National Review Panel

Overview of the main points arising in reviews of the deaths of four children known to child protection services.

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1. Introduction

This report provides an overview of the deaths of four children from different families known to child protection services. Reviews were carried out by the National Review Panel (NRP) and submitted to the Child and Family Agency. It has been decided by the Agency that these reports will not be published in full in the interests of the families concerned. This overview outlines the key findings, learning points and recommendations which emerged from the reviews.

2. The children

In each of the cases reviewed, the children lived with one main carer who was their parent. They had varying degrees of contact with their other parent, and in each case had contact with extended family. All of the children were under ten years of age and two were infants.

3. Findings from the reviews

The reviews found in each of these cases that there was no link between the nature or extent of services provided and the sad deaths of the children concerned. Nonetheless, a number of findings in respect of the practices and interventions of the different agencies involved were highlighted by the reviews as follows.

3.1 Response of the HSE Children and Family Services to the initial reporting in these cases

In one of the cases, reports to the then HSE Social Work Departments (SWDs) were made by family members and in the other three cases, by professionals. The length of contact between the SWDs and the families varied in the different cases, from just a few days to eighteen months. It was notable that in two of the cases, the thresholds operated by the SWDs were clearly higher than those of the referrers. One of the cases was open to family support services for the duration of the child's life, and the staff involved had, on numerous occasions, requested the SWD to allocate a social worker. When this request was eventually acceded to it was not possible to allocate the case immediately because of staff shortages and it was held on duty or managed by the social work team leader. While these arrangements allowed for a certain level of surveillance, they lacked the consistency and depth of social work intervention required at the time. The NRP is well aware of pressures under which some areas are operating but nonetheless is obliged to make this observation.

3.2 Assessment

Each of these cases was subject to different types of assessment. In all cases, numerous services were involved, including parenting support, early years education, adult mental health, child and adolescent mental health, Gardaí, domestic violence services, maternity services and active GP and school involvement. It was clear to the NRP when reviewing these cases that firstly, when different

pieces of information were put together in hindsight by the review teams, a significantly more concerning picture emerged in each case, and secondly that some of these services were assessing family members in different settings without full knowledge of the broad range of factors affecting their day to day their lives.

In one case, it was not until extended family members made a coordinated effort to inform the different services of their worries that the full range of information became clear and in another case, one particular service had to make very concerted attempts over several weeks to persuade the SWD that a risky situation prevailed. The review teams noted that in all the cases involved in this overview, the main carers of the children did not always disclose and in some cases actively concealed information which challenged the ability of services to gain a full picture. Nonetheless, the reviews highlight the importance for practitioners dealing with vulnerable children to attain as full a history, both past and recent, as possible and not to assume that they have all the relevant information until all potential sources have been contacted.

It was notable in one case that the *type* of assessment conducted was inappropriate, because its focus was principally on the parent's ability to meet their child's basic needs without paying sufficient attention to indicators of risk which had already been displayed in terms of parental behaviour. This assessment was used as the basis for an important decision which, in the opinion of the relevant review team, was made in the absence of important knowledge and as a result was over optimistic. In another case, risk factors had been brought to the attention of the SWD by the child's extended family but the family's concerns did not appear to have been taken seriously and the account provided by the child's main carer was accepted without challenge.

In one of the other cases, a child was placed with extended family members where there had been past concerns about that family's ability to care safely for their own children. While nothing untoward happened to the child in their care, the review team noted that no assessment had taken place of their current capacity and regarded this as an unsafe decision.

3.3 Sharing of information

It has already been pointed out that assessments were completed in some cases without attention to the full range of information and in some cases in the absence of information. In one example, two key health/mental health services were each unaware for a long period that the other service was involved. At interview, they told the review team that even when the involvement of other services came to their attention it did not change their perspectives on the case. This, in the opinion of the review team, does not reflect the holistic and coordinated approach to practice that is proposed in Children First and demonstrates that where a child is the subject of concern, all services should be pro-active in considering how parental factors may impact on their safety and welfare.

3.4 Ecological approach

Social workers are trained and advised in guidance to use an ecological approach to assessment and intervention, in other words, to consider all of the contexts in which children live and to intervene at the most relevant points. In all of these cases, there were factors in the extended family networks that were of direct significance to the welfare of the children concerned but the focus of attention

was only on the immediate context, i.e. the child and their main carer while opportunities to work with the wider family were not taken up.

It was noted in one case that the child's non resident father was not seen by the investigating social worker because 'he hadn't been identified as somebody who was playing a significant role' in his child's life, a conclusion that did not fit with the perception of other staff who reported that he saw his child frequently and regularly and had a positive relationship with them.

