due to Sudden Unexplained Death in Infancy.

A duty management sheet completed in the second Local Health area indicates that this was regarded as a 'child welfare' case. This is taken to mean that there were no child protection concerns, but that the children, i.e. J and her younger siblings, were considered to be vulnerable and in need.

9. Services involved with G, J and their family

- The principal service involved in the case was the **HSE Children and Families Social Services.** The case was transferred between two social work teams in 2009 because of changes in the area boundaries, and was held in the duty system in both areas. In each area, one duty social worker took responsibility for the case, Social Worker A in the first area and Social Worker B in the second area.
- **An Garda Síochána** were involved in investigating incidents of alleged domestic violence which were acknowledged by J's mother
- There was a family **GP**
- The principals of the **two schools** attended by J's younger siblings were involved, as well as two Home School Liaison Teachers (HSTLs) from the younger sibling's school.
- J attended **Youthreach** for part of the time under review
- J attended a **maternity hospital** and had contact with ante-natal staff, a hospital social worker and a psychiatrist at the hospital
- The HSE **family support service** for the area was involved for part of the period under review
- Attempts were made to link J with a **HSE mental health service** suitable for adolescents
- A **public health nurse** became involved following the birth of baby G
- J's mother had significant health problems and was involved with hospital services but they did not form part of the network of services involved.

10. Summary of J's and G's needs

J was described as vulnerable and prone to depression and had been prescribed anti-depressants. It was known to the Gardai, who communicated this fact to the HSE social work service that her parents had an ongoing violent relationship, though this was denied by all family members. The domestic violence in the home clearly had a considerable impact on J's emotional and psychological wellbeing. She had dropped out of school prematurely and had not engaged satisfactorily with Youthreach. She claimed to have a good relationship with her boyfriend, but he had been in prison during her pregnancy and the file records that their relationship broke up shortly after G's birth because he was unsupportive. J's principal needs were for mediation between herself and her parents to improve their relationship, attention to her mental health, financial help and suitable

accommodation and support in caring for her baby. It was the view of Social Worker B and the maternity social worker that J was not capable of living on her own with an infant.

The public health nurse saw J and G on four occasions during April and May and her notes indicate that G was making good progress. There was no evidence that her needs were not being met. However, the social work record indicates that J tended to bring the baby to stay with friends quite a lot in order to escape tensions at home, which must have created certain instability.

11. Chronology of contact between J and her family and HSE Children and Family Social Services

1998 – 2004

The family were referred in 1998, 2003 and 2004. Each time the reports were followed up and then closed with no further action. They mainly concerned alleged neglect, child behaviour problems, maternal depression, and alleged drug use. Domestic violence was not mentioned in referrals at that point.

2006 – 2008

In late 2006, a Garda notification was made, about domestic violence between J's parents. This was followed up by HSE Children and Family Services with a number of letters to J's parents during early 2007 offering office visits which were not attended. The first two letters were sent to both parents and the third to J's mother only. Efforts were made to contact J's mother again in mid 2008, to no avail and face to face contact was finally established in October 2008 by Social Worker A, who had just started working in the area and was allocated the case on duty. Social Worker A conducted a planned home visit. Domestic violence was denied by J's mother, and the children's schools were subsequently contacted by Social Worker A. Youthreach staff commented that J was withdrawn and had told them that her father drank a lot. One of the sibling's school expressed concern about the child's attendance and performance, while the other had no concerns. Several appointments were sent to J and her mother by Social Worker A and not attended and a further domestic violence notification was received from the Gardai in December 2008. Despite efforts by Social Worker A to make contact, none was achieved following Christmas 2008 and the case was transferred to another team in early 2009 as the area boundaries had changed. The transfer summary notes that 'concerns regarding the impact of domestic violence on the children have not yet been discussed with the parents and in addition, the children's schools have expressed concern'.

2009

The case was allocated to the duty team in the second area in April 2009, and in June 2009 contact was made by the duty social worker (Social Worker B) with the schools and the referring Garda. The Garda was of the view that J's mother was a prisoner in her home, and that her husband was violent and drank a lot. The schools expressed concerns about the younger children, mainly about poor school attendance and performance, though also about physical neglect. Letters offering office visits were sent to J's mother in June and July 2009. These were not attended, and ultimately Social

Worker B conducted an unannounced home visit and successfully established contact in September 2009. Both parents were met at this point, domestic violence was again denied by J's mother, and the social worker learned of J's pregnancy. A further home visit was made by Social Worker B in December 2009, following a referral from the maternity hospital.

January 2010

Social worker B maintained regular contact with the family from December 2009 to March 2010, with a strong focus on providing support to J to prepare for her baby and attempting to link her with services (which she tended to turn down), as well as attending to the family's financial and accommodation problems and providing emotional support to J's mother. During this time, J was attending a psychiatrist in the maternity hospital who prescribed her anti depressants and sleeping tablets. He recommended her to attend a community mental health service, and commented that her problems were associated with her home situation. Information from the youngest siblings' schools indicated concerns about general neglect, attendance and punctuality. The schools appeared willing to liaise with the family with regard to these issues.

February 2010

Social Worker B continued to give regular support to J, and work with her family to try and improve their relationship with her. Social Worker B made contact with a mother and baby unit to be told that J was unsuitable because she was under 18; other options were unsuitable because they were too far away or were private. As there was no accommodation available Social Worker B concluded that living with the family was J's only option. Social Worker B made links with family support service, and the family GP, and attempted without success to link J with a community based mental health service (the service did not accept referrals for young people under 18). Social worker B also linked with the young children's schools and the referring Garda. Social Worker B maintained contact with the maternity social worker

March 2010

Social worker B continued to provide support and practical help to J, including clothes and equipment for the baby. A family support worker was introduced and contracted to work for two days per week with the family on practical issues and particularly with J to help her to prepare for the baby. Baby G was born in March, three weeks premature and kept in hospital for two and a half weeks.

