Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review of the death of an infant, Jake, known to child protection service

Executive summary

Introduction and background

Jake died when he was two weeks old. His mother, here called Jackie, and her family were referred to the Child & Family Agency child protection services during her pregnancy with Jake because of reported concerns about her drug use and its potential impact on her unborn baby. An earlier referral in one of her previous pregnancies had been followed up and closed as no concerns existed at that time. At this time, there were a number of professionals involved, including the social work department (Social Worker 1), the HSE public health nurse, the maternity hospital ante natal clinic and a local addiction service. Jake's mother, here called Jackie, had a history of heroin use and had been taking methadone for a number of years prior to his birth. On her previous pregnancies, she had decreased her methadone intake in order to reduce its potential impact on her babies. This time, however, she was struggling with her addiction and screenings taken regularly during her pregnancy were positive for opiates. It was also reported that she was underweight and looked unwell. An incident of alleged neglect of her young child was also reported. The SWD made an initial decision that it did not have the resources to follow the referral up immediately but asked the PHN to call. The PHN reported that while Jackie seemed vulnerable and under pressure, her children were doing well.

Social Worker 1 made contact with Jackie seven weeks after the referral, and eventually met her with her partner and her children and kept in regular contact. Jackie and her partner were resistant to social work contact, claiming that it was upsetting them and putting them under pressure. Jackie minimised her opiate use. While the family had good support from relatives in the area, neither extended family was aware of Jackie's drug use and both she and her partner were anxious that this information was not shared with them.

Concerns remained over the following months as Jackie's screenings continued to be positive for opiates and she was admitted to hospital with high blood pressure. The baby was observed to be 'hyper' and Jackie was quite agitated during her admission, requiring her methadone dose earlier than normal. The social worker kept in contact with the family and other professionals. Two weeks prior to Jake's birth a child protection conference was held, attended by both parents and the relevant professionals apart from maternity staff. By this stage, Jackie's regular screenings were negative for opiates and her attendance at clinics was consistent. A plan was included in the child protection conference minutes, including the decision to transfer the case to the further assessment team and address concerns related to Jackie's drug use, as well as make unannounced home visits to assess the family's routine and structure and provide intensive family supports. A review child protection conference was planned for ten weeks hence. Jake was born two weeks later with a

congenital defect and he died soon afterwards. The pathologist who conducted the post mortem did not mention maternal drug use in his findings.

Findings and conclusion

The review found that the initial response of the SWD, whereby contact was made with the family seven weeks after the referral, was unacceptably slow given the circumstances. Once contact had been established however, the social worker was diligent in her efforts to work with the family. The case raises issues about the about the right of individuals to self-determination and the extent to which the State (in the form of the Child and Family Agency) may intervene when it perceives an unborn child to be at risk. The SWD was not able to take any coercive action in this case, despite their serious concern for Jake's health and welfare. There were no grounds for believing that the capacity of the parents to care for their existing children was inadequate and the main concern centred on the impact of Jackie's health and drug use on her unborn baby. In this context, the SWD had little option but to encourage Jackie as far as possible to comply with the drug treatment service and the guidance of her medical advisors. The review finds that the SWD did as much as possible to promote Jake's health and welfare and took the most appropriate actions available to them, in the course of which they communicated well with their colleagues in the health and addictions sectors.

Key Learning

The following learning points are elaborated in the full report:

- This case profiles a complex issue, which is how best to promote the health of pregnant women who use drugs so as to maximise the potential for the delivery of a healthy baby. There is extensive literature on the risks for unborn babies associated with maternal drug use, and research points to the lack of policy or guidance for child protection social workers dealing with this issue, where no specific legislation or practice framework exists.

Recommendation

The establishment of a nationwide Drugs Liaison Midwife service is not within the remit of the Child & Family Agency. However, it is suggested here that any opportunity to promote its establishment is

taken by the agency, possibly by highlighting the matter at the Children First Interdepartmental Group.

Helen Buckley, Chairperson