Painéal Athbhreithniú Náisiúnta
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a young person who had contact with HSE/ Tusla child protection services

Joe

Executive Summary

July 2016

1. Introduction

This report concerns a young person, here called Joe, who very sadly took his own life at the age of 15. Joe's family had been known to the HSE Children and Family Services since he was a young child. He had lived predominantly with his father, at times with both parents and for short periods with his mother. There was a history of domestic violence in the family home, along with alleged alcohol abuse and the children experienced a level of instability as a result of all these factors. The case was opened and closed the SWD at different periods over a number of years, and for most of the time that it was allocated, the main focus of attention was on Joe's younger siblings. As Joe grew older his relationship with the education system became problematic and in the months prior to his death he attended CAMHS for mental health and behavioural issues. Joe's father struggled to manage the children's behaviour and sought support from services. The case was wait-listed as a high priority for over a year prior to Joe's death but according to the evidence provided to the review, it could not be allocated because of staff shortages.

2. Findings

The review team notes the loss that Joe's family have experienced and extends sympathy to them. It has found no evidence that action or inaction by the HSE services involved with Joe directly contributed to his death and has reached the following conclusions:

- An overview of this case indicates that the children were experiencing a level of neglect over many years, contextualised in parental alcohol misuse, alleged domestic violence and a lot of instability. The case should have received consistent intervention from an early stage, whereas the response of the SWD was very incident based and decisions for closure at different times were not based on any evidence that the children's situation had improved.
- The SWD did not make an appropriate response to the reports of concern about Joe at different points, and particularly during the months before his death.
- A number of practice weaknesses were evident throughout the chronology of contact between the SWD and this family over the years, including lack of assessment which meant that the family's needs were neither identified nor met, lack of follow up to a child protection conference plan, inconsistent supervision of frontline staff and the lack of a child centred focus with regard to Joe and his siblings.

- The inability of the SWD to manage the high number of referrals that was received in the area had a knock on effect in this case in that the SWD could not progress the case within an appropriate time frame.
- The review team has particularly noted the very difficult staffing situation in this area and has taken it into consideration when analysing the practices of staff in the area. It concludes that this staffing situation contributed considerably to the deficits identified above in respect of the services offered to Joe and his family during the last two years of his life.

3. Key Learning

This report has attempted to reflect on the challenges faced by Joe and the staff who worked with him and his family and it highlights a number of areas where lessons may be learned. These are elaborated in the full report and may be summarised as follows:

- Assessments should be ongoing and completed in a timely manner and any incidents regarded as potentially risky or harmful must be carefully examined.
- The impact of parental substance abuse, mental illness and domestic violence on parenting capacities to meet their children's needs should be kept in mind by practitioners.
- All professionals and agencies involved with a child and his or her family must work together to deliver a coordinated response and efforts must be made to promote contact and overcome any obstacles to a satisfactory working relationship.
- Where resistance to intervention is displayed by families, workers need to examine the causes and also be aware that they themselves may play a contributing part in the process.
- It can be difficult for social workers to validate allegations made by parents against each other in the context of acrimonious breakups. However, research indicates that a number of allegations made in such circumstances are likely to be accurate. It is also possible that erroneous or groundless reports are made, given that they occur in a context where parents are upset and angry and are unable to communicate rationally with their former partners. This situation alone warrants a helpful response if children are not to become embroiled in the conflict and thereby emotionally damaged.
- At times, staff can be so focused on supporting parents that they may fail to challenge poor parenting in a satisfactory manner. It can be difficult for workers to achieve the correct balance given that it is hoped that by supporting parents that their parenting capacity can be

enhanced. However, it is essential to continually assess the family situation to ensure that required progress is taking place

- Children First (DCYA, 2011) highlights the need for adequate and regular supervision of staff. There is a dedicated HSE Supervision Policy that applies to all Social Work staff (HSE, 2010) which aims to support workers to provide safe, quality care for children and families. Supervision provides a regular, structured opportunity for workers employed in a complex and stressful environment to discuss their practice in a reflective manner and identify areas for own development**.**

Dr. Helen Buckley

National Review Panel