Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review of the death of Jeff, a young person who was in the care of the HSE Children and Family Services

September 2015

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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 CEO and from there to the NRP. The CEO and the Chairperson of the NRP together decide 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. Jeff

Jeff was 19 years of age when he died. He had been in the care of the HSE/health board from the time that he was three years old. As a small child he was described as a 'worried little boy' who craved attention. Later, he was described as an introverted and quiet young man who was kind and gentlemanly. He also had a dark side to his personality; he had occasional outbursts and in his later years, he seemed to internalise his emotions and tended to self-harm. From all the accounts given to the review team, he was well liked, he had friends including a girlfriend and he was the father of a young child when he died.

5. Level and Process of Review

This was a comprehensive review where the relevant health board and HSE had been involved with Jeff from the time he was an infant until his death. The review team consisted of Helen Buckley, Chair, Ceili O'Callaghan and Paul Murray. All the team are independent of the HSE and had no previous knowledge of or involvement with Jeff.

The methodology employed by the review team consisted of an analysis of the relevant health board and HSE files relating to Jeff and his family, written submissions and face to face interviews with seven staff members and managers from the HSE and three foster carers. His mother was offered the opportunity to meet the review team but declined. The review team were unable to make contact with his father despite numerous efforts.

The timeline covered by the review extends back to the period before Jeff was placed in care and focuses in more detail on the four years prior to his death. The review team is grateful to all those who attended for interview and also acknowledge that the passage of time since Jeff's childhood meant that it was difficult for some interviewees to remember precise details.

6. Terms of Reference

(i) To examine the services provided to Jeff by the HSE and HSE funded services prior to his death

(ii) To identify opportunities for learning arising from the findings of the review

(iii) To determine compliance with local and national policies and procedures in this case

(iv) To provide a report to the Child and Family Agency with conclusions and recommendations.

7. Background and reason for referral to HSE Children and Family Services

Jeff was one of a number of siblings, the youngest of whom was born around the time Jeff and his other siblings were made subjects of full care orders. Jeff was 18 months old when his family first came to the attention of the health board social work department (SWD) due to parental neglect, alcohol abuse and domestic violence. The SWD initially tried to support the family in the community with part-time and respite foster care, but when no sustained improvement was visible, court orders were obtained and the children were ultimately placed in full time foster care. It was a further four

years before the court made full care orders on the children. Jeff's behaviour had become very challenging at this point and his first two placements ended within a relatively short period. He was then placed with foster carers, here called the C family, where he remained for ten years. Mr. And Mrs. C met with the review panel and told us that Jeff's behaviour was initially difficult, but improved once he settled. When he entered his teens, his behaviour became challenging again, and the placement ended by mutual agreement between Jeff and his foster carers when he was 14. He moved to another family for six months and then spent nine months in residential care before being placed once again in foster care where he stayed until he was 18. He remained with the same foster family in aftercare but sadly took his own life. He had experienced mental health problems, including suicidal ideation, in his late teens and had been engaged in treatment at different periods.

8. Services involved with Jeff

- Children and Family Services; Jeff was supported by both social work and social care staff at different times. He was without an allocated social worker for a number of years while in foster care.
- Public health nursing in early years.
- Garda Síochána, mainly in early years with family because of domestic violence and neglect of children and alleged sexual abuse.
- Child psychiatric services through the HSE Department of Child and Adolescent Psychiatry.
- HSE psychology services
- A low to medium support residential centre managed by the HSE.
- Play therapy support and child care worker intervention during his first two foster placements.
- Jeff attended an education project when he left mainstream school after his Junior Certificate.

9. Summary of Jeff's needs

At a very young age Jeff was exposed to his parents' alcohol use and parental domestic violence. Along with his siblings, he suffered severe neglect. His first need was for safety and respite from the effects of these adverse factors, and he also required therapeutic input to help him deal with the

emotional difficulties which resulted from his early experiences. He needed interventions to deal with challenging behaviour in his foster placements and at school. Later he needed a therapeutic response to his self-harming behaviour and suicidal ideation.

10. Chronology of contact between Jeff and his family and HSE Services

Early childhood: 18mths – 3 years

The Social Work Department (SWD) first became aware of problems in Jeff's family following a request for intervention by a public health nurse when Jeff was 18 months old. A social work report from a case conference held shortly afterwards described the children as suffering from neglect. Jeff's father spent some time in prison; while he was at home he was violent towards the family. A social worker, here called Social Worker 1 was allocated to the family. Social Worker 1 told the review team that she felt the children's mother had been overwhelmed and isolated at the time. It is evident from the records that professionals considered the children had a good relationship with their parents but were at risk from parental domestic violence and alcohol misuse. The domestic situation did not get better; the children's mother's drinking got worse following the birth of a new baby. While the family's progress was monitored no specific timeframes were set for action to be taken and there was still a hope that parenting standards could improve. Throughout this period referrals about the family were made to the SWD by a variety of professionals concerning chronic domestic violence, excessive alcohol use and the children being left unsupervised. Social Worker 1 remained involved and her notes indicate that, in addition to day and respite fostering, a child care worker had become involved and counselling appointments had been made for both parents. However, while the children's mother attended an alcohol treatment service for a limited period, these interventions did not prove effective. Social Worker 1 told the review team of her recollection that Jeff got very little attention from his parents, compared with his siblings.