April 2010

The family support worker remained available to work with J and family two days per week on the care of G and other practical matters, including a housing application. However, she had great difficulty in getting into the house. The public health nurse visited J and G three times during April, and gave advice about feeding, immunisations, safety, infant care and services. She also discussed aspects of maternal health care with J. No concerns were noted about J's care of G, though the family support worker and social worker noted on a home visit that the house was very overcrowded, tensions were high and this affected J's handling of the baby.

May/June 2010

During May and June the family support worker found it difficult to get into the house as J was either in bed late or staying with friends. Social Worker B and the family support worker did a home visit in mid June, and found that tensions in the house were still very high. The public health nurse made numerous attempts to see J and G but was only able to make one contact with J up to the end of May.

July 2010

The family support service made a decision to withdraw in mid July because of lack of engagement by J or her family. Social Worker B and the public health nurse tried unsuccessfully to contact each other in early July prior to Social Worker B going on leave. They left messages for each other but did not manage to have a conversation. Baby G died in mid July.

12. Analysis of involvement of HSE Children and Family Services with this case

Note: According to the social work survey conducted by the HSE in 2008, the area where the family resided had an extremely high number of unallocated cases. This fact was reiterated by Social Worker B in a response to extracts from the report. It was pointed out that this was one of 150 cases on a duty list which was being managed by two full time workers who were also dealing with intake on a daily basis. The comments made in this analysis must be considered in that context

12.1 Response of the HSE Children and Families Social Services to referrals

Earlier referrals of the family to the HSE in 1998, 2003 and 2004 had been quickly investigated and closed; this review concentrates on contact from December 2006 onwards.

A notification from the Gardai to the HSE social work service about domestic violence between J's parents was made on 18 December 2006. Six weeks later, a letter was sent inviting both parents to a duty appointment, followed by another letter for an appointment two weeks later as the first one was missed. The second letter stated that if the appointment was not kept that the social worker 'may have to arrange a home visit'. The appointment was not kept and a home visit was not arranged at that point. It transpired that these letters were being sent to the wrong address, and the correct address was obtained in March 2007 from the referring Garda, who again expressed concern about the domestic violence being experienced by J's mother. At that point a further letter was sent inviting J's mother to the office by herself. This appointment was not kept and it appears from the file that no contact was made for a further fifteen months until July 2008 when the duty team leader allocated it to a duty social worker with a view to arranging an office visit and an initial assessment on the family. However, no contact was made until Social Worker A joined the Social Work Department in late September 2008 and subsequently sent a letter to J's mother offering an office appointment which was again unattended and followed by another letter. Face to face contact was finally made by Social Worker A, via a planned home visit on 23rd October 2008, some twenty two months after the initial notification was made. A further notification of domestic violence was made

by the same Garda in December 2008. Social Worker A again made a number of attempts to contact J's mother prior to January 2009, and tried unsuccessfully to get messages to her via a Home School Liaison Teacher. Social Worker A left the area in February 2009, and the case was transferred to a different team following realignment of area boundaries. When the case was transferred it was held in the duty system in the second area, and the same pattern of sending office appointments was resumed, despite the fact that this approach had been unsuccessful in the previous area. Again, contact was not made until the Social Worker B conducted a home visit in September 2009. At that point, there had been no face to face contact between HSE social work services and the family for nine months.

While it is known that families experiencing domestic violence may be reluctant to engage with services, it is also well documented that children living in these circumstances are adversely affected and that domestic violence often coincides with physical and sexual abuse The practice of sending an invitation to both parents in response to a referral of domestic violence is questionable and guidance on working with domestic violence normally suggests seeing the victim on their own as they are likely to feel intimated in the presence of the perpetrator. It is noted that the third letter invited the mother only, but when she did not attend, the matter was not pursued despite the concern expressed by the Garda. Without underestimating the challenges in this case, including the turnover of staff, the response time between getting the original report and making contact with the family is unacceptable, and opportunities for intervention were missed. The process of engaging victims of domestic violence and their children can be slow and difficult, and it requires the strategic input of a number of professionals. However, it cannot be initiated until contact is made and in the meantime, the negative impact on the children continues.

The records indicate that when Social Worker B had established contact with the family, and had become aware of J's pregnancy, her response to this new concern and a number of other difficulties being experienced by the family was timely and conscientious.

12.2 Assessment:

There were no formal initial or full assessments on file from either area of either J or of her younger siblings. It must be acknowledged that this family were difficult to engage and were secretive as is common in situations where domestic violence is present. Following the one contact with the family in the first area, Social Worker A noted in her file under the heading of 'Assessment' that the children presented well, that J's mother gave a good account that all domestic violence had stopped, and that 'the older children in the home provide security in the case of domestic violence'. In hindsight, this assessment was erroneous, as a further notification of domestic violence was made two months later by the same Garda that had notified it previously. While J's mother was presumably persuasive with the social workers in her response that domestic violence had ceased, contact with the Gardai at the time of the assessment would have been informative. The HSE have subsequently issued a Practice Document on Domestic Violence[1], which outlines a framework for

[1] Health Service Executive Dublin South West Social Work Children and Families Department (2010) *Practice Document on Domestic Violence: a guide to working with children and families'.* www.hse.ie

assessing risk associated with domestic violence. This, or a similar tool, would have been useful as part of an assessment and may have assisted Social Worker A in helping to determine the extent and nature of the violence that was occurring at the time.

