Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a young person, here called Adam, who was in the care of the HSE

April 2016

1. Introduction

This review has been carried out in accordance with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* issued by the Department of Children and Youth Affairs in December 2014. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Children in care;
- Children known to the Agency's social work department or an Agency-funded service; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.
- In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:
- A child protection issue arises that is likely to be of wider public concern;
- A case gives rise to concerns about interagency working to protect children from harm; or
- The frequency of a particular type of case exceeds normal levels of occurrence.

2. National Review Panel (NRP)

A national review panel was originally established by the HSE (now replaced by the Child and Family Agency) and began its work in August 2010. The NRP consists of an independent Chairperson, a Deputy Chair, and approximately twenty independent members with relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and receives administrative support from the Child and Family Agency. When a death or serious incident fitting the above criteria occurs, it is notified through the Agency to the office of the Director of Quality Assurance and from there to the NRP. The Chairperson of the NRR decides on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, conclusions, key learning points and recommendations. Depending on the nature of the case, one of the following types of review will be conducted.

Major: to be held where contact with the Child and Family Agency prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least two panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.

Comprehensive: to be held where involvement of the Child and Family Agency has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions, key learning points and recommendations.

Concise: to be held where the involvement of Child and Family Agency services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions, key learning points and recommendations.

Desktop: to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by one panel member with oversight from the chair. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions, key learning points and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

Internal: Under *Children First: National Guidance for the Protection and Welfare of Children*, all areas should conduct a review where a child in receipt of services has died. Internal reviews should be sent to the Chair of the National Review Panel. In certain circumstances, e.g. where the death has been from natural causes, or where the death or serious incident has more local than national implications, the internal review, once quality assured by the National Review Panel, may suffice and the NRP will not conduct one.

4. Child Death

This case refers to a young person known here as Adam who took his own life. This case was referred to the National Review Panel because Adam was in the care of the HSE Child and Family Service up to the time of his death and the case was referred to the National Review Panel by the Independent Child Death Review Group.

5. Level and Process of Review

This was a comprehensive review as the involvement of HSE services had been reasonably intense over a period of 15 months. The review team comprised two members: Dr Declan Bedford and Dr Ann

McWilliams with oversight by the chair, Professor. Helen Buckley. Members of the review team did not have any previous involvement in the case.

For the avoidance of doubt, where the review team has described the circumstances of any person mentioned in this report, it has based those descriptions on information contained in the relevant records furnished to the review team and from interviews. The review team is not to be taken as expressing any view on the veracity or otherwise of any such item of information.

The review team read the files from the HSE social work department (SWD) and the Child and Adolescent Mental Health Service (CAMHS), the Child Care Manager, a special care unit, reports in relation to proceedings in the High Court, the report from the Ombudsman for Children, the Significant Incident Systems Review and the Independent Child Death Review Report and compiled a chronology of contacts between Adam's family and HSE Children and Family Services. The review was held up for several months due to delays in receiving some files. The following were invited and attended for interview: Adam's parents, five professionals from the Social Work department (SWD), one professional from Child and Adolescent Mental Health Services (CAMHS), one professional from a special care unit and a Guardian ad Litem (GAL).

6. Terms of reference

The review was undertaken with the following terms of reference:-

- To take cognisance of the Independent Child Death Review Group request to review this case
- To examine the response provided to the family by the HSE prior to Adam's death
- To identify opportunities for learning from the findings of the report
- To provide an objective report for the Child and Family Agency.

7. Adam

Adam was described as being an attractive young boy. He was tall for his age and looked older than his years but in fact was quite immature. This left Adam rather disadvantaged and also led him at times to mix with an older age group. His mood was volatile in that he could be calm and cooperative but then become quickly angry and difficult.

8. Background and reason for involvement of HSE Child and Family Services

Adam was reared by his mother, here called Ruth, alone for his early years although she enjoyed the support of her extended family to whom she was close. Ruth met (and later married) her husband James when Adam was about eight years old. Initially the family were close and James and Adam got on very well together. The family went to live abroad for a year and then returned to Ireland. They subsequently had another child. Adam had no contact with his birth father until they met when Adam was 13 years old. According to the files, when he first moved in with Ruth and Adam, James believed that Adam was rather spoiled as he got everything he wanted but as a new step-father he decided not to interfere. However, as the years went by, he became more concerned about the need for discipline. Therefore, when Adam was about 12 years old, he became more actively involved. Adam reacted negatively to this and James and Ruth did not always agree on the best approach to managing Adam's behaviour. Adam's refusal to abide with his step-father's wishes caused considerable conflict in the home.

The HSE Child and Family Service Social Work Department received a referral when Adam was 13 years old and worked with Adam and his family until his death.

9. Services involved with Adam

Others involved included:

- HSE Child and Adolescent Mental Health Service (CAMHS)
- An Garda Síochána
- General Medical Practitioners (GPs)
- HSE Special Care Unit

- Independent residential unit
- Educational and Welfare Officer (EWO)
- Youthreach for a short period
- A youth service for a brief period
- Guardian ad Litem (GAL)

10. Brief Summary of Young Person's Needs

Adam had a number of diverse and complex needs. He needed care and protection because of his impulsive and risk taking behaviour. He had limited insight into the consequences of this behaviour. Adam needed security and clear boundaries. He needed help to develop his coping and problem solving skills and to control his behaviour. Adam's mood was low at times and he needed additional support then. He also required guidance about his sexual behaviour, peer relationships and the use of drugs and alcohol. He needed protection from older youths and also from sexual abuse by adults. Adam was assessed as low average intelligence with learning difficulties including dyslexia requiring additional support in school. He needed a school placement that met his educational needs.

His parents needed parenting support particularly in managing and coping with Adam's behaviour.

