Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death experienced by a child known to Tusla child protection social work services

Ray

Executive summary

March 2019

1. Introduction and background

This review concerns a young child here called Ray who was three years old when he died following a tragic accident whilst in his father's care. Ray's parents, here called Cathy and Ritchie both had difficulties with addiction. They were involved with a number of services and their extended families also offered them support. When Ray was born, a referral was made to the social work department (SWD) because of concern about Cathy's recent drug use. The SWD became actively involved; two child protection conferences took place and Ray was listed on the child protection notification system (CPNS). Subsequently, both parents made good progress with their addiction treatment. Contact from the SWD lessened as improvements were noted. A year later, further concerns were raised again about Cathy's and Richie's drug use and the SWD increased their involvement once more. Further child protection conferences took place and a child protection plan was developed.

In the meantime, Ray was thriving and no concerns about his welfare were reported. Cathy was finding it very difficult to deal with her addiction and in line with the child protection plan moved back to her family who supported her and supervised her care of Ray. It was arranged for Ray to attend a crèche attached to Cathy's community drug rehabilitation centre. By this point, three separate social workers had been allocated at different times and the case had been transferred between teams. The NRP was informed that the SWD was under severe pressure at this time. During certain periods, there was very little contact between the SWD and Cathy and her family. An assessment was due to be conducted but several months passed before it took place. When Social Worker 4 took over the case she undertook a comprehensive assessment which concluded that each parent had a poor understanding of the impact of their drug use on Ray which, as long as it continued, posed a risk to his safety. She also noted that contrary to the safety plan, Cathy was bringing Ray out on her own to her former home, from which she had been advised to stay away because of the risk that she would relapse in her drug use. Concerns had been reported about the influence of her drug using friends.

A further child protection conference was held when Ray was two years old and his name was again listed on the CPNS. The child protection plan reinforced the condition that Cathy was not to have care of Ray without one of her parents present. At this point they were sharing his primary care with her. It was also stipulated that she was to remain engaged with addiction services. Richie's contact with Ray was also to take place in a supervised family situation. Over the following months, the social worker visited and telephoned Cathy regularly. Cathy continued to struggle with her addiction while Ray thrived. He benefited from the considerable care and support provided by his extended family and also had a positive relationship with both his parents who, despite their

difficulties, related to him affectionately and appropriately. Other professionals who were contacted confirmed that they had no concerns in respect of Ray's safety.

At a review child protection conference, Ray's name was delisted from the CPNS as he was not considered to be at risk due to the extended family support. The child protection plan was replaced with a family support plan. Cathy and Ritchie were no longer in a relationship at this point but Richie remained in Ray's life. Cathy entered a new relationship and the family support plan was amended, stipulating that she was to continue to live with her family and that her new partner was to be interviewed by the SWD to establish his suitability to take care of Ray. During this time, Richie complained that he had not been involved in discussions and meetings and the SWD apologised to him.

When Ray turned three, Cathy became pregnant and as her drug problem was still active, opted to go into residential detoxification treatment. Her long term goal was to resume care of Ray and her expected baby. Ray was to be cared for by Cathy's parents with daily crèche and some time at the weekends with Richie, under family supervision. While she was in the detox unit, Ray tragically died as a result of an accident whilst in Richie's care. Later toxicology results indicate that Richie had a number of substances in his system at the time of the accident.

2. Findings

The review found that the SWD was prompt in responding to referrals and made appropriate referrals to therapeutic and support services whereby Cathy and Ray's progress could be observed. It also found that greater contact should have taken place with Richie, Ray's father, whose involvement in his life needed to be considered. It was noted that assessment of how Richie's contact with Ray would be supervised could have been more thorough.

Overall the review found that while immediate concerns about Ray's safety were always responded to, the long termer options for Ray could have been given more consideration as there were extended periods where no evident improvement in either of his parents' drug treatment was occurring.

The review found that although there were gaps in contact between the SWD and the family during the early months of involvement, there were also examples of good quality and consistent work. Social Worker 4 in particular maintained regular contact and linked well with other professionals involved in the case. Child protection conferences were well attended. There was good information sharing in general, but communication between the addiction services and the SWD was limited.