3.5 Interagency collaboration

As outlined, numerous services were involved in each of the cases and the reviews found examples of both excellent and poor practice. One of the most obvious factors impeding collaboration was the difference in perceptions and expectations held by some services in relation to others. In one case, it took some time before the concerns of hospital staff were clearly understood and accepted by the SWD. There was a lack of mutual understanding about the role and contribution of adult mental health services in two of the cases. The reviews found that the multi-disciplinary and inter agency input into all these cases more often fragmented than coordinated. The causes of this were complex, but lack of understanding of both the nature and significance of different roles and lack of a child protection focus on the part of some services were common themes which led to misunderstandings, unrealistic expectations and some delayed actions.

3.6 Decision making and case closure

This overview has already highlighted that where assessments lack appropriate focus and are limited in scope, the result will inevitably be poorly informed decisions, planning and intervention. In all of these cases, decisions about closure were made at different points, including one case where risk factors had not been fully addressed. This was largely because, as outlined above, the type of assessment conducted in the case had not directly addressed aspects of parental behaviour but had concentrated on the ability of the child's main carer to carry out parenting tasks. In another case, closure was planned but not finalised because the necessary administrative processes had not been completed. This may have prevented a decision to allocate an alternative service to the family concerned.

4. Learning points

This section offers an overview of the learning points identified in each of the cases

4.1 **Risk assessment**

A factor that was very pertinent to one case, and also relevant to two others, was the need for practitioners to recognise that there are some situations where a *risk* rather than a *parenting* assessment is required and that issues about a child's physical safety should at times take immediate priority over their more general needs. This involves paying attention to parental behaviours and implies that any assessment must consider the possibility that immediate measures may be required to keep a child from harm. The NRP believes that this issue is particularly pertinent in the light of current reforms. The recently introduced service delivery model implies that assessment will play an

increasing part of the work of community organisations, and it is vitally important that a clear understanding is reached between the statutory and community sector as to the nature of assessment that each service can and should conduct. It will also be important for family support organisations to be familiar with the concept and content of risk assessment so that they can clearly identify and articulate to the Child and Family Agency situations where they believe a risk assessment is required.

4.2. **Adult mental health services and child protection**

An underlying theme in these cases was the interface between adult mental health services and child protection services. In two cases, adult mental health services were dealing with the carers of the children concerned but appeared to see their own function as quite distinct from that of the child and family social work services. Evidence available to the review teams indicated that mental health services were not always familiar with the role and function of statutory social work, nor of how they themselves could contribute constructively to the management of a child protection case. Although the majority of parents who experience mental illness do not harm their children, research indicates that parental mental illness features in a significant number of child protection reports, with prevalence increasing when other factors co exist[1]. This suggests that the impact of mental illness on family and children needs to be actively considered by adult mental health services. Whilst being cognisant of the sensitivities involved in confidential therapeutic relationships, the NRP suggests that the child protection and mental health services should work towards a protocol which may permit improved information exchange. Evidence indicates that protocols must be supported by efforts at the frontline to develop and maintain relationships.

4.3 **Working with families**

In one of the cases, the extended family of the child's main carer attempted to communicate their worries about the safety of the child concerned to the SWD. Their method of communicating with the SWD was very direct, and their style of communication was very forthright, in contrast to the more restrained manner of the child's main carer whose account of events held sway with the SWD. The extended family felt that they were not heard, and ultimately ceased their efforts to persuade professionals that there was serious cause for concern. As a learning point arising from the review, it is suggested that professionals should routinely challenge their own perceptions about the motives of extended family members who express concerns forcefully. It is also suggested that, where family conflict has the potential to upset or impact negatively on a parent, work to address that conflict should be part of any intervention, and that this work should be carried out or coordinated by the service with which the child and parent have the closest and most trusting relationship.

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[1] Darlington, Y., Feeney, J. & Rixon, K (2005) Inter-agency collaboration between child protection and mental health services: Practices, attitudes and barriers, *Child Abuse & Neglect*, 29: 1085-1098; Cleaver, H., Nicholson, D., Tarr, S., and Cleaver, D. (2007) *Child Protection, Domestic Violence and Substance Misuse: Family Experiences and Effective Practice.* London: Jessica Kingsley.

An additional learning point here is the avoidance of assumptions that when a father is non-resident that he does not play a significant role in his child's life.

5. **Recommendations**

The reviews made the following recommendations based on their main findings

5.1 The HSE and the Child and Family Agency should establish workable and ongoing channels of communication between child welfare and protection services and adult mental health services.

5.2 There are currently 70,000 staff in the HSE whose work brings them into contact with children, or with adults who have children. Investment in training, sufficient to promote an adequate awareness of all staff members' responsibilities in child protection and factual information about the operation of the child protection system is vital. The responsibility for this undertaking does not belong solely to the Child and Family Agency but the Agency should ensure that it is brought to the attention of the HSE and the Department of Health.

5.3. It is recommended that in the context of the Prevention, Partnership and Family Support initiatives being established by the Child and Family Agency, community services are provided with guidance about the identification of risk to assist them in identifying when a family may need to be referred back to the Agency for risk assessment.

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