11. Chronology of contact by HSE Children and Family Services

13 years old

According to his mother, Adam began to show signs of behavioural problems about a year before he was referred to the HSE services. He was initially referred to the Child and Adolescent Mental Health Service (CAMHS) and this was followed almost immediately by referral to the HSE Social Work Department by his step-father, and also by CAMHS. The principal reason for referral was behaviour management issues. It was reported that Adam was refusing to adhere to rules at home, declining to attend school, absconding from home, drinking alcohol and smoking hash. There were also concerns about possible self-harm and sexual activity. Around the time of the referral, Ruth gave birth prematurely to a baby. It appears that the family were at crisis point.

The family were seen in CAMHS within days of referral and a treatment plan was drawn up which included individual therapy for Adam and parenting work with Ruth and James. An urgent referral was also made to adult mental health services for an assessment of Ruth's low mood. Referrals were also made for family support services by the CAMHS to provide practical support to Ruth and to the Educational Welfare Officer to ensure support for Adam to return to school. A HSE social worker (Social Worker 1) was allocated to the family within a month of referral, the case having initially been dealt with by the duty service.

Although initially there was some improvement in the home situation, it deteriorated again within weeks with conflict between Adam and James escalating to the extent that there were concerns about Adam's safety. There was also increasing tension between Ruth and James. Following a serious confrontation between James and Adam, Adam left the family home late at night saying he felt like killing himself. His grandmother phoned Adam and made arrangements for him to spend the night with an uncle. It was agreed between the family and Social Worker 1 that Adam would stay with family members and also attend a residential youth service for respite and assessment for a short period. During his stay there, he engaged well with this service and when motivated, was described as being very capable of interacting positively with both peers and adults. Subsequently, he refused to continue to attend this youth service.

Shortly after these events, Adam hung a rope on a tree and reportedly thought about suicide but decided against following this through. He was referred by CAMHS to a facility for young people with mental health disorders for his own health and safety but was not admitted. The child psychiatrist told the review team that this referral was largely as a result of Adam's vulnerability given his social situation rather than concerns about his mental health per se. He was staying with relatives for a period at this time.

The HSE convened the first strategy meeting which was attended by members of Adam's family, the EWO, staff from CAMHS, and the Social Work Team Leader (SWTL). It was decided that Adam would return home and Social Worker 1 was to meet with the family to agree rules about Adam's behaviour and his return to school. Some agreement was reached about rules but there was continuing tension between James and Adam and also between James and Ruth. As the weeks went by, Adam's behaviour began to deteriorate in that he became cheeky, staying out late and drinking alcohol. Adam met his birth father at his own request during this period and the meeting apparently went well.

Ruth and Adam attended a meeting with the principal of his former school about his possible return there. However, the meeting did not go very well and both Adam and Ruth expressed concern about his possible acceptance back to the school and how he would get on if he did return. Social Worker 1 encouraged them to try it out and review it in a few weeks. Adam did eventually return to school but only for a few days, after which he refused to return.

A short period later, Ruth phoned Social Worker 1 reporting deterioration in the home situation which had led her to feel that she could not keep Adam while his behaviour remained so difficult and demanding. Social Worker 1 advised her to discuss his behaviour with CAMHS and suggested that she might attend a parenting course. The record shows that Adam was arrested shortly afterwards for drunk and aggressive behaviour. He continued to go missing on occasions.

A further crisis point was reached when Adam took James's car and crashed it. James became very angry. It was agreed that Adam needed a placement out of home. Social Worker 1 discussed various options with James and Ruth, pointing out the difficulty in finding a placement that would meet his needs. Ruth agreed to see if Adam could stay with a family member. Social Worker 1 met with Adam and although he appeared to be shaken following the crash, he did not seem to really acknowledge the seriousness of what had occurred. He told Social Worker 1 that he had taken the car after his mother told him she was leaving home and added that he had wanted to crash the car and kill himself. He also admitted that he had been smoking hash at the time.

Social Worker subsequently 1 contacted CAMHS and the psychiatrist agreed to travel to see Adam in the SWD office as he was refusing to attend the clinic. Social Worker 1 also contacted the Out of Hours Service (OOHS) about a placement for him but she was informed that, under the policy operating at the time, that Adam would have to contact the service himself later that night. At a meeting in the SWD, a Reception into Care form was signed by his mother. On hearing his mother say that he could not return home, Adam became distressed and ran out of the office. Ruth also became very upset and agreed to seek medical attention for herself.

The Gardai located Adam later. Social Worker 1 described him as very upset, crying and stating that he wanted to go home. A foster placement was arranged for Adam, for the weekend only, with a foster family nearby.

Social Worker 1 collected Adam the following Monday morning and the foster mother reported that while he had got on well over weekend, he was anxious about what was happening. It was suggested to

Adam that he should return to the office later in the day, however he responded by saying he would stay with friends.

The child psychiatrist again contacted a facility for young people with mental health disorders but was again told that no place was available. Adam told the child psychiatrist that he no longer wanted to attend any more sessions with her. Attempts to find a youth service during the day were unsuccessful.

At this time, Adam was transferred from Social Worker 1 to Social Worker 2, in line with the area policy to transfer cases that were likely to be open for a lengthy period to members of the 'long term' team. The review team was told that both Ruth and Adam were upset by this, because Adam had a very positive relationship with Social Worker 1.

On taking up the case, Social Worker 2 advised the family that a foster placement was available for the night times but in the event, Adam chose to stay with his grandmother some nights and slept rough on others. It was reported that Adam spent a night in the toilets in a local business but later went missing.

An emergency child protection conference was convened at this point, and a number of actions were agreed. Adam expressed his wish to return home but Ruth and James felt unable to accede to it. It was then decided that Ruth would move out of the family home to private rented accommodation taking the children with her and, in the meantime Adam was to stay with his grandmother. The HSE was to provide a family support worker to assist Adam's grandmother to care for him during this period. The plan was conditional on Adam staying there and not absconding, and was to be reviewed within three weeks. It was agreed that if Adam absconded again, an application for a special care order would be made.