3. Conclusions

The review team acknowledges the loss experienced by Ray, Cathy and Richie's families together with the impact on those involved in their care. The following conclusions have been reached:

- There was a prompt initial response to the first referral and later referrals received by the SWD in respect of Ray's immediate safety. However, a continued focus on his long term needs was also required.
- The focus of intervention was Cathy. There was very little consideration of Ray's father's parenting ability, the risk he presented to Ray and the nature of their ongoing relationship, despite their acknowledged attachment. No assessment took place in relation to Cathy's new partner.
- While there were examples of very good practice at times, the service provided by the SWD was inconsistent over the three years of Ray's life. From the time of the second referrals to the point where Social Worker 4 was allocated, gaps in professional support were characterised by periods where no direct social work contact took place. These had implications for both parents motivation to engage with protection and family support plans. It also negatively affected newly allocated social workers' understanding of the case history.
- There was a high turnover of social workers during the lifetime of the case. There was no evidence of transfer/handover or closing summaries on file. As result, focus on key issues relating to Ray's safety and future care was inconsistent.

4. Learning points

- Research indicates that consistent engagement with fathers from the earliest point can make social workers statutory obligations to promote the welfare of children easier to discharge.[1] It provides a means by which any risk they may present to the safety of a child can be assessed. They may then be a resource to resolve identified problems and be supported in establishing positive relationships with their children, nurtured through regular contact and support.[2]
- The purpose of a review child protection conference is to consider the progress or otherwise that has been made in ensuring a child's safety and to consider if amendments to the child

[1] Ferguson, H. and Hogan, F. (2004). *Strengthening families through fathers: Developing policy and practice in relation to vulnerable fathers and their families*. The Centre for Social and Family Research, Waterford Institute of Technology. Pp 1-5

[2] Brandon, M., Philip, G., Clifton, J. (2017): *"Counting Fathers In": Understanding Men's Experiences of the Child Protection System.* Centre for Research in Children and Families. University of East Anglia. Chapter 7.

protection plan are necessary. As a first step, the decisions of the previous child protection conference should be reviewed from the perspective of their implementation and success in meeting a child's needs. Minutes of the child protection conference including the child protection plan should be circulated without delay[3] to ensure that family members, professionals and others involved know and understand the actions necessary to ensure the ongoing safety of a child.

- Partnership between professionals and families is a key factor if intervention to provide safe care for a child is to be successful.[4] The core group is the forum through which information is shared. For the role to be effective, the identity and function of the key worker needs to be shared with its named members.[5] The effectiveness of the core group may also be assisted if the frequency of its meetings is established at the outset.
- In the absence or departure of the allocated social worker, continuity is assisted by the existence of a brief summary outlining the circumstances of the case, key issues of concern and outstanding issues to be addressed.
- The purpose of a comprehensive assessment is to consider key dimensions across a child's life and propose interventions designed to meet the needs identified.[6] Since circumstances are likely to change, continual reflection on short, medium and long-term implications of progress is necessary so that support to children and families is adjusted as is appropriate to their developing needs.
- UK serious case reviews have identified disguised compliance by parents who want to give the appearance of cooperation, or to avoid and delay intervention, as a factor inhibiting progress in implementing CP plans. Professional supervision is an important mechanism by which this issue may be identified and addressed with social workers[7]. Objectivity is an important supervisory function in providing support and education to staff and identifying issues that may cloud a frontline social workers perspective.[8]

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Chair, National Review Panel

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[3] DCYA(2011): *Children First: National Guidance for the Protection and Welfare of Children.* Para 5. 9. 2

[4] Brady, B., Dolan, P., Canavan, J . (2004).: *Working for Children and Families Exploring Good Practice,* Department of Health and Children. Dublin.

[5] DCYA(2011): *Children First: National Guidance for the Protection and Welfare of Children.* Para 5. 9. 1. (vi)

[6] Buckley, H., Horwath, J., Whelan, S. (2006): *Framework for the Assessment of Vulnerable Children and Their Families.* Dublin: Children's Research Centre, Trinity College.

[7] West of Berks LSCB Forum (2017) "Disguised Compliance ". www.readinglscb.org.uk/GetAsset.aspx?id=fAAzADgAOQA3AHwAfABGAGEAbABzAGUAfAB8ADMANgB8AA2

[8] Morrison, T., (1993): *Staff Supervision and Social Care: An Action Learning Approach*. pp 19, 96. Pitman publishing.