Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a young person who was in care

Michelle

Executive Summary

June 2017

Introduction

This review was outside the normal remit of the National Review Panel and concerned a young woman who died a number of years ago. The review was commissioned by Tusla following a following a recommendation made by the Independent Review Group on Child Deaths (2012). The review has been compromised the length of time that has passed and the fact that staff who had been involved in the case had left their posts or retired.

The young woman who is the subject of the review, here called Michelle, died aged 21 from a drug overdose. Michelle was described as an attractive young woman who was friendly and warm when in good form but was also very troubled, experiencing difficulty maintaining relationships. She had been known to health board social work services since she was 14 years old, and was the mother of two young children when she died. Michelle had come to the attention of the social work department because of challenging behaviour and difficulties between herself and her family. Her parents signed her into voluntary care at the age of 15 and she had numerous admissions into different types of care settings, mostly supported lodgings. During this period, her pattern of living became very unstable as her placements tended to disrupt within a short time. She returned home on several occasions but living with her family became unsustainable. The social work department (SWD) was aware that Michelle did not fit the normal profile of a child requiring care as there was no doubt about her parents' ability or willingness to meet her physical needs. Michelle always had an allocated social worker when in care and continued to receive social work support up to six months before her death. Contact between the social work department and the family was frequent and many attempts at mediation and reunification were made. However, Michelle's parents were unable to tolerate her behaviour and Michelle was unable to modify it. Although they all wished to live together as a family, efforts at reconciliation were unsuccessful.

Disruptions in Michelle's care were compounded by the lack of suitable accommodation for someone with her level of challenging behaviour and the inability of the HSE to find a placement that could manage her and where she could be content. Her care career followed a pattern whereby she would initially settle into a placement but would rapidly become unsettled and challenging; her carers found her attitude and her tendency to stay out all night or go away without permission for days at a time to be unmanageable and the placements would terminate. There were periods where nobody knew Michelle's whereabouts, during which she sometimes stayed with her boyfriend who was ten years older and was allegedly violent. Michelle had two children during the time she was known to the SWD and after the birth of the second child she lived independently though in close contact with her parents. Her relationship with the children's father was volatile and ended when

the children were very young. Michelle looked after her children on her own until the eldest was two years and the youngest was one year old, and had the support of nurses, social workers, family support workers and a fulltime crèche paid for by the Health Board. Her parents looked after the children on many occasions and supported her in finding accommodation. She had two further relationships with men, one of whom was allegedly violent towards her. Although Michelle provided good physical care for her children and settled for a while in rented accommodation when they were young, she ultimately found herself unable to cope and the children were received into care at her own request two years before she died. At this time, the SWD was becoming concerned about her ability to meet their emotional and psychological needs and, although reunification was initially planned, it was decided after a year that the children should remain in care for their own safety and welfare. Michelle's mental and physical health declined after her children went into care. Although regular access was facilitated, her visits with them became sporadic and she went out of contact from time to time. She was put in touch with counselling and therapeutic services but rarely availed of them. She had used drugs earlier in her life and reverted to drug use again after her children were received into care.

Findings

The review found that while the social work department (SWD) was responsive to Michelle and her family and tried to find solutions as quickly as possible, the type of care placements that were available to her were not suitable for a young person of her age and fell short of meeting her needs. From the records it appears that Michelle was a very troubled young woman whose inability to sustain relationships with carers or to comply with other people's living arrangements or settle in school made her life very problematic and while it is acknowledged that she was offered services, it was unfortunate that no in-depth psychological analysis of her behavioural difficulties took place.

The relationship difficulties which existed within the family also extended to relations between the SWD and the family. The record shows that at times, Michelle's mother was very dissatisfied with the service she received and very forthright in expressing her views. Michelle was also volatile at times in exchanges with social workers, particularly in the last year of her life. However, the social work files show that the SWD had frequent and regular contact with Michelle and her mother from the time Michelle was 15 and, despite occasional tensions, developed open and workable relationships with them. There is evidence that the first social worker in particular made efforts to mediate between Michelle and her parents and siblings. The family support workers allocated to Michelle when she was living independently with her children appear to have had good relationships with her, and to have provided valuable support.

Conclusions

The ability of the reviewers to reach fair conclusions is hampered in the same way as the review was curtailed by the distance between the events outlined in the report and the current time. It is also complicated by the fact that the child protection services that currently exist are very different in quality and quantity from those that operated at the time.

- In light of the information available to them, the reviewers conclude that the alternative care provided to Michelle between the ages of 15 and 18 was not satisfactory and did not meet her needs. It is notable that the matter was not escalated to senior management level when it became apparent that Michelle's behaviour could not be contained within the placements that were available.
- The review notes that neither Michelle's very complex needs nor the basic needs of her children were fully ascertained. However, it also acknowledges that no assessment frameworks were in operation at the time this case was open.
- The review also concludes that Michelle's psychological difficulties and her relationship with her family which were strongly linked, did not receive the multi-disciplinary professional interventions that would now be expected when dealing with particularly complex emotional and behavioural difficulties. It is also acknowledged that offers of services were made to Michelle that were not taken up.
- The reviewers also conclude that both Michelle's family and the SWD made strenuous and persistent efforts to prioritise Michelle's welfare even in the absence of adequate placement options. The health board social work service provided consistent support to Michelle and tried to keep an open relationship with her over a number of years.

Dr. Helen Buckley

Chair, National Review Panel