Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of the death of an infant whose family had contact with TUSLA

Tommy

Executive Summary

March 2021

1. Introduction

This review concerns the death of an infant, here called Tommy. He and his family were known to Tusla social work services prior to his birth. Tommy and his older sibling lived with his mother and his father lived elsewhere but was in touch with the family. Both parents had a history of homelessness, physical and mental health problems and domestic violence and their extended families were also known to social services. Tommy sadly died at six weeks old, from SIDS. Prior to his death, he had been referred to hospital for failure to thrive. Tommy's mother does not recall the GP referring Tommy to Hospital for failure to thrive. It is her recollection that she brought him to the GP because he had very bad reflux and was not keeping his formula down so she was worried about this. She said the GP recommended changing formula and once changed the issue was resolved.

Because his mother, here called Helen, tended to move around a lot, the family had lived in a number of locations in the three years prior to his birth. Up to that point, five different social work departments had been involved with the family, as well as different public health services and GPs.

2. Background and involvement of services

The family first became known to services over two years prior to Tommy's birth, when a number of referrals were made to different social work departments about his older sibling, here called Mary. The referrals mainly concerned his mother Helen's alleged drug use, domestic violence between his parents, homelessness and instability caused by frequent moves. An initial assessment was conducted by a Tusla social worker and it highlighted the lack of consistent support to the family who led a transient lifestyle. Although there were no concerns about Helen's relationship with her daughter, the little girl was considered to be under stimulated and had some language delay. The assessment also noted Helen's own health problems and need for her to improve her self-care. It concluded that Mary was at risk of emotional abuse due to her exposure to domestic violence as well as inconsistent and unpredictable care. The family was referred to support services available in their sheltered accommodation and the case closed in the SWD.

The sheltered accommodation service made five referrals to the SWD over the following months concerning Helen's anti-social behaviour which eventually led to her departure from the service. There were no available records of the responses made to these reports. A further referral was made by a GP several months later alleging that Mary had been exposed to interpersonal violence. The family was now in short term accommodation and was referred by the SWD to a voluntary service for

support. At this point, Helen was pregnant with Tommy and a further referral from a maternity hospital led to a decision in the SWD to request a voluntary service to carry out an initial assessment.

The assessment worker had some difficulty in meeting with Helen who eventually agreed to the assessment. However she refused consent for the children's father to be interviewed on the basis that he was mentally unwell. Helen disclosed a history of complicated relationships with partners and with her family of origin. She denied using drugs and said her greatest need was for stable accommodation and a crèche place for Mary. Her current living situation whereby she was staying with a relative was described as materially satisfactory but short term. The assessment worker observed that Mary looked well cared for, healthy and content. Helen described an ambivalent relationship with the children's father who was currently subject to drug related criminal proceedings. She said that she had to supervise meetings between him and Mary.

Despite the efforts of the worker involved, the assessment was held up because of difficulties accessing previous social work records. The assessment worker sent a number of emails trying to expedite their retrieval.

Tommy was born while the assessment was ongoing. He was discharged from hospital with no concerns and the family remained in their short term accommodation although they were due to leave shortly. The assessment worker helped Helen to get a crèche place for Mary and also tried to advocate on her behalf with a housing association. She continued to contact professionals as part of the assessment process. It was difficult to contact the public health nurses who had been involved because of the family's numerous moves as well as some staff turnover. Ultimately the assessment identified vulnerabilities in respect of the family's instability and frequent moves and both parents' physical and mental health. The file was to be passed back from the voluntary agency to Tusla with a recommendation for further comprehensive assessment and intervention. Sadly, Tommy died from SIDS at this time. The post-mortem report indicated that he had been referred to hospital by his GP because of failure to thrive. Helen does not recall the GP referring Tommy to Hospital for failure to thrive. It is her recollection that she brought him to the GP because he had very bad reflux and was not keeping his formula down so she was worried about this. She said the GP recommended changing formula and once changed the issue was resolved.

3. Review Findings

The review was limited by the fact that not all the social work records from the earlier period of social work involvement were available. Its scope was further limited by the failure of the GP and public health nursing services to provide records when requested.

From available records, it appears that opportunities were missed to address allegations of interpersonal violence and drug misuse at an earlier point. The first initial assessment was an appropriate response to the referral made at the time. A later referral to support services was not, in the opinion of the reviewers, an adequate response to the report made by the family's GP but it is noted that it was followed quickly by a decision to commission a second initial assessment which was the most appropriate action at the time. The first assessment, conducted by the SWD, addressed many important issues and usefully included observations of Mary and her interactions but did not sufficiently address Helen's own background and relationships to establish any potential risks. The second initial assessment, conducted by a worker from a community based family support service, was constrained and delayed by the unavailability of previous social work files. While it was detailed and addressed the impact of Helen's antisocial behaviour, her mental and physical health and allegations of drug use, it did not sufficiently consider any risks in relation to the children's father and Helen's family of origin.