Unfortunately the plan was short-lived; Adam's grandmother became unwell and was admitted into hospital. The record indicates that Ruth began to waver in her decision to leave the family home because of her doubt that Adam would live with her. For the next few days, Adam was thought to be sleeping rough or with friends and his whereabouts were not always known. However, he maintained contact with his family through occasional visits and by mobile phone.

The SWD found it difficult to source a placement for Adam. A review meeting took place, at which Ruth reiterated her wish to have Adam with her but explained that she was having difficulty getting suitable accommodation. Adam still wanted to live with his mother and said he also wanted to go back to school. It was reported that while he was not attending CAMHS regularly, he benefited from the sessions that he did attend. A Social Care Worker (SCW) had by now been allocated following an earlier

recommendation and a family support worker was also available to the family. A place in a local youth service which would have provided some support was offered to Adam but rejected by him.

At interview with the review team, Social Worker 2 said that she believed inconsistent messages were being conveyed to Adam at this time about Ruth's future plans. She also recalled feeling concern about Ruth's mental health and her ability to care for Adam and the baby on her own.

Records indicate that Adams's behaviour deteriorated over the next few days. He was known to be sleeping rough, taking drugs, engaging in criminal behaviour. He refused contact with counselling or therapeutic services and would not engage with any professionals other than the SCW, whom he briefly met. He told her of his sense that nobody cared about him and of his intention to make his own decisions. The SCW in turn became concerned that he might self harm or attempt suicide. His family continued to feel under pressure. Social Worker 2 tried unsuccessfully to find him a local placement.

It was the view of the CAMHS service at this point that he required a special care placement both to keep him safe and to provide an opportunity to have his mental health assessed. This opinion was endorsed by attendees at a review child protection conference. A place was offered in a special care unit on condition that an onward placement could be identified; this took a few weeks to organise and in the meantime, Adam continued the same pattern of living rough with intermittent contact. His parents were concerned about self-harm. It was learnt that a gang had beaten him up.

14 years old

As soon as an onward placement was identified and approved for Adam, an urgent pre-admission meeting to the special care unit was set up at which an admission date three to four weeks hence was proposed. In the meantime, Adam was not answering calls or texts from Social Worker 2. Three weeks later, the High Court granted the order to detain Adam under the Child Care (Amendment) Act 2001. For the two days prior to this Adam's whereabouts had been unknown. Ruth said she would prefer if Adam was not picked up in the local town by the Gardaí when he was being brought to the special care unit. In the event, a lack of available Garda support delayed Adam being brought to the special care unit until the day after the order was granted. He remained there for almost three and a half months. In the meantime, the High Court appointed a Guardian ad Litem (GAL).

Admission into special care

Adam initially settled well into the special care unit and got on well with other young people and the staff. He participated in programmes and events. He attended school, was eating well and played football. He was positive about the unit initially, but approximately a week after admission he self harmed by cutting. This occurred in the context of an incident involving other residents with the staff. He had previously asked Social Worker 2 if cutting himself would result in his being moved out of the unit. His wounds on that occasion were superficial and he later expressed remorse about the incident to Social Worker 2.

While Adam was in the Special Care Unit, Ruth and James consulted a private psychologist as they were unhappy with the service being provided by the HSE. They wanted to engage the psychologist, and requested the HSE to pay the costs involved, which would have included the psychologist spending a day with Adam. It was decided by the HSE after consultation with the CAMHS psychiatrist that the intervention of the private psychologist would not contribute anything additional to the service already in place, and the request to cover costs was not approved. Social Worker 2 and CAMHS then met with Ruth and James to discuss a plan for individual and family work. The social work record indicates that after the first month of Adam's detention, Ruth became more positive about her ability to manage him though it was still uncertain whether or not she would be parenting him on her own when he was discharged.

During Adam's stay in the special care unit, Social Worker 3 took over to cover Social Worker 2's maternity leave. Social Worker 3 was a newly qualified and inexperienced social worker.

A Child in Care (statutory) Review meeting was held a month after his admission. After approximately five weeks, Adam's detention was extended by the High Court for a further four weeks at which point a review was to be held. According to records, Adam and Ruth were concerned that the onward placement was not fully confirmed.

According to the social work record Adam was visited regularly by his family and by Ruth in particular. The visits were generally considered to be positive. Another Child in Care Review was held almost two months into Adam's stay and Adam's key worker gave a positive report about him, describing him as cooperative, generally well behaved and participating in activities.

At this stage, considerable uncertainty had developed about the availability of Adam's onward placement. A number of issues arose as a result. Adam absconded and was missing for five days. A meeting in the special care unit was cancelled due to the lack of confirmation of the onward placement. The GAL's solicitor wrote to the HSE complaining that the situation was not good enough claiming that Adam was being let down. When it became clear that the planned onward placement was not available, an alternative private placement was proposed, but approval for funding was delayed whilst an alternative HSE run placement was sought. These delays upset Adam, who informed CAMHS at a subsequent Child in Care Review that he no longer wanted to engage with their service. The child psychiatrist who had been treating him wrote expressing concern about the uncertainty of his future placement. It was agreed that Adam would stay in the special care unit for another month.

Two weeks later Adam visited the now approved onward placement that had been arranged for him, and subsequently told Social Worker 3 that he did not want to take it up, reiterating he still wanted to go home. In addition he wanted a placement in a unit nearer home. However, he went on another overnight visit to the placement which apparently went well. While there, he asked about the likely consequences of absconsions from the unit. He was also apparently frustrated that no school placement had been identified.

