Painéal Athbhreithniú Náisiúnta
NATIONAL REVIEW PANEL

# Review undertaken in respect of a death of a young person who had contact with HSE/ Tusla child protection services

## Tim

## Executive Summary

**July 2016**

## Introduction and background

This review was carried out because Tim was known to HSE/Tusla social work services prior to his death by suicide at age 15. Social work records were reviewed, and interviews were held with social work staff and family members. Reports were also provided by the family GP and Tim's school.

Tim was described as a talented young man who was easy going, upbeat and a bit stubborn at times. His parents separated when he was a toddler, and he spent most of his childhood in his father's care, while having contact with his mother from time to time. He had half siblings, including an older sister. His mother had a drug problem which was ongoing for a number of years. Although Tim had been a placid child, his behaviour became very challenging in his early teens and he expressed a wish to go and live with his mother. His father was uneasy about this plan but felt he had little choice, so Tim moved to stay with his mother and half sibling in another area. Rita and her youngest child had been known to the social work department (SWD) where they were living previously. Not long afterwards, a report was made to the local SWD where they were currently residing that Tim and his half sibling were being neglected and drawn into their mother's addictive behaviour. Tim had been diagnosed with ADHD around this time. The SWD intervened in response to the report and Tim and his half sibling, who also had some special needs, subsequently went to live with their older half sibling, here called Tara. Tara was in her early 20's at this time and was working, and the arrangement was intended to be short term. However, while the SWD was aware that Tara was taking on a big responsibility, no onward plans were made. Tara was offered no financial assistance by the HSE and had to rely on her mother to provide money for their upkeep. The SWD had also asked her to abide by certain conditions, e.g. not to leave the boys unsupervised with their mother. In reality, however, Tara had to rely on her mother for practical tasks such as school runs which rendered the conditions unworkable.

The arrangement went on for several months. In time, it appeared that the children's mother began to manage her addiction and the youngest child returned to her care. Tim expressed a preference to remain with Tara. His death by suicide when he was 15 came as a terrible shock to his family, though Tara told the reviewers that she later became aware of allegations that he was being bullied at school.

## Findings and conclusions

The review found that the SWD acted correctly and quickly to reports about the children, but note that apart from one brief initial assessment no further assessment of their needs and no social

history was compiled or recorded. The SWD was unaware of a lot of the details of Tim's past life in particular and made no contact with his father, even though Tim had lived with him for most of his life. The recent change in his behaviour prior to his leaving his father's home was unexplored. It was also notable that no assessment was made of Tara's capacity to care for Tim and his sibling and that unrealistic expectations were held of her, both in terms of her own ability as a young single person to provide for them, and at the same time to supervise the children's contact with their mother. While the allocated social worker did stay in touch with the family including undertaking unannounced home visits, overall the contact was intermittent. The review team became aware of significant staffing issues affecting the SWD. This meant that even though the case was allocated to a social worker, her ability to give it the time it warranted was compromised. Overall, the review team concluded that while there was no evidence that action or inaction on the part of the SWD was directly connected to Tim's very sad death, there were weaknesses in services as follows:

- Lack of assessment of the children's needs or their sibling's capacity to care for them
- What was initially considered to be a short term emergency placement was allowed to drift
- Insufficient support was provided to Tim's sibling to assist her care of the children
- Contact with the family was fragmented
- The staffing situation in the area is likely to have contributed to weak practice.

## Learning points

The review highlighted a number of learning points which are presented in more detail in the full report. They may be summarised as follows:

- Where it is known that a family has had problems going back over previous years, it is essential to compile a chronological history of the case as part of an assessment in order to understand how the current situation developed and identify any future risks.

- While family placements often work very well for children and young people, they are subject to certain vulnerabilities and require very specific supports.

- Excluding fathers means that an important element of family relationships may be missed.

**Dr. Helen Buckley**

**Chair, National Review Panel**