There is evidence from the records that all the workers involved did their best to establish positive relationships with Helen and her daughter and were focused on Mary's development and welfare. Helen was not consistent in her contact with services, and her capacity to engage and put her children's needs first needed to be considered as part of the analysis of risk to her children.

There is evidence of management oversight of the case, though this was limited due to the unavailability of some records. While there is evidence of good interagency collaboration in relation to the assessment, it appears that not all professionals involved were in possession of full information about the family. For example there is no evidence in the social work or assessment records that the practitioners involved were aware that Tommy had been referred by his GP to a hospital for failure to thrive. Helen does not recall the GP referring Tommy to Hospital for failure to thrive. It is her recollection that she brought him to the GP because he had very bad reflux and was not keeping his formula down so she was worried about this. She said the GP recommended changing formula and once changed the issue was resolved.

The information gaps may be explained by the family's frequent moves as well as frequent changes of personnel. In the opinion of the reviewers, an interagency professional meeting would have provided a useful opportunity for information sharing.

4. Conclusions

The review team acknowledge the loss that has been experienced by the family and the impact of Tommy's death on the professionals involved. The review team have reached the following conclusions:

Tommy died from natural causes. The post-mortem report states that he had been referred to hospital by his GP for failure to thrive shortly before his death. Tommy's mother does not recall the GP referring Tommy to Hospital for failure to thrive. It is her recollection that she brought him to the GP because he had very bad reflux and was not keeping his formula down so she was worried about this. She said the GP recommended changing formula and once changed the issue was resolved.

- Tommy's mother and sister had experienced a lot of instability in previous years and were both vulnerable.
- Frequent moves by the family affected the continuity of assessment and interventions by various professionals with Tommy and his family.
- There is evidence that the assessment worker from the voluntary support agency developed a positive and supportive relationship with Helen, but the assessment was limited by the unavailability of previous Tusla files and also by the children's mother's refusal to consent to their father's participation.
- Overall, good inter-agency communication took place for most of the time although there was evidence that not all relevant information was known to all members of the professional network.

5. Key Learning Points

This report has attempted to reflect on the challenges faced by the family and the staff who worked with them. The review team consider that there are areas where lessons can be learnt:

- The importance of timely access to information and the sharing of information to inform assessments and analyse risks is highlighted by this review. Previous social work files and public health nursing records were not available to staff which limited the comprehensiveness of assessments. The recent implementation of the National Child Care Information System (NCCIS) should now facilitate all 17 social work areas to access one integrated, up to date information system to manage child protection and welfare cases[1].

- The fact that the father of the children was not involved in the assessment limited the effectiveness of the process. The Child Protection and Welfare Practice Handbook (HSE, 2011) highlights the importance of involving both parents. The focus of the initial assessment is to make a preliminary determination of risk and unmet need. Messages from research indicates that the 'mother is often the focus of social work interventions, with the exclusion of the father, based on family members' accounts and/or workers failing to make contact. An assessment which does not include fathers may result in incomplete information about the family. Including the father means that any risk they may present to the safety of the child can be assessed. They could 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 involvement of fathers can therefore impact positively on risk assessment and management in the child welfare process.[3] Contact with Tommy's father was obstructed by Helen withholding her consent for him to be contacted, although the Children First National Guidance 2017[4] states that contact for initial assessment should be made with the parents of the children. The Tusla Child Protection Handbook 2[5] also advocates the inclusion of fathers. Greater clarity is required for workers in circumstances when one parent decides to withhold consent for the second parent to be involved. Guidance is needed on whether, during an initial assessment, the consent of one parent is needed for the other parent to be contacted.

[1] https://www.tusla.ie/news/tuslas-new-national-integrated-information-system-goes-live/

[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.
[3] Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. and Tolman, R. (2012), Engaging fathers in child welfare services: a narrative review of recent research evidence. Child & Family Social Work, 17: 160–169.

[4] Children_First_National_Guidance_2017.pdf
[5] Tusla_Child_Protection_Handbook2.pdf

- It is recognised that the family's transient lifestyle, moving from place to place may have a detrimental effect on the child's health and wellbeing[6] and exacerbate the situation. Evidence shows that homelessness and temporary accommodation during pregnancy are associated with an increased risk of preterm birth, low birth weight, poor mental health in infants and children, and developmental delay. All of these factors are, in turn, associated with the risk of poor outcomes in later life[7].

- Research has demonstrated the importance of clarifying membership of and relationships within a household, to inform assessment and identify any risks presented, which is essential to a good assessment.[8] [9]

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Chair, National Review Panel

[6] Tusla_Child_Protection_Handbook2.pdf
[7] Stein & Gelberg, 2000; Richards, Merrill & Baksh, 2011 homelessness_babies_families.pdf
[8] learning-from-case-reviews_hidden-men.pdf
[9] HARINGEY LOCAL SAFEGUARDING CHILDREN BOARD SERIOUS CASE REVIEW 'CHILD A' March 2009 second_serious_case_overview_report_relating_to_peter_connelly_dated_march_2009.pdf