At this time, Adam expressed upset that James had not been to see him since he absconded from the special care unit. James was not attending CAMHS despite their insistence that it was important for both James and Ruth to attend given that Adam wanted to return home as soon as possible. It was pointed out to them that an improvement in the atmosphere at home would benefit the entire family. The CAMHS records indicate that during a home visit, Ruth and James acknowledged that there were difficulties in their relationship and they agreed to meet with CAMHS for three sessions in an attempt to resolve them. This was arranged on the basis that if the parents were working together they would in time address the issue of parenting Adam together.

After almost three and a half months, the High Court recommended that Adam be discharged from special care. On the day of his planned discharge, Adam absconded from the unit but despite this he arrived later in his planned new placement. Later the same day, he left that unit, and returned to the special care unit in the early hours of the following day.

It was noted that Adam had written some of his thoughts on the wall of his room in the special care unit, including his wish to be with his mother. He had also written what appeared to be at the time a goodbye

note with reference to seeing people in heaven. In view of those events, Ruth believed at the time of his discharge that he should have stayed in the special care unit and not been transferred to the onward placement unit until a school had been found.

Discharge from special care

Adam moved to his onward placement the day after his planned discharge. The plan was for a six month stay in the new residential unit, with a review after three months. It was envisaged that a suitable school could be found that Adam could continue to attend when he returned home. It was agreed that the child psychiatrist would continue to see him in the residential unit. Ruth and James were also to continue to work with CAMHS on their relationship and their parenting.

The day after his admission to the new unit, Adam left without permission. The Gardaí were contacted. Several hours later he returned in a taxi. Two days later on a visit home, Adam refused to return to the unit. The Gardaí were informed. He also missed an appointment with the child psychiatrist. Several texts to Adam from Social Worker 3 went unanswered. A few days later Adam contacted Ruth but did not reveal his whereabouts.

A strategy meeting held at this time in the SWD was attended by Social Worker 3, Ruth, the GAL, staff from the residential unit and the Gardaí. The meeting heard that Adam had contacted Ruth and told her he had not eaten for four days but was safe.

Over the next few weeks, Adam's whereabouts were largely unknown but he had some contact with his family and Social Worker 3 and stayed on occasion with his grandmother. He was drinking, was very abusive at times and Social Worker 3 believed that on one occasion he threatened her with a knife. His mother, who was present, disputed this saying he was just fiddling with it. He would not attend appointments with CAMHS where concern was expressed that he was going downhill. It was agreed between professionals that the best option available was to apply for Adam's readmission to the special care unit. Ruth and James, who were going away for ten days, were worried about him and signed him into HSE care. Adam's GAL, through her solicitor, once again expressed her concerns in writing about Adam's lack of supervision, the fact that he was not at school and his involvement with the Gardai.

During Ruth and James' absence, Adam's grandparents agreed to provide him with a bed and clean clothes if he came to them, but he did not avail of this arrangement. Other family members were also

available to provide support. James arranged for a take-away to give him meals. On one occasion, Adam went with his grandmother to his family home to have a shower. While he was there he took James's car. He also allowed a friend to drive it and it was damaged.

When she returned from abroad, Ruth informed Social Worker 3 that Adam had been staying with a woman called, Patricia, for the purposes of the report. He had met her though her children. Ruth was concerned about this arrangement, because Patricia was not an authorised carer, had not been assessed and did not have Garda clearance. There were also concerns about Adam's legal status and his general care and supervision.

The GAL also expressed her concerns about Adam's living arrangement and was informed that the application for readmission to the special care unit had been refused as re-admission was not considered to be in his best interests. The refusal was appealed.

Social Worker 3 visited Patricia who confirmed that Adam had been living with her family for the previous two weeks and had stayed with her on occasion over the last year. She told Social Worker 3 that she believed that Ruth and the Gardaí knew he was there. Social Worker 3 contacted the Gardaí to see if they knew Patricia and they informed her that there were no known criminal records on her or anyone else in the house.

Social Worker 3 met Adam at a home visit to Patricia's house. He appeared clean and healthy. Patricia confirmed that she had provided bed, food and the use of facilities and she treated him as one of the family. Social Worker 3 met Adam alone and he confirmed that he was happy staying there. Frequent calls were made to Patricia and Adam by Social Worker 3. Patricia responded positively to these calls and outlined Adam's whereabouts and general well-being. Adam claimed to feel safe in her home. He also expressed interest in going to Youthreach, although no places were going to be available for at least two months. He was prepared to go to a local school as an alternative but again, there was no place available.

During this period, Patricia told Social Worker 3 of an allegation that had been relayed to her by one of her children, concerning possible sexual abuse of Adam by a woman who had previously lived in the area. This was followed up some weeks later (see below).

Adam continued to stay in Patricia's house intermittently over a couple of months, between episodes of rough sleeping. His behaviour continued to be erratic, with alcohol use. He told Social Worker 3 that he

had been having more contact with his mother recently but was not sure at this stage what he wanted, and did not see himself returning home at that point.

In the meantime, a month after his discharge from the special care unit, a Child in Care Review was held. The GAL was unavailable to attend this meeting but met Social Worker 3 and her team leader beforehand to express her concerns about Adam's reckless behaviour and her view that he required full time care, or special care. She also expressed her opinion that Ruth would be too emotionally fragile to attend the review. Ultimately the review was attended by Ruth, Adam and his grandmother and Patricia attended for the final part. It was agreed that Adam should be placed again in special care and should return home following this placement. It was proposed that, pending the placement, 'co-parenting' would be shared between Ruth, Adam's grandmother and Patricia including communication between them regarding his whereabouts and agreed boundaries and rules. The fragility of this arrangement was acknowledged and it was agreed that it was not an adequate substitute for special care. Regular family therapy for Ruth and James was also recommended. The allegation of sexual abuse was not raised at that meeting.