Social Worker A subsequently contacted the younger siblings' schools and ascertained that one was doing reasonably well and the other had poor attendance. She contacted Youthreach and was told that J tended to get upset easily. As there was no formal assessment as such, it was difficult to see how these problems were going to be addressed comprehensively.

When Social Worker B met the family over a year later, she documented a number of needs being experienced by different family members, including J's mother's poor physical health, the children's educational needs, J's mental health needs, overcrowding, the lack of a bed in J's room, and the family's financial struggles. While the assessment was not formally structured, it clearly identified a number of significant needs and also outlined plans to address each of them and the resources that would be required. However, it also failed to capture the domestic violence that, as it later transpired, was a constant occurrence at the time and was undoubtedly central to a number of the prevailing difficulties.

There is no record of any assessment of J's capacity to care for a new born baby which, given the concerns about her vulnerability would have been important. Significant risk factors here were the fact that G was born prematurely, J had mental health problems, she was very young and had a low level of educational attainment, and lacked support from her family. The family support report in the file notes that after G was born, 'due to numerous cancellations on the part of [J] it was difficult to assess her progress as a parent'. However, there is no record that any attempts were made to ascertain her capacity prior to the birth. The first entry on the public health nurse's records refers to the notification of G's birth by the hospital. Opportunities for joint pre-birth discussions between hospital staff, the HSE social worker and the PHN were missed.

Assessments should normally include at least one multi-disciplinary meeting where information is shared and plans are agreed. No such meetings took place in this case. The inability of either of the social workers to get beyond the family's denials of domestic violence and conduct a full assessment of their situation was not helped by the absence of a multi-disciplinary approach.

12.3 Compliance with regulations,

Children First 8.10.1 states that all child protection concerns should be followed up as soon as possible. The 2006 notification of domestic violence was not successfully followed up for twenty two months, thus delaying the potential for positive interventions to be made. While the initial referral did not provide direct evidence that the children in the family were being harmed, it is known that domestic violence presents significant risks, so it could be inferred that the slow response in this case was in breach of Children First.

Chapter 6 of Children First outlines the roles and responsibilities of agencies and personnel working with children, and makes the point that 'no one professional has all the skills, knowledge or resources necessary to comprehensively meet all the requirements of an individual case. There is no evidence in this case that individual professionals or agencies reneged on their responsibilities but at

the same time, there is little evidence of collaborative work other than that between Social Worker B and the maternity social worker, and the family support service. It is now acknowledged that a strategic approach is required in domestic violence cases, and such an approach is missing in this case.

Section 9 of Children First deals with working arrangements between the HSE and An Garda Síochána and outlines a protocol for liaison following a notification. This was not followed in this case, and no strategy meeting was conducted. Such a meeting may have provided a way forward to address the problem of domestic violence in this family.

Section 9.15. of Children First deals with under-age pregnancy. While it is acknowledged that this is a complex and sensitive topic, there is no evidence in the file to demonstrate that any strategy was in place to consult with the An Garda Síochána regarding J's pregnancy.

Section 13.2.2 of Children First identifies the importance of regular and adequate supervision for staff. Whilst Social Worker A received regular supervision over a limited period, there is no evidence that Social Worker B received it. The inability of the social workers to address the domestic violence in the family as well as the problems experienced in engaging J and G in services after March 2010 should have been addressed in supervision. A HSE national policy on supervision was implemented in 2009, but there is no evidence in the record that it was operated locally.

12.4 Quality of practice

12.4.1 Interaction with child and family

The records indicate that Social Worker A and Social Worker B were aware that domestic violence was present in the family, and that it could have adverse effects on the children. In fact, the records show that in this case, J was demonstrating many of the known effects of domestic violence: early school drop-out, poor relationship with her parents, early pregnancy, depression, secrecy and reluctance to engage with services. The information in relation to the younger siblings' school experiences indicates that they were similarly impacted by it. Unfortunately, neither of the social workers was able to directly address the problem because of the denials by the family that it was currently an issue. Both social workers brought up the topic directly with J's mother, and Social Worker A encouraged her to seek help in the future. Social Worker B also brought it up with J's father and with J herself. While not underestimating the challenges and sensitivities involved in addressing domestic violence and the lengths to which families will go to conceal it, a more strategic approach to the issue might have borne fruit. There were opportunities for joint work with the Garda that had investigated the allegations. The file records the Garda's view at one point that a joint visit might have unintended negative consequences, but further consideration may have found a way, and enabled interventions to be made with J's father, the perpetrator of the domestic violence. Social Worker B, in response to the draft extracts of this report, pointed out that there were several tentative arrangements made to conduct a joint visit but these had to be cancelled because either Social Worker B or the Garda had to deal with crises in their other cases.

The involvement of a specialist in domestic violence could have provided advice and guidance, and an inter agency meeting could have developed a multi-agency plan to deal with it. The issue of domestic violence was clearly central to the family's difficulties, particularly J's vulnerability. The prospects of positive change for any of them were limited as long as it was not addressed.

