Painéal Athbhreithniú Náisiúnta
NATIONAL REVIEW PANEL

Review undertaken in respect of the death of a young person who was known to HSE child protection services

Executive Summary

Avril

July 2016

Introduction and background

Avril died when she was almost 17. Her family had been known to the local social work department (SWD) for a number of years prior to her birth, as her older siblings were in care when they were young. Her family background was characterised by domestic violence, criminality and changes of accommodation. Avril's mother, Annie, was a victim of domestic violence and found it difficult to manage her children. Although social work records from the time of Avril's childhood refer to assessment and child protection plans but there is no evidence that these took place at the time, or were developed. Avril attended a youth project when she was 11 and an assessment conducted in the project found her to be unhappy, out of touch with her emotions and lacking confidence. It appears from the records that project staff believed that 'increased statutory involvement' was required for the family but in fact the case was closed to the SWD when Avril was 12 and she also ceased attending the youth service around this time. Reports were made to the SWD during Avril's early teens to the effect that she was often out of her mother's supervision and also out of school for long periods. The review notes that Avril and her mother displayed a lot of resistance to social work involvement and could be very aggressive with social work staff, but that Annie was prepared to engage about matters to do with finance and housing and would occasionally engage with workers. The case was opened on more than one occasion by the SWD which made brief responses to the various reports but then closed, following network checks, on the basis that no child protection concerns existed. Avril had been out of contact with the SWD for nearly two years when she died.

Findings and conclusions

The review did not find evidence that action or in action of the social work services was linked in any way to Avril's death. However, the review also found that opportunities to intervene when Avril was younger were missed. It also found that the rationale for closing the case, i.e. that no child protection concerns existed, overlooked Avril's significant vulnerabilities and that the SWD did not satisfy itself that her needs were being met by alternative services. It acknowledged the hostility displayed by Annie in particular towards working with services in connection with the children's welfare but concluded that the pessimism held by the SWD about engaging the family stifled opportunities for finding creative ways of meeting Avril's needs.

Key learning

The review identified a number of learning points which are detailed in the full report and summarised below:

- Assessment should be conducted at an early stage. When it is undertaken by another service i.e. a project or family support service, its implications should be fully considered by the full network of services with responsibility for meeting the child's needs, and joint plans should be made and their impact evaluated within a given period.

- Working with resistant service users requires social workers to make the best of any opportunities presented to them and apply their skills to motivate families to engage further. Section 3.2.8 of the HSE Child Protection and Welfare Practice Handbook, as well as a number of social work text books on the topic of involuntary clients, provides guidance on working with families who are uncooperative or hard to engage.

- Consideration needs to be given to how judgements about case closures are made and whether a determination of whether concerns reach a 'child protection' threshold should the deciding factor in keeping a case open to the SWD.

Dr. Helen Buckley

Chair, National Review Panel