At this stage Ruth was very concerned about Adam's emotional vulnerability, his appearance, his references to self harm, anger and crying bouts and his claims that his 'head was wrecked'. She felt he had gone downhill in a week. Ruth also commented that she was unhappy about having to contact Patricia and complained that little was being done for Adam.

The GAL brought Adam's case back to the High Court for review as she was concerned about Adam's safety and well-being. Subsequently, a special care placement was offered, to start approximately four weeks later. In the meantime, Adam was offered an alternative residential place which he refused. He continued to go missing for periods of time. During this time, a weeklong trial in Youthreach was arranged for Adam. Unfortunately, and to his great disappointment, he was unsuccessful in gaining a place after the trial.

During the same period, CAMHS made many unsuccessful attempts to contact Adam and his family to encourage them to return to their service. Ruth informed CAMHS of Adam's intention not to attend anymore and it was agreed that CAMHS would text him in an attempt to engage him again. However, he did not respond. Ruth informed CAMHS that she did not want to attend their service either.

Approximately five weeks after the allegation about sexual abuse concerning Adam and a local woman that had been reported to her by Patricia, Social Worker 3 followed it up. She talked to Adam about it,

and he told her what had occurred. He also mentioned that he had not told his mother about it. Social Worker 3 subsequently informed Adam's grandmother, Ruth and the GAL (who was informed prior to this by Ruth) about the allegation and notified An Garda Síochána.

Adam's chaotic lifestyle continued throughout the month prior to his placement becoming available. This included alcohol misuse, stealing and getting involved in rows. Ruth found an aerosol paint can, and attributed his aggressive and agitated behaviours to the possibility that he was sniffing substances. According to the file, Adam threatened in an exchange with Ruth that he would hang himself if he had to go back to the special care unit. Ruth subsequently informed Social Worker 3 of this.

High court order on special care renewed

As soon as the special care place became available, the High Court granted the special care order. Social Worker 3 had forewarned the Gardaí about the impending order, suggesting that he may be upset and that they might make themselves available to him. This was agreed by the local Gardaí who said they would do whatever was required. As soon as the court order was granted, Social Worker 3 informed Ruth, the GAL, Gardaí, grandmother and Patricia. However, Adam had his phone turned off and he did not respond to calls or texts. He eventually contacted Social Worker 3 and hung up when she told him about the court order. Social Worker 3 then asked Ruth to send him a supportive text, which she did.

Adam's whereabouts were unknown for the next three days. Ruth told the GAL that she had sent him a long text. The GAL advised her not to send more as she felt he could be under too much pressure and commented that it was the Gardaí's responsibility to find him and bring him to the special care unit.

He had phoned his mother over the weekend. He sounded drunk and asked for the phone number for the special care unit saying that he would consider going back there in about a month's time. In the meantime, he did not respond to texts or calls from Social Worker 3. When she contacted the Gardaí to update them, they informed her that he was staying with a local family. When she asked them when they were going to pick him up and bring him to the special care unit, the Garda was non-committal and told her that would depend on when backup would be available. Social Worker 3 told Ruth who commented on the fact that the Gardaí had already known his whereabouts for two days but had neither informed her nor picked him up.

On the fourth day after the order was granted Adam presented at his mother's house in the evening and agreed to go to the special care unit. He then locked himself in the car and drove off. Ruth reported the incident to the Gardaí. When he was found a few hours later, he had taken his own life.

12. Analysis of the involvement of HSE Children and Family Services

This analysis of the quality of services provided is presented under a number of headings as follows:

12.1 Response to Referrals

When Adam was first referred to the CAMHS service by his family, the service responded within days. The HSE SWD responded within three weeks to the referral, they contacted the relevant family members, and linked with other services as required. The review team was informed that the SWD prioritised Adam's case in the context of a very busy workload. After one month Adam was allocated to Social Worker 1. The Review Team considered that the action taken at that time was prompt and appropriate.

12.2 Assessment

The initial assessment was undertaken by CAMHS and was followed by an assessment by the duty social work team. These assessments identified the crisis being experienced by the family and the need for urgent action, and recommended support to Adam and his family from CAMHS and the SWD. Adam was allocated to Social Worker 1. Within weeks, a short-term placement on a youth residential programme was identified. A multidisciplinary strategy meeting was held within six weeks. These were all appropriate actions.

During the period covered by the review, Adams' immediate needs were continuously assessed. However, following his discharge from the special care unit, Adams' lack of engagement with both SWD and CAMHS in particular, meant that his on-going needs could no longer be properly addressed.

At interview with the review team, Ruth and James expressed criticism of what they believed to be an excessive focus on their marital relationship as a causal factor, maintaining that there were no difficulties in their relationship until Adam's behaviour became out of control. However, they acknowledged that they each had different parenting styles when responding to Adam's behaviour which had implications for Adam and the services.

The review team are of the opinion that there was insufficient attention paid to Adam's relationship with his parents and there was no comprehensive assessment of the origin of Adam's difficulties.

12.3 Compliance with regulations

There was evidence of compliance *with Children First: National Guidelines for the Protection and Welfare of Children (DOHC, 1999)* in convening child protection conferences and strategy meetings in a timely manner attended by appropriate key professionals and family members. There was also compliance in arranging Child in Care Reviews. There was also evidence of consultation and involvement with Adam and his family in relation to these meetings. However, there was a lack of clarity in regard to the purpose of some meetings, the tasks allocated and their timelines. There was also a lack of evidence to confirm that the family members who attended these meetings received written confirmation prior to the meetings of the agenda and purpose of the meetings or a written copy of the outcome of the meetings. This view was supported by Adam's parents at interview.

There was a lack of compliance with The Child Care (Placement of Children with Relatives) Regulations, 1995 which require a full assessment of suitability of the proposed carer and his/ her home to be carried out. There were two placements where a proper assessment was not carried out. Firstly, Adam's placement with his grandmother and more significantly when he stayed with Patricia. Whilst it might be argued that the SWD did not actively place Adam in either placement, the fact remains that he was in the care of the HSE and as such any placements should have been appropriately assessed. However, it is acknowledged while Adam was with Patricia, Social Worker 3 checked with the Gardaí to see if the family was known, and visited Patricia and Adam three times during the time he spent there.