Social Worker B worked diligently to support J throughout her pregnancy, and the records indicate that in response to the initial assessment of J's needs, Social Worker B explored a number of possibilities, including family support, counselling services, alternative accommodation and mental health services. Unfortunately, J was ambivalent about engaging with services and declined to avail of counselling, displaying behaviour that is commonly associated with exposure to domestic violence. Social Worker B could find no appropriate alternative accommodation for a pregnant young woman under 18, and community based adolescent mental health services proved very difficult to source. Social Worker B helped J prepare for the baby's arrival and provided her with clothes. She also worked with J's parents in an attempt to improve their relationship with J. The records indicate that Social Worker B managed to see J at least every two weeks coming up to the baby's birth and sometimes more often than that and that she did a considerable amount of work on the case in between. Social Worker B made a referral to the family support service and when the family support worker started working with J, a clear list of tasks was set out for her by Social Worker B.

However, contact between J and the HSE services waned following the baby's birth. The PHN's records show that she made nine attempts at home visits and numerous phone calls to J between mid April and mid July but had four actual contacts with J and baby G after her discharge from hospital in early April and did not manage to see them after the end of May, although she spoke to J on the telephone in July. The PHN notes indicate that the baby was looking and feeding well, and that she was aware that the social worker had arranged family support for J.

The family support worker was involved for part of the time, but not as much as had been anticipated. It appears from the notes that Social Worker B saw J with baby G on two occasions, one in April and one in June and both she and the family support worker were concerned about the effect that the tension and fighting at home was having on J and the way that she handled baby G.

There is no record on the file of any direct contact between the PHN and Social Worker B. The PHN notes indicate that a family support service was available for two hours twice a week, but she would not have been aware that the family support worker was having difficulty gaining entry. The social work notes indicate that the PHN had done ten visits, but do not show that she only gained entry on four occasions. It is possible that each of the practitioners was working on the assumption that the others were seeing J and G regularly.

J and G were apparently staying with friends most of the time, and there is little information in the record about the suitability of her accommodation other than a comment in the social work summary written after G's death that 'social work had no concerns about this arrangement'. A written response was made by Social Worker B to a request made by the author of this review for further information about the whereabouts of J and G on the night of G's death. Social Worker B's response indicates that while she regularly asked J who her friends were, J did not provide her with any names but assured her of their suitability. Social Worker B's statement adds that J's mother and

sister indicated that they were familiar with her friends and found them to be appropriate. However, none of the professionals involved in the case actually saw where J and G were staying or met with any of her friends.

Notwithstanding the difficulties for those concerned in trying to make contact, what actually transpired could not be considered adequate given the context of a very young infant who had been born prematurely with vulnerable young mother who suffered from depression and was herself only seventeen years of age. Even a joint meeting between social worker and PHN could have established a plan for engagement.

12.4.2 Child and family focus

As stated, Social Worker A had one face to face contact with the family and saw J's parents and the two younger siblings on that occasion and had sourced information from teachers. Social worker A made several efforts to follow up matters directly with J and her mother with regard to J's emotional state and other concerns raised by Youthreach as well as the further notification of domestic violence by the Garda, but she was unable to make further contact.

Social Worker B met with J, her parents, and the younger siblings but the main contact was with J. The record indicates that she was able to engage well with the parents and elicit a certain amount of trust once she had gained entry to the home, though the domestic violence was not acknowledged by them. Likewise, the record demonstrates that Social Worker B was able to engage warmly with J and facilitate her to talk about how she felt.

There is no evidence that the younger siblings were singled out for individual attention though their teachers were, according to the file, concerned about them and dealing with some of their educational problems. Reports from the teachers elicited by the social workers indicate that there were problems with attendance and performance, and also concerns about their physical and emotional wellbeing. Their welfare was likely to have also been affected by the violence at home and it would have been important to address that.

In common with many domestic violence cases, the father in this case (G's grandfather), who was the alleged perpetrator of the violence, received very little attention. Social Worker B spoke to him about the history of reported domestic violence but was unable to pursue it with him because of his denials. The lack of a strategic multi-disciplinary approach in the case prevented any further intervention from occurring with him.

There is very little in the social work notes about baby G other than comments about J managing well and some concerns that the tension in the family home was affecting the way that she handled the baby. The public health nursing notes comment that she was looking and feeding well, and notes from the last visit in May state that G was smiling.

12.4.3 Recording

The social work records and family support report on this case were typed and easy to follow. It appears that almost all contacts, by home visit or telephone, were recorded and there appear to be copies of all correspondence in the file. The majority of case notes were kept in the second Local

Health area, by Social Worker B as she had more involvement in the case. The notes are dated, well organised and clear and each entry ends with a bullet pointed plan of action. The quality of the social work recording is good and the notes give a sense of what is happening in the case, including the efforts made by the worker to contact the family and to access other services. The notes also give a good sense of the quality of relationship achieved by the social worker with the family, which seemed to be positive despite the family's resistance to involvement. Supervision notes from the first Local Health area are included and link back to previous notes. Duty management sheets from the second Local Health area are included for part of the time and signed by the team leader. These records summarise actions which were detailed in the case notes. There were three of these documents in all, completed over a four week period in May. The first sheet had a note under 'Case Action Plan' to 'continue to support [J] re pregnancy' even though G had been born several weeks previously. This is either an error or indicates that these notes were written without discussing the case with the workers involved.

The PHN notes are handwritten, and note each domiciliary visit, attempted visit and telephone call. The notes also record the matters that were discussed at each contact as well as comments on the baby's wellbeing. PHN notes are traditionally very economical, but within those constraints the notes were easy to follow.

12.5 Management

12.5.1 Allocation

Although the involvement of Social Worker B was consistent from the first time she made contact with the family, the case appears to have been held on the duty system in both Local Health areas, over a span of three and a half years. The fact that it was not allocated is a significant management issue.