Entry into foster care; three years old

After over a year of interventions, a case conference agreed that application for care orders for all the children should be made for at least a year to allow effective change to occur within the family. The review team note that no assessment of the children's individual needs took place at this time. An incident where the children were abandoned by their mother while drunk resulted in emergency

care orders being taken and the children were placed in foster care. Jeff and a sibling were placed with foster carers, here called Family A.

Solicitors for the Health Board, on the expiration of the emergency care orders, applied for interim care orders for three months. When Jeff had been living with Family A for almost two months, a case conference was held to discuss future plans for the children. There was a discussion about Jeff's very destructive and attention seeking behaviour and aggression towards the foster carer's child. A decision was made to seek an extension of three months to the interim care order and to consult a child psychiatrist about Jeff's behaviour. Jeff saw a child psychiatrist called Dr. P, who concluded that his disturbed behaviour was a result of his experiences at home. The children had weekly contact with their parents, which was difficult at times due to their father's aggressive attitude towards health board staff. The care orders were extended for three months with the judge directing the Health Board to consult the psychiatrist about the least traumatic way of affording access to the parents. Social Worker 1 told the review team that the SWD put considerable work into improving the way that the parents related to the children at access and discouraging them from arguing with the social workers in front of the children. Jeff became reluctant to attend at one point and according to the file exhibited behavioural difficulties during and after access.

The SWD subsequently referred Jeff's parents to a clinical psychologist for assessment and parenting work. Having assessed them over a period, the psychologist was of the view that the children should not be returned home at that time as parents had not fully acknowledged their behaviour and its impact on the children.

In the meantime, when Jeff had been in his foster placement for four months and was aged nearly three and a half; he disclosed what was regarded as a credible account of sexual abuse by his father. This was denied by his parents, but the SWD referred him for assessment to the local child sexual abuse assessment service. They also notified An Garda Síochána and made access between Jeff and his parents conditional on supervision. At the same time, Jeff made it clear that he did not want to see his father, and access did not occur for a period. At assessment, Jeff disclosed a number of alleged sexual incidents perpetrated by his father and conclusion of the multi-disciplinary team was that on the balance of probabilities, he was telling the truth. They also noted that he had disclosed physical abuse.

In the light of the child sexual abuse disclosure and the steps taken to validate that by a multi-disciplinary team, the SWD now concluded at a case conference that serious concerns existed for the children's future safety and applications for extended care orders for Jeff and his siblings were

made. The court extended the care orders for Jeff and his siblings for a further six months. It would appear from the short term nature of the orders that the judge was optimistic about the prospects of reunification of the children with their parents and it is not clear that evidence about the child sexual abuse was heard in court at that time.

While the above events were occurring, Jeff's foster care placement with family A had broken down due to his challenging behaviour and he was moved to family B; he was just three and half years old at the time. There is no evidence that any review was carried out in respect of the placement breakdown, nor of any particular preparation to support family B in dealing with Jeff's behaviour.

When the information about the child sexual abuse allegation was brought to the judge's attention, he directed the health board to have psychiatric profiles prepared in respect of both parents and, if deemed necessary, to have Jeff assessed by a child psychiatrist. The SWD subsequently referred the parents to psychiatrist and Jeff was re-referred to Dr. P who saw him regularly after that for a period.

Dr. P also formed the view that Jeff had probably been sexually abused by his father. He noted that Jeff was a friendly child of normal intelligence with appropriate development for his age who showed no symptoms of a psychiatric disorder, even though his behaviour was challenging. He was judged to be happy in his new foster home and it was noted that he not want to return to his natural parents 'because Daddy hit Mammy a lot'. The social work file notes that the way he played with objects was somewhat sexualised at this time. Social Worker 1 told the review team that a lot of social work time went into arranging and transporting the different siblings to the access venue and talk to the foster carers about it afterwards.

On the expiry of the six months the health board sought care orders for Jeff and his siblings. The judge extended the orders for a further 12 months with a review after six months. He advised the parents that should there be a substantial improvement in their lifestyle he would consider returning the children to them on the expiry of the care orders. Legal correspondence on file indicates that in light of the father's denial of the child sexual abuse allegations, the judge suggested that the health board investigate the father's understanding of 'horseplay' with a view to reaching a conclusion on the veracity of the allegations. Further 12 month care orders were made until Jeff was seven years old and court ordered access was frequent.

Jeff remained with family B for around 17 months. The case was transferred from Social Worker 1 to Social Worker 2. While Jeff appeared generally content, his behaviour continued to be difficult. He was described by Social Worker 2 in a case conference report as a 'demanding young child with a lot

of trying and testing behaviour'. His playschool teacher described him as attention seeking, with behaviour ranging from spitting and swearing to exposing himself. As outlined earlier, Jeff had refused to attend the access visits to his parents with his siblings but eventually he was persuaded by social workers to attend. His parents had difficulty handling his behaviour during the visits. When Jeff was five, his placement with family B broke down. After he left, Jeff alleged that he had been punished there by his foster mother with a wooden spoon. This was investigated; the foster carers denied the allegation but the outcome of the investigation is not clearly reported in the file, other than that Jeff was medically examined and further information about the placement was required.

There is evidence on file of regular planning meetings and case conferences at this time, but the first record of statutory Child in Care reviews was eighteen months into the children's full time care placements. Throughout this period, Jeff was involved in regular play therapy, recommended by child sexual abuse assessment service. There is also evidence in the file that Jeff had the support of a child care worker. Jeff was seen from time to time by his psychiatrist, Dr. P, who wrote regular review