There was a lack of clarity regarding Adam's care status for much of the period under review. He was received into care on a voluntary basis approximately four months after referral and no discharge from care form was signed. Two further Reception into Care forms were signed by his mother. The most serious lack of compliance relates to the allegation of child sexual abuse where there was failure to comply with *Children First: National Guidelines for the Protection and Welfare of Children (DOHC, 1999).* Whilst it is acknowledged that the alleged abuse had occurred many months previously and that there were many crises to be dealt with, there were delays in commencing the assessment, interviewing Adam, informing his parents and notifying the GAL and the Gardaí. Therefore the HSE failed to investigate the allegation in a timely manner.

12.4 Quality of Practice

12.4.1 Interaction with child and family

Adams' parents met with the review team and gave their perspective on the interaction that they had with the SWD and other HSE services. They told the review team that they believed that overall their contact with the HSE services had a negative impact on the situation and wondered if they would have been better off if they had never contacted the HSE services in the first place. They struggled to understand how Adam went from a naive 11 year old who still believed in Santa to a 13 year old smoking hash and mixing with young adults who had negative influence on him.

The review team explained that this review was limited to the HSE and HSE funded services. James and Ruth were of the view that what was required was a more holistic review as recommended by the Report of the Independent Child Death Review Group. James and Ruth wanted all services involved in Adam's life including An Garda Síochána and education services to be included in a review.

12.4.2. Provision of Services by the SWD

The review team found evidence of frequent contact between Adam, his family and the SWD involved over the period that is subject to this review. This contact was initiated by Adam, his parents and the SWD. Contact was not always easy especially over the last months of the review period as Adam frequently failed to return calls or texts or was not available for visits. Contacts or attempted contacts with Adam and his family took place almost on a daily basis from Monday to Friday for significant periods. However, the lack of a local out of hour's service during weekends resulted in Adam, whilst in the care of the HSE, being without an adequate service. In this regard, his family noted the lack of contact from both the HSE and An Garda Síochána over the weekend prior to Adam's death. At this time there was a High Court order in place and Adam had previously threatened that he would kill himself if he had to go back to special care. The Review Team agree that the lack of an out of hour's service at the time contributed to an unsatisfactory situation.

James and Ruth were critical of the decision to tell Adam of his impending re-admission to the special care unit and the manner in which he was told. The decision to tell him that way was made because Adam refused to meet his social worker face to face and his whereabouts were unknown. The nature of this decision highlights the challenges faced by professionals. The delay in executing the special care order by the Gardaí was not in Adam's best interests.

In the opinion of the review team, the SWD endeavoured to identify Adam's needs on an ongoing basis and attempted to meet those needs even though there was an over-emphasis on crisis management at the expense of long-term planning. The SWD correctly considered and sought many different services including youth services, child care workers, family support services, respite, foster placement and residential units. There was also evidence of liaison with other agencies including the Gardaí, the EWO, schools and CAMHS. Whilst there were many multidisciplinary meetings held, no family welfare conference took place in this case.

The SWD was hampered at times by Adam's unwillingness to engage and by his refusal to accept services when offered. The SWD also faced considerable challenges given the stress the situation placed on Ruth and James and their differing viewpoints on how his needs should be met.
In the opinion of the review team, the main problem was the lack of appropriate services and resources to meet Adam and his family's needs, in particular his need for an appropriate care placement and a school place.

12.4.3. Provision of Services by CAMHS

The other key service that was involved with Adam and his family was CAMHS. This service was involved from the initial referral to the time of Adam's death, although there is no record of any contact with Adam or his family in the final three weeks of his life. There is evidence that CAMHS responded promptly to the initial referral as Adam was seen within three days. It undertook an appropriate assessment and an urgent referral to the SWD, the family support service, the educational and welfare service and in the case of Ruth made a referral to the adult mental health service to provide support. CAMHS was flexible and responsive by offering home visits and visited Adam in the secure unit and by continuously trying to engage with Adam and his family. Evening appointments were offered to make it easier for the family to attend. In total, Adam and his family were offered 57 appointments. Of these, Adam attended 22 and his parents attended 15 appointments.

There was evidence of frequent contact between CAMHS and Adam and/ or his family for most of period of the review. Whilst James's involvement was limited, Ruth engaged very well with the services until Adam's discharge from special care. From this point onwards, it is evident that they did not avail of all services offered to them, although they dispute this. The family informed the review team that they had lost trust in the services at this stage. The last face to face contact between CAMHS and Adam was

prior to his discharge from the special care unit. However, the service continued to attempt to engage with Adam but he refused to attend appointments both in the clinic and elsewhere. CAMHS did not notify his family on each occasion of his non-attendance.

Adam's parents felt from a mental health point of view that he was not adequately assessed. They believed that Adam was clinically depressed and suffered from ADHD. They felt that the time Adam spent in face to face consultation in CAMHS was insufficient. However, the opinion of the review team is that CAMHS assessed Adam's needs appropriately when possible and worked to meet those needs despite the difficulties presented by his challenging behaviour and his lack of engagement. The review team also suggests that the lack of a structured care environment for Adam after his discharge from special care adversely affected the CAMHS's ability to provide and Adam's and his parents' ability to accept, the ongoing support offered.

12.4.4. Recording

There was evidence of good recording practices for most of the period under review. However, there were gaps where some entries in the SWD cases notes and other reports were either unsigned and/ or undated. There was a lack in some instances in the recording of the outcomes of meetings. There was no copy of a Birth Certificate for Adam on file.