12.5.2 Inter-agency meetings or cases conferences

It is notable that despite the challenges presented by the family's continuous denial that domestic violence was an issue, and the number of services dealing with the various concerns, there was no inter-agency meeting or case conference. Such a meeting may have been able to develop a multi-disciplinary approach to the family which may have elicited more success in bringing the domestic violence issue to the surface. It would also have provided important information to some health services involved with the family, particularly with J's mother.

It is also very surprising that there was no pre-discharge case conference when G was born. There were a number of risk factors in this case, in addition to unresolved resource issues such as the unavailability of mental health services and suitable accommodation. It was also known that J found it difficult to engage with services. A pre-discharge conference could have addressed these issues, provided comprehensive information to the public health nurse and GP and developed a multi-disciplinary plan to coordinate services. G was kept in hospital for two and a half weeks, which would have allowed ample time to arrange a meeting.

Likewise, after G was discharged from hospital into J's care, their situation was very unsettled. J could not get on with her family, and was apparently moving between different friends, with no stable base for herself or the baby.

All of the above issues were sufficiently serious to warrant an inter agency meeting or case conference and the lack of resources, including both accommodation and appropriate mental health services, warranted management oversight.

12.5.3 Supervision

There are three sets of supervision notes from the first Local Health area, each of which gives an impression of good oversight during particular periods by the team leader, who noted at one point that tasks agreed in an earlier session had not been completed. These indicate that supervision took place regularly over a limited period, which was between September 2008 and January 2009. There are three Duty Management Sheets signed by the team leader in the second Local Health area, dated May 2010, outlining current plans. Other than that, there is no evidence in the record of supervision provided to Social Work B, despite the implementation of a National Supervision Policy by the HSE in April 2009.

12.5.4 Policy

Importantly for this case, there was no evidence of a local or national policy for dealing with cases where domestic violence was a significant issue.

12.5.5 Inter-professional and inter-agency collaboration

There were a number of services involved in this case, but very little evidence of collaborative work other than discussions between Social Worker B, the family support worker and the maternity social worker as well as some conversations with home school liaison teachers. Otherwise, it was up to Social Workers A and B to try to maintain contact with the other professionals involved and with a very few exceptions, it seemed that they had to initiate all the contacts themselves right throughout the case. As outlined above, the lack of case conferences of inter-agency meetings meant that important issues were not comprehensively addressed. Other opportunities for collaboration were missed, including joint visiting between An Garda Síochána and Social Worker B. There are records of Social Worker B and the public health nurse missing each other's phone calls but no record to show that they made contact, which is very surprising given the history and context of this case. The previous section has noted the lack of a pre-discharge conference but it is also surprising that the PHN was not involved in discussions with the other staff prior to G's birth. Both social work and PHN records indicate that they tried to contact each other in early July and failed. However, it would not have been difficult to establish a time that was mutually convenient for them to have a meeting or conversation at some point between March and July.

There were two other health services involved; the GP and the service being attended by J's mother for her own medical problems. Research has indicated that health services are well placed to address domestic violence, but it does not appear that they were aware of it in this case.

There are two compelling reasons why more inter-agency work should have taken place in this case, firstly because domestic violence impacts negatively on all the children in a family and is very difficult to tackle where it is being concealed and secondly, because J's vulnerability and her problematic home environment would be expected to impact on her parental capacity and needed a multi agency response to find a solution. The apparent absence of a strategy in this case meant that the responsibility was left to social work and despite the efforts of the two workers involved the approach to the case was not cohesive.

13. Conclusions

13.1

In line with the terms of reference, this review sought to see if any action or inaction on the part of the HSE Child and Family Social Services was a contributory factor in G's death. The post-mortem report in the records confirmed that there was no evidence of any maltreatment and that G had been a well nourished baby. Therefore the review concludes that there was no direct connection between any action or inaction on the part of the HSE services and the very sad event of baby G's death.

13.2

The review also notes that J and G, both of whom were vulnerable, were leading a very unsettled existence at the time of G's death. The problems at home which drove J to this unsettled existence were undoubtedly related to domestic violence and its effects.

Many of the weaknesses observed and highlighted in this review are systemic and had a cascading effect on how the case was managed. The time lapse between the notification by An Garda Síochána to the HSE Children and Families service in December 2006 and the first face to face contact between HSE social work services and the family in October 2008 is unacceptable. This was followed by an equally unacceptable delay between the transfer of the cases and contact with the family by social work services in the second Local Health area. These setbacks, together with the fact that the case remained in the duty system for three and a half years and was not subject of any inter-agency discussion indicate a serious weakness in the functioning of this area in respect of its duties to promote the welfare of children.

13.3

The lack of a local multi-disciplinary policy for responding to reports of domestic violence was an impediment to progress in the case and the inability of workers to penetrate the family's efforts at concealment of domestic violence impacted on later events, particularly J's need to bring the baby to stay with different friends where she was subsequently inaccessible to professionals. There is evidence of significant efforts by the social workers involved, and the interventions of Social Worker B in particular showed strong commitment to J and G's welfare, as well as that of other members of

the family. They would have been assisted by a strategic multi-disciplinary approach such as the policy which was launched by the HSE in February 2010[2].

