Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review of the death of a child known to child protection services

Sandra

April 2018

Executive summary

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Introduction and background:

This desktop review concerns a young woman, here called Sandra, who died from complications associated with a chronic long term illness when she was 16 years. She and her family had been known to Tusla services prior to her death. Her mother had died some years previously and when well enough, Sandra had taken on a caring role in respect of her father who had addiction and mental health problems. She went to school as much as possible and was described as bright and sociable. The family was referred to social work services by the medical team that was treating Sandra, who were concerned because her father was finding it difficult to comply with the very strict treatment regime that she required. Extended maternal and paternal relatives also helped out with Sandra and her siblings, but tensions resulting from past events triggered occasional conflicts between the two sides of the family. The case was closed when things were going well and opened again when new reports were made. Overall four social workers were involved, the last one of which had very specific knowledge about Sandra's medical condition. Although there were no specific child protection concerns, the social work department played a key role in coordinating the various services that were involved, monitoring Sandra's father's progress with his addiction treatment and providing support to the family.

When Sandra entered her teens, she was due to have an elective and potentially life-saving medical intervention which would require her to have intense support in very hygienic conditions. Her medical team were concerned about her father's ability to provide this. A number of support services were working with the family at this stage, and Sandra's father was finding it difficult to cope with the number of professionals interacting with him on a daily basis. He resented the involvement of the social work service because of the implication that he was not competent to provide the required level of care. However, Sandra's medical team insisted that he accepted all the support on offer and the possibility of her having the medical intervention was made contingent on this. Sandra was clear that she did not want to be separated from her father. Two family welfare conferences were held, and a shared family care plan was developed.

Over the following months, Sandra's father's ability to manage his addiction varied and wider family relationships became strained from time to time. On occasions the children's schools reported concerns about physical neglect. Support services, including private nursing services, continued their involvement with Sandra and the other children in the family and were coordinated by the allocated social worker. Sadly, Sandra's father took his own life after a period where his drug use became out of control. The children including Sandra were cared for by different relatives over the next few months on short term arrangements. The social worker urged them to make a definite plan and

adhere to it. Eventually, Sandra's medical intervention was scheduled and completed successfully but sadly, she succumbed to a post-operative infection two weeks later and died.

Findings

The review found that Sandra's sad passing was due to her chronic medical condition and her chances of survival were compromised regardless of the level of medical or social supports in place. It found that the service she received from the social work department was supportive, consistent and child centred. The case was allocated when required and even when closed was subject to a watching brief by the social work department. Although earlier assessments lacked depth, later assessments were well considered and thorough. There was regular interaction by the social work department with the family and despite Sandra's father's unwillingness to engage, the social workers involved were clear about their function and maintained an appropriate level of vigilance. Opportunities were taken to promote Sandra's welfare and her views were heard as much as was safely possible. Her wish not to be separated from her father and siblings was respected, and the social work services did their best to optimise the existing situation. The level of interagency cooperation was generally good and the records reflect good oversight at team leader and principal social worker levels.

Key Learning

The review has identified the following learning points:

Drug use and its impact on parental capacity

Sandra's father struggled with addiction. While the SWD was vigilant in terms of its monitoring of his drug treatment, there is less evidence that practitioners fully understood the impact of using drugs on his capacity to look after his children. Where the main concern in a case is parental drug use and its impact on parental capacity, it is important for practitioners to gain a full understanding of its implications – its effect on the health, mental health and behaviour of the drug user, as well as the type of intervention that is likely to be most effective. This could be achieved by communication with drug treatment services and their involvement in planning.

Service user experiences

This case provides an example of dissonance between the perceptions of service users and social work services. Sandra's father, was a reluctant user of social work services, which he found to be fault finding and unsupportive. It is notable that the Tusla SWD was aware of his feelings and noted his comments. While it is not always evident, it seems that the social workers involved acknowledged his unease and that of Sandra. It is also notable that during a time when his drug use was becoming particularly erratic, he had sufficient trust in the social worker to confide in her and there are examples of where she affirmed his positive efforts.

Potential for involvement of the HSE primary care social work service

Research demonstrates that is not uncommon for families to feel threatened by the involvement of child protection services, particularly when they are vulnerable and trying their best. It also demonstrates that the most positive outcomes result from the development of helpful and supportive relationships. It appears to the reviewers that when the case was first referred, the concerns of the medical team could have been addressed by the HSE primary care team (PCT) social work service whose membership of a multidisciplinary and largely medical team would have brought distinct advantages. This case raises questions about the role and function of primary care social work services and implies that some agreement needs to be reached as to what it can and should offer.

Dr. Helen Buckley

Chair, National Review Panel