12.4.5. Child and Family Focus

From the records, there is evidence that the SWD and CAMHS attempted to form positive relationships with Adam and his family. There was evidence of empathy towards all those involved. However, Social Worker 2 informed the review that the volume of work involved in trying to find placements and other supports hampered her ability to form a meaningful relationship with Adam. Social Worker 2 was mindful of this and requested the involvement of a social care worker to work directly with Adam.

There was considerable contact with Adam and his family for most of the period under review. Towards the later period covered in the review most of the contact, though frequent, was by way of mobile phone and text.

There is also evidence that Adam and his family were listened to. However, the family had a somewhat different perception and did not feel that they were listened to enough. James and Ruth considered the recommendation from the first child protection conference that she move out to rented

accommodation as unrealistic. She told the review team that she could not do this because she was out at night searching for Adam and would have had no one to care for the baby.

James and Ruth identified that there was insufficient attention paid to their needs in relation to planning meetings. They described how they were anxious to participate fully with the services. They said there were inadequately prepared for meetings and found them intimidating. Meetings were often held at times to suit the services rather than a mother with a young baby (e.g. 9am-9.30am). The Review Team agree with this.

Whilst acknowledging that his detention in the special care unit kept Adam safe and therefore brought them some relief, Ruth and James told the review team that they did not believe that it was a suitable place to meet his needs. They described the physical environment as inappropriate for young people of his age.

There is also evidence that Adam's needs were prioritised by the HSE as a far as possible. His parents identified his educational needs as his number one priority and the lack of a school placement as detrimental to his well-being. CAMHS considered that his priority need was for a secure care base which would enable Adam to return to school. The review team concur with this view and consider the lack of structure (as a result of not attending school) in Adam's daily routine added to the difficulty in planning to meet his needs.

The SWD and CAMHS constantly reminded themselves of Adam's young age despite his size and behaviour. They persisted in seeking alternative solutions when an intervention was found to be either unavailable or unacceptable to Adam.

Overall, it is the review team's opinion that the services endeavoured to maintain a child and family focus. As mentioned earlier, Adam formed a very positive working relationship with Social Worker 1 and was upset when a new social worker was allocated. The system in operation at that time meant that cases active for more than three months were transferred to the long term team which meant a change in social worker. This could not be considered to be child centred. Furthermore, the complexity of this case warranted more than subsequent re-allocation to a newly qualified and inexperienced social worker. The Review Team was informed that this was due to the unavailability of more experienced social workers.

12.5. Management

12.5.1. Management by the SWD

In the early stages, the case was managed well. However, the management of the case became more problematic when four months after referral; Adam was received into voluntary care of the HSE following a family crisis. Thereafter, the provision of suitable care arrangements when required presented considerable challenges to the management of the case and this is evident for most of the final year of the review period.

Although all involved agreed that Adam needed to be placed in special care urgently, an offer of a place was delayed by the prolonged time it took to identify an onward placement following discharge. There is evidence that budgetary constraints contributed to this delay. Whilst budgetary considerations are necessary in any service, they should not be the cause of unnecessary delays.

During his stay in special care, there was a lack of consistent planning in relation to his onward placement despite frequent Child in Care Reviews. This caused considerable unnecessary distress to both Adam and his family and may have raised concerns for the family about the priority given to Adam's needs. When a potential placement was eventually identified, there was still confusion about whether it was actually available or not. At interview, Ruth indicated that there was a lack of attention paid to her and Adam's views in relation to the proposed onward placement and this was confirmed from the records.

Following his discharge from special care, Adam's refusal to remain in his placement presented further challenges to the management of the case and he effectively did as he pleased. Despite considerable efforts on the part of professionals to get Adam to work with the services, he did not have the capacity or maturity to engage. During this time, no school was available and attempts to get him into Youthreach proved unsuccessful. The net effect was that Adam and his family lost trust in the ability of the services to meet his needs.

From this time until his death, Adam's lifestyle was chaotic and his whereabouts were frequently unknown. James and Ruth were also critical of the decision made by the SWD to allow Adam to continue living with Patricia. As referred to above, the assessment and management of the informal placements were not in compliance with the regulations.

Adam's parents were unhappy with how the allegation of child sexual abuse was handled for a number of reasons. These include the delay in informing them, the fact that Ruth's mother was informed before them and in interviewing Adam without informing them. They also complained about a lack of clarity as to whether An Garda Síochána had been notified or not. The Review Team are satisfied from the records that the Gardaí were notified in writing. This occurred four days after Ruth was informed. The Review Team consider that the assessment of the child sexual abuse allegation and the communication around it were not managed properly and caused unnecessary stress to Adam and his family. Ruth and James were also critical of the fact that the alleged perpetrator was interviewed without ensuring that Adam was safe. However, the SWD were satisfied that the alleged perpetrator (who admitted to having sex with Adam) was no longer living in the area and no longer had contact with Adam.

A feature of the management of the case was that it was largely crisis driven which militated against a more reflective and strategic planning approach. In addition, the lack of written policies and protocols to deal with a range of difficulties such as children missing in care and of children in the care of the HSE choosing to live in informal/unapproved placements hindered the SWD's ability to manage this case more effectively.

12.5.2. Supervision

This was a very demanding case and the inability to provide the required placements caused great frustration and concern for the workers involved. There was evidence of records of supervision in relation to the management of the case by social team leaders during the period of review. This was confirmed in interviews by social workers and team leaders. The review team consider the supervision other than the lack of strategic planning to have been adequate.

12.5.3. Interagency Collaboration

There was evidence of good interagency collaboration at times. This was confirmed through attendance at a number of meetings such as strategy meetings, child protection meetings, child in care reviews and other planning meetings. There was also evidence of numerous personal communications between the different professionals involved including SWD, CAMHS, GAL, An Garda Siochana, educational and youth services and others. However, there was an evident gap in exchange of information at times, for example, between SWD and the GAL in respect of the allegation of child sexual abuse. In addition, there were communication difficulties between the SWD and the Gardaí where the SWD had to deal with different Gardai and Garda stations. Finally, the delay in the Gardai executing the Special Care Order

presented considerable difficulties in the management of Adam's case. The non- committal attitude of the Gardai was unhelpful and was not indicative of shared responsibility.