13.4

Notwithstanding the family's resistance to services, the quality of assessment in the case was not sufficient to highlight the impact of domestic violence on all the family members and lead to a comprehensive plan that would address all their needs. Assessment was essentially restricted to the social workers' views and the views of teachers from the children's schools. No multi-disciplinary meeting for case conference was held as part of the assessment and consequently it was not complete enough for a complex case such as this. The lack of a multi-disciplinary assessment meant that a comprehensive multi-disciplinary plan was not developed and this affected how the case was subsequently managed.

13.5

The aforementioned failure to hold multi-disciplinary meetings or case conferences at any stage meant that coordination and collaboration were weak. It also meant that serious resource deficits, such as the lack of accommodation for adolescent parents and the lack of suitable mental health services were not tackled. As a result, there was no whole family overview, plan, strategy or understanding and as such the issues impacting upon individuals were less well understood than they should have been. The combination of these factors with the long time lapse between referral and contact in each area meant that the chances of engaging with the family were lessening as their situation was deteriorating. Ultimately they impacted on the ability of the frontline practitioners, each of whom made considerable efforts to make any progress in the case. The level of supervision in the case, while good for a limited period, was not consistent, and not in compliance with the HSE national policy.

13.6

Within these constraints, the frontline practitioners (social workers, family support worker and PHN) made considerable efforts to work with the family. Social Worker B in particular showed a lot of skill in engaging J and her mother and demonstrated considerable determination and commitment in her efforts to support J practically and emotionally during her pregnancy.

13.7

Contact with J and baby G was less than it should have been from the HSE services (Family support, social work and public health nursing) following the baby's birth, given the risk factors involved. A pre-discharge multi-disciplinary conference should have been held. Making contact with J after the baby's birth was undoubtedly difficult because she was either unavailable or on the move but this situation may have been avoided if earlier input into the case had been more timely, collaborative and strategic. It was unacceptable that J had no alternative setting in which to care for her baby other than a series of temporary overnight arrangements.

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[2] HSE (2010) HSE Policy on Domestic, Sexual and Gender Based Violence. www.hse.ie

14. Key Learning Points

The review has identified the following key learning points from this case:

14.1

The case illustrates that when the rate of child protection and welfare reports to an area is consistently beyond the capacity of the staff to make effective and timely responses, or to allocate cases, the situation is unlikely to change, and some consideration should be given to reform and the development of alternative methods of managing intake. Alternative methods for dealing with high reporting rates that have been tried internationally include the Differential Response Model[3] whereby referrals are quickly screened and diverted into different tracks, the more serious reports triggering an investigation and the less serious reports receiving a needs assessment.

14.2

The case also illustrates the insidious and destructive effects of exposure to domestic violence on children and the risks it can create for them as they enter adolescence. It also demonstrates how difficult it can be to penetrate the secrecy maintained by families affected by it. The fact is that the longer a family are living with domestic violence, the more difficult they are to help as they become more closed and reluctant to engage with services. Inability to deal with earlier incidences of domestic violence in the household was undoubtedly a root cause of later difficulties in engaging J in services. The implication arising from this is that early, strategic and multi-disciplinary intervention, based on an agreed and established policy, is likely to achieve the best outcome. Given the complexities involved and the research evidence that families experiencing domestic violence are reluctant to engage with mainstream child protection services[4], the matter of which service is best place to take the lead in such cases should be considered.

14.3

Bearing in mind that all family members are likely to be impacted by domestic violence, this case illustrates the importance of using a standard assessment framework to identify the needs of the children against established benchmarks and specifically consider the effect of exposure to domestic violence on their physical, psychological and emotional welfare[5].

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[3] M. Connolly (2005) ,"Differential Responses in Child Care and Protection: Innovative Approaches in Family-Centred Practice" *Protecting Children,* 20:8–20;P. Harrison, *American Humane's 2007 Conference on Differential Response in Child Welfare,* CAAB Newsletter Winter 2007

[4] Buckley, H., Whelan, S and Carr. N., 'Like waking up in a Franz Kafka novel': Service users' experiences of the child protection system when domestic violence and acrimonious separations are involved, *Children and Youth Services Review,* 33, (1), 2011, p126 – 13. Humphreys, C., Domestic Violence and child protection: Challenging directions for practice (Issues Paper No. 13) (2007) Australian Domestic Violence & Family, Sydney. Available from *http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/IssuesPaper_13. pdf.* Last accessed February 12, 2010;

[5] HSE Dublin South West Social Work Team, , *Practice Document on Domestic Violence: a guide to working with children and families, HSE March 2010*

14.4

Given the challenges involved in engaging young and vulnerable mothers and motivating them to use support services, this case illustrates the importance of shared responsibility between hospital and community based services and of using opportunities for pre-birth and pre-discharge assessment and planning. It may be necessary to formalise the coordination of tasks and sharing of responsibility in contracts and service level agreements.

14.5

An important key learning point from the case is that despite the facility now provided by mobile phones and email, inter-professional and inter-agency communication is inevitably difficult to achieve, and does not occur automatically. Research shows that even when communication does take place, its meaning is not always mutually understood[6]. The case shows that longer term collaboration is also difficult to achieve and maintain, particularly without inter-agency meetings where roles and responsibilities can be clarified and information exchanged. Unless deliberate efforts are made to anticipate and understand obstacles and apply practical solutions, these inter-agency and inter professional difficulties will continue to feature in child protection work and will be persistently highlighted in reviews and inquiry reports.

15. Recommendations:

In line with the above conclusions, the following recommendations are made:

15.1

The two issues of delayed responses to notifications and the practice of holding cases on duty for indefinite periods need examination. If the situation has not improved since the recent allocation of additional social work posts, HSE senior management need to consider alternative methods for managing high referral rates.

