Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a child who was in the care of the Child and Family Agency

Oisin

Executive summary

December 2017

Introduction and Summary

This review concerns the very sad death from an illness of a thirteen year old boy, Oisin, who was in long term foster care with relatives. Oisin was known to services from the time he was four years old, as his mother, here called Niamh, had problems with alcohol and mental health. He was described as a pleasant, friendly and resilient young person who loved sports and got on well with everyone. Oisin was in voluntary care on three separate occasions with two separate sets of relative carers. In between, he returned to his mother's care but a decision was finally made when he was 11 that his long term welfare and safety would be better served if he remained in long term foster care. His relatives were assessed and approved as long term foster carers. Oisin agreed with this plan, and remained close to his mother whom he saw regularly. The extensive support provided to both Niamh and Oisin by extended family members precluded the need for legal intervention which would otherwise have been inevitable.

Over the years and periods of contact with the HSE/Tusla social work departments, Oisin had contact with different social workers but mainly with Social Workers 1 and 2. He did not have an allocated social worker for the final ten months of his life. His death from a viral illness was sudden and unexpected and no concerns had previously existed about his health. When he became ill, his relatives sought immediate medical help and after his condition deteriorated he was rushed to hospital but did not respond to treatment.

Findings

The review has found that the HSE/Tusla social work department (SWD) responded appropriately to the referrals made about Oisin as a young child and kept good records of the involvement of different professionals. . The social work assessment correctly ascertained his mother's capacity to care for him as well as his own wishes. Ultimately, when the SWD concluded that Oisin should stay in the care of his relatives, their decision was in line with his own views. The SWD provided appropriate support to his extended family as well as to Oisin's mother, and there was a strong sense from the records that the two social workers who were principally involved had developed trusting relationships with Oisin. Both the SWD and the adult mental health services that were treating Oisin's mother communicated regularly with each other. Up to the ten months preceding his death, he received regular visits from social workers and at different times, other workers were allocated to him to help him deal with the emotional impact of his mother's difficulties. Although it was regrettable that Oisin had no allocated social worker during the last few months of his life, it was

evident that the SWD had oversight of the case and likely that any requests for contact or assistance would be responded to. Overall, the review concluded:

- While certain procedural and regulatory deficits were identified, the evidence reviewed in this case shows that Oisin received a consistent, child centred service from the time he was first referred to the SWD. He was securely placed with approved relative carers. His views were elicited, respected and heeded. The aforementioned deficits were highlighted in a local review, which made specific recommendations and brought them to the attention of local management.

- The SWD managed to develop positive and effective relationships with Oisin, his mother and his extended family and mediated effectively when required.

- Cooperation and communication between the different services appears to have been open, regular and useful. It was notably child focused

- Oisin's extended family played a significant role in securing his safety and welfare.

Dr. Helen Buckley

Chair, National Review Panel