13. Conclusions

The review team notes the grief that has been experienced by all of Adam's family and the professionals that worked with him, and extends sympathy to all of them. It has found that Adam was loved by his family and liked by the professionals who worked with him. His death elicited a lot of reflection in the SWD and CAMHS.

The review has concluded that neither action nor inaction by the HSE services involved with Adam contributed to his death and have reached the following conclusions:

- Adam's behaviour became problematic for his parents when he was about 12 years of age. As time passed his behaviour continued to deteriorate. Whilst his family did their best and professionals offered a number of services, many of which Adam declined, it appeared that no person or service in his life was able to provide the constant secure base and the authoritative caring that he required.
- The family presented in crisis initially and this pattern of crise**s** continued. The SWD responded to this case by managing these crises rather than adopting a more strategic, holistic and long-term approach to meeting the needs of Adam and his family. This pattern continued throughout the duration of the case. There was no comprehensive assessment of the origin of Adam's difficulties.
- Adam was a child at risk of significant harm whilst in the care of the state especially when his whereabouts were unknown or when he was in an unapproved placement.
- The failure of the HSE to provide suitable resources, in particular care placements hampered the ability of the SWD to meet Adam's needs promptly and appropriately.
- The lack of a suitable school placement resulted in Adam's educational needs not being met. This impacted greatly on Adam, his family and the ability of the SWD to meet his needs.
- The nature of Adam's needs meant that he was not typical of many of the referrals to the SWD and as such required a different and unique response built around his needs. In reality, Adam had to fit into the existing system that was in place.

- Given the risks that his lifestyle posed, it was appropriate to seek Adam's readmission to special care. The review team are concerned that this was refused given the risks posed by his then risky lifestyle and consider the grounds for refusal should have been made more explicit. This refusal was rightly appealed and was ultimately successful. However, there was no place available at that time and it was not expected that one would be become available for a further four weeks. This highlights once again the great difficulties presented to the SWD in managing children such as Adam when the required resources are not available, when needed.
- The SWD response to the allegations of child sexual abuse was not totally adequate.
- The delay on the part of the Gardai in executing the second special care order was not in Adam's best interests.
- A lot of time and effort was given to Adam and his family by the professionals involved. However, the complexity of the case and the lack of available and suitable resources when required meant that they were unable to meet his needs to an acceptable level.

14. Key Learning Points

This report has attempted to communicate the complexities of this young person, and to reflect the challenges faced by those staff who tried to work with him and his family. The review team has found evidence of considerable efforts by a variety of dedicated and committed professionals to engage with Adam, to address his needs, and to express concern about his safety and wellbeing. However his needs were too complex to be met by any one agency or setting, and he required, a high degree of shared assessment, planning and co-ordination. In the absence of an appropriate care planning structure to provide this, particularly in relation to his educational and safety needs, the work became increasingly reactive and driven by crisis management.

The impact of the lack of a school placement on Adam's wellbeing cannot be underestimated. Education is a fundamental right of every child. Besides offering a daily routine and structure, education affects all aspects of the development of young persons. Research has shown that the difficulties in education that are experienced by children in care are rooted '...far more in the care and education systems than in the children themselves' (Jackson and McParlin, 2006: 91)[1].

[1] Jackson S. and McParlin, P. (2006) *Education of children in care. The Psychologist 19*(2): 90-93.

One of the issues in respect of special care is the appropriate length of placement. Whilst there are legitimate concerns about deprivation of a young person's freedom and that learned behaviour could be detrimental, this has to be balanced by the need to keep the young person safe. It is the review team's opinion that a clear and confirmed care pathway (including the length of the placement) suitable to the young person's on-going needs is identified during regular Child in Care Reviews whilst in special care.

Children in care are more likely than children not in care to go missing (Rees and Lee, 2005)[2] and thereby be more vulnerable to exploitation and substance misuse. The Handbook on Alternative Care (Tusla, 2014)[3] highlights the importance of having an Absence Management Plan in place.

Many of the young person's behaviours clearly illustrated that a number of high risk factors were at play in this case. Managing risk should be an on-going process and having a Risk Management Plan in place facilitates professionals and families in making informed judgements about certain risks and interventions required to manage the risks (Tusla, 2014)[5].

Support and guidance for staff working with young people who are difficult to engage, ambivalent, and/ or hostile should be available. The services need to make continuous efforts to devise innovative ways of meeting the needs of such young people and in overcoming their resistance.

15. Recommendations

The review team recommends the following:

- A review of the process of how applications for care are dealt with.
    - If a young person requires care, they should not have to wait for an excessive period before being offered a place.
    - A clear rationale of the grounds should be provided if a request for special care is unsuccessful.
    - The issue of having to identify a specific onward placement in advance of getting a place in special care should be reviewed. Whilst this may be important to avoid blockages and

[2] Rees, G and Lee, J. (2005) *Still running. Volume 2: Findings from the second national survey of young runaways*. London: The Children's Society.
[3] Tusla (2014) *Handbook on Alternative Care.*

to avoid drift in care, it may not always be in the best interests of a young person as it presupposes their needs have been fully assessed and will remain static whilst in special care. It is essential that there should be no undue delay in the identification of the onward placement once the needs of the young person have been thoroughly and appropriately assessed whilst in special care.

- The Child and Family Agency, the Department of Education and Science and other relevant agencies should develop and implement a policy in relation to the education of children in care that addresses the additional challenges faced by many of these children.

Professor Helen Buckley

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