15.2

The HSE should fully implement the *HSE Policy on Domestic Sexual and Gender Based Violence* launched in February 2010, along with the *HSE Practice Document on Domestic Violence* launched in March 2010. Training should include a component on dealing with concealment and promoting the motivation and capacity of victims to address the violence.

15.3

The HSE should adopt a consistent framework for initial and full assessment of child welfare and protection concerns. This should include the inputs of a range of relevant disciplines, address the needs of all children in the family and should develop plans to be put in place within specific

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[6] P. Reder and S. Duncan (2003) 'Understanding Communication in Child Protection Networks' *Child Abuse Review*, Vol.12: 82-100

timeframes. Full assessment requires an inter-agency meeting. Specific attention should be paid to notifications of domestic violence including the challenges involved in engaging with victims. The plan that evolves from the assessment should address the needs of **all** children in the family who are affected by domestic violence

15.4

Inter agency meetings should be routinely held in cases that remain open and require multi-disciplinary and multi-agency input. On the basis that inter-agency cooperation is difficult to achieve and maintain, protocols should be developed at a local level in order to promote and support it.

15.5

A protocol for meeting the needs of vulnerable young mothers and their infants should be agreed between maternity hospitals and the HSE and should routinely include a pre-discharge multi-disciplinary meeting to coordinate service provision.

15.6

Supervision of open cases, whether on the duty system or allocated on a longer term basis, should take place regularly in line with the HSE National Policy on Supervision.

15.7

When lack of necessary resources has a significant impact on a case, e.g. inaccessibility of adolescent mental health services or out of home accommodation for adolescent mothers, the matter should be examined by local management and escalated if necessary.

Signed: [signature]

Date: 13-5-11

Review undertaken in respect of the death of a child known to the child protection system: Baby G

Executive Summary

May 2011

Introduction:

This desktop review is concerned with the death of a four month old baby G, who is in the care of her seventeen year old single mother, J. A post-mortem concluded that the baby died from Sudden Unexpected Death in Infancy with no signs of abuse or neglect. The review was conducted because J had been known to the HSE over a number of years following concerns about the impact on herself and her siblings of domestic violence between their parents and latterly because of her own vulnerability. The timeline covered by the review was from 2006 to 2010, and the terms of reference were:

- to examine events leading up to the G's death and determine whether action or inaction on the part of HSE Children and Family Social Services had been a contributory factor
- to examine the quality of service provided to G, J and J's family by HSE Children and Families Services and the level of compliance with procedures, protocols and standards of good practice
- to provide an objective report to the HSE

Method

The review was conducted as a desktop exercise and examined the HSE records on the case. No interviews were held with staff. It was conducted by the Chair of the National Review Panel, Helen Buckley. The records consisted of a social work file containing letters, emails, supervision notes and case notes. The public health nursing notes were also examined. A request for a specific piece of information was made to the area and a written response received which was incorporated into the review report. Extracts of the report were sent to relevant key staff and their responses were considered in finalising the report.

Conclusions

The review concluded that there was no direct connection between any actions or inaction on the part of the HSE with baby G's death. It also noted that J and G led a very unsettled existence prior to G's death, without suitable accommodation.

The review found that the quality of service provided to J's family following the most recent notification of domestic violence in 2006 and up to G's birth was negatively affected by the following systemic issues which cascaded down to the frontline and impacted on practice:

- The case was held on the duty system for three and a half years and the response time of twenty two months between initial notification and face to face contact with the family was unacceptable. Even though the duty worker, Social Worker B worked consistently with J during her pregnancy, the case remained on the duty system.

- There was no standard method or framework for assessment in operation. Assessment in the case was not sufficient to determine the extent and nature of the violence that was occurring in J's family home or to evaluate its impact on all family members and formulate appropriate plans for intervention. No pre-birth assessment was conducted to ascertain J's capacity to care for an infant, and the assessments suffered from a lack of formal inter-agency discussion and consultation.

- The fact that no case conferences of inter-agency meetings took place at any time meant that opportunities for collaboration between an Garda Síochána, the education services, the maternity hospital, health services and mental health services, which may have enabled the family to address the violence, were missed. The fact that no pre-discharge conference was held before G was discharged from the maternity hospital, despite the risks that had been identified, meant that an opportunity to develop a multi-disciplinary strategy to promote G's welfare was missed. Subsequent inter-professional communication was poor and contact between the services and J and G was less than it should have been given the risks involved.

- The review found that the quality of frontline practice and interaction with the family was hampered by the inability of services to address the domestic violence in J's family home, which itself was impeded by the lack of a multi-disciplinary strategy or policy on domestic violence. Frontline practitioners, including two social workers, a family support worker and the public health nurse made consistent efforts to work with J, her mother and her siblings, and later to support J in her care of G. However the secrecy and concealment that had been operated by the family over a number of years meant that it was difficult to engage them in services and professionals found it very difficult to contact J after G's birth.

- The lack of certain services for under-18 year olds meant that some of J and G's needs could not be met. These included adolescent mental health services and accommodation for young vulnerable mothers and their babies.
- The review also found that compliance with Children First in the area was patchy; the slow response to the notification of domestic violence breached the stipulation that all child protection concerns should be followed up as soon as possible. Inter-agency collaboration was very weak, and the protocol on joint work between the HSE and An Garda Síochána does not appear to have been followed in respect of either the domestic violence notification or Jade's under-age pregnancy. The HSE national policy on supervision was not followed.

