Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death experienced by an infant whose family had contact with Tusla

Marcus

Executive Summary

September 2019

1. Introduction

This review concerns an infant here called Marcus who died aged eight weeks. He had been born prematurely and was observed to have 'jittery' symptoms. Toxicology results from tests taken at his birth revealed the presence of cannabis and other substances in his bloodstream, some of which had not been prescribed to his mother.

Marcus was the youngest child of Marie and Mike. His parents and siblings had been known to the child protection and welfare services over several years because of a history of parental domestic violence and drug misuse and other vulnerabilities including risk of homelessness. Marcus' siblings had been listed on the Child Protection Notification System (a list held by Tusla when children were considered to be at on-going risk of significant harm) for two periods prior to his birth. Two child protection conferences and two review child protection conferences had been held, as well as a professionals' meeting. Both Marie and Mike demonstrated cooperation with child protection plans and made progress while the children's names were listed on the CPNS but their engagement with addiction and family support services was not consistent over the longer term.

A referral was made to the SWD by the maternity hospital when Marie was 16 weeks pregnant with Marcus because of the fact that the children's names were still on the CPNS at that time. During Marie's pregnancy, she was asked by the SWD to provide regular urine samples for screening at her ante natal visits, but she did not attend the majority of appointments offered and no screenings were available. As no child protection concerns or evidence of risk of significant harm were evident to the SWD, it was decided to de-list the children from the CPNS two months prior to Marcus' birth and following assessment, a decision was made to close the case to the SWD just before he was born.

Immediately following Marcus' birth, the case was re-referred to the SWD as his presentation was jittery and there were concerns about parental drug use. The SWD commenced an assessment and professionals visited very frequently over the following weeks. Marcus' development was normal and worries about his health abated. Sadly, he passed away at eight weeks of age, from Sudden Infant Death Syndrome.

2. Review findings

The review team acknowledge the very sad loss that has been experienced by the family and the professionals involved. It found that the SWD had frequent contact with the family, including face to face contact, from the time that Marie's pregnancy was known. The children were met with

regularly and provided with opportunities to express their views. The decision to close the case to the child protection services prior to Marcus' birth was made on the basis that there was no evidence at the time that the children were at risk of significant harm and the threshold for further social work intervention was not met. The reviewers have observed, however, that despite the lack of evidence that the children were at risk, several of the concerns identified by the allocated social worker remained and the protective factors identified were not all operative, particularly in relation to parental engagement with addiction services. The review also found that following Marcus' birth and the re-opening of the case, services worked closely to monitor Marcus' progress. It was noted that even though good communication took place between health and social work services, a multi-agency strategy meeting following Marcus' birth would have given professionals an opportunity to share concerns and establish a unified approach.

3. Conclusions

The following conclusions have been reached:

- Marcus died from SIDS. Earlier concerns about his health had abated in the weeks following his birth.

- The SWD had regular contact with the family. The allocated social worker did her best to develop a positive relationship with the parents and identified appropriate support services for the family even though the parents did not fully engage with these.

- The decision to close the case just before baby Marcus' birth was made on the basis of an assessment that the children were not at risk of significant harm. However there was a lack of accurate information in respect of his mother's substance use during pregnancy, mainly because of her minimal contact with services that could provide assurance that she was not misusing drugs. This meant that the SWD did not have an entirely comprehensive picture of the risks to herself, her unborn child and to the other children. From the family's history, there was no guarantee that they would continue to engage with services.

- Following Marcus' birth there was awareness of Marcus' needs and all the relevant services responded in a proactive manner.

- There was good communication between the SWD and other agencies following Marcus' birth.

4. 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:

- It appears that there was disguised compliance in this case and this led to an assumption of parental compliance with conditions that were in reality only partially fulfilled. The HSE Child Protection & Welfare Handbook (2012) offers practical guidance on working with families who are uncooperative. An NSPCC Factsheet (2010) explains disguised compliance as involving a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention[1]. This can lead to a misguided optimistic view of the competency of the parents and their capacity for change (Tuck 2013)[2]. Professionals can be misled by intermittent incidents of disguised compliance. Factors which can help to mitigate this have been identified by the NSPCC. These include establishing facts and gathering evidence, building chronologies, recording the children's perspective and situation, identifying outcomes, and the use of staff supervision to challenge beliefs (NSPCC 2014)[3].
- Child protection and welfare concerns have been found to arise when parents use substances such as drugs (both prescribed and illicit) and when other parental problems exist. Parental substance misuse brings disruption to family life leading to significant stress to the children's health and wellbeing, affecting their overall ability to parent. It also has consequences for children's mental health, social skills, academic achievement and substance use (Horgan, 2011)[4]. Detailed assessment and analysis regarding the degree of drug use linked with regular drug testing is helpful in order to have a clear picture of the level of concerns. This is outlined by a review of case reviews undertaken by the NSPCC. It found professionals too often trusted the parents' self-reporting of their drug and alcohol consumption. A clear picture of the user's drug and alcohol consumption and behaviour must be properly analysed to understand the risks posed to the children which should

[1] NSPCC Disguised compliance: An NSPCC factsheet March 2010 https://www.nspcc.org.uk/globalassets/documents/information-service/factsheet-disguised-compliance.pdf

[2] Tuck, V. (2013) 'Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy'. *Child Abuse Review*, Vol. 22, 1 (5–19) http://www.in-trac.co.uk/wp-content/uploads/2015/11/Resistant-Parents-and-Child-Protection-copy.pdf

[3] NSPCC (2014) *Disguised compliance: learning from case reviews - Summary of risk factors and learning for improved practice around families and disguised compliance* March 2014 https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

[4] Horgan Dr. J. (2011) *National Advisory Committee on Drugs Parental Substance Misuse: Addressing its Impact on Children A Review of the Literature.* October 2011 Dublin: Published by the Stationery Office

include an assessment of parenting capacity and where other risk factors are also present (parental mental ill health, domestic violence), the relationship between these factors and a parent's substance misuse should be taken into account.

- Placing children on the Child Protection Notification System (CPNS) is a serious step and a review child protection conference should be called if the child protection plan is not being complied with. In addition, it is necessary to consider how long children's names require listing on the CPNS in order to effect real change particularly where there are long standing issues of drug misuse, domestic violence and mental health. When children's names are removed from the CPNS, and effectively relegated to the 'welfare' category, the family's take up of support services should be reviewed for a period in the aftermath to ensure that the children's safety and welfare is not compromised. Furthermore, a renewed focus on the assessment and analysis of the risks should be undertaken when children are relisted on the CPNS within one year. Ideally, an experienced manager/practitioner not involved in the case should undertake a review which should give an indication as to whether additional steps are warranted.

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