Within these constraints, the frontline practitioners (social workers A and B, family support worker and PHN) made considerable efforts to work with the family. Social worker B in particular showed a lot of skill in engaging J and her family and demonstrated diligence and commitment in her efforts to support Jade practically and emotionally during her pregnancy.

Key Learning Points

The review has identified the following key learning points from this case:

- The case illustrates that when the rate of child protection and welfare reports to an area is consistently beyond the capacity of the staff to make effective and timely responses, or to allocate cases, the situation is unlikely to change, and some consideration should be given to the reform and development of alternative methods of managing intake. Alternative methods for dealing with high reporting rates that have been tried internationally include the Differential Response Model[1] whereby referrals are quickly screened and diverted into different tracks, the more serious reports triggering an investigation and the less serious reports receiving a needs assessment.

- The case also illustrates the insidious and destructive effects of exposure to domestic violence on children and the risks it can create for them as they enter adolescence. It also demonstrates how difficult it can be to penetrate the secrecy maintained by families affected by it. The fact is that the longer a family are living with domestic violence, the more difficult they are to help as they become more closed and reluctant to engage with services. Inability to deal with earlier incidences of domestic violence in the household was undoubtedly a root cause of later difficulties in engaging J in services. The implication arising from this is that early, strategic and multi-disciplinary intervention, based on an

[1] M. Connolly (2005) ,"Differential Responses in Child Care and Protection: Innovative Approaches in Family-Centred Practice" *Protecting Children,* 20:8–20;P. Harrison, *American Humane's 2007 Conference on Differential Response in Child Welfare,* CAAB Newsletter Winter 2007

agreed and established policy, is likely to achieve the best outcome. Given the complexities involved and the research evidence that families experiencing domestic violence are reluctant to engage with mainstream child protection services[2], the matter of which service is best place to take the lead in such cases should be considered.

- Bearing in mind that all family members are likely to be impacted by domestic violence, this case illustrates the importance of using a standard assessment framework to identify the needs of the children against established benchmarks and specifically consider the effect of exposure to domestic violence on their physical, psychological and emotional welfare[3].

- Given the challenges involved in engaging young and vulnerable mothers and motivating them to use support services, this case illustrates the importance of shared responsibility between hospital and community based services, and of using opportunities for pre-birth and pre-discharge assessment and planning. It may be necessary to formalise the coordination of tasks and sharing of responsibility in contracts and service level agreements.

- An important key learning point from the case is that despite the facility now provided by mobile phones and email, inter-professional and inter-agency communication is inevitably difficult to achieve, and does not occur automatically. Research shows that even when communication does take place, its meaning is not always mutually understood[4]. The case shows that longer term collaboration is also difficult to achieve and maintain, particularly without inter-agency meetings where roles and responsibilities can be clarified and information exchanged. Unless deliberate efforts are made to anticipate and understand obstacles and apply practical solutions, these inter-agency and inter professional difficulties will continue to feature in child protection work and will be persistently highlighted in reviews and inquiry reports.

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[2] [2] Buckley, H., Whelan, S and Carr. N., 'Like waking up in a Franz Kafka novel': Service users' experiences of the child protection system when domestic violence and acrimonious separations are involved, *Children and Youth Services Review*, 33, (1), 2011, p126 - 13Humphreys, C., Domestic Violence and child protection: Challenging directions for practice (Issues Paper No. 13) (2007) Australian Domestic Violence & Family, Sydney. Available from *http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/IssuesPaper_13. pdf.* Last accessed February 12, 2010;

[3] HSE Dublin South West Social Work Team, , *Practice Document on Domestic Violence: a guide to working with children and families, HSE March 2010*

[4] P. Reder and S. Duncan (2003) 'Understanding Communication in Child Protection Networks' *Child Abuse Review*, Vol.12: 82-100

Recommendations:

1. The two issues of delayed responses to notifications and the practice of holding cases on duty for indefinite periods need examination. If the situation has not improved since the recent increase in social work posts, HSE senior management need to consider alternative methods for managing high referral rates.

2. The HSE should fully implement the *HSE Policy on Domestic Sexual and Gender Based Violence* launched in February 2010, along with the *HSE Practice Document on Domestic Violence* launched in March 2010. Under this policy, training on domestic violence should be available to a wide range of health and social service professionals and include a component on dealing with concealment and promoting the motivation and capacity of victims to address the violence.

3. HSE Children and Family Services should adopt a consistent framework for initial and full assessment of child welfare and protection concerns. This should include the inputs of a range of relevant disciplines, address the needs of all children in the family and should develop plans to be put in place within specific timeframes. Full assessment requires an inter-agency meeting. Specific attention should be paid to notifications of domestic violence including the challenges involved in engaging with victims. The plan that evolves from the assessment should address the needs of all children in the family who are affected by domestic violence

4. Inter agency meetings should be routinely held in cases that remain open and require multi-disciplinary and multi-agency input. On the basis that inter-agency cooperation is difficult to achieve and maintain, protocols should be developed at a local level in order to promote and support this.

5. A protocol for meeting the needs of vulnerable young mothers and their infants should be agreed between maternity hospitals and the HSE, and should routinely include a pre-discharge multi-disciplinary meeting to coordinate service provision.

6. Supervision of open cases, whether on the duty system or allocated on a longer term basis should take place regularly in line with the HSE National Policy on Supervision.

7. When lack of necessary resources has a significant impact on a case, e.g. inaccessibility of adolescent mental health services or out of home accommodation for adolescent mothers, the matter should be examined by local management and brought to the attention of senior HSE management if necessary.

Signed:

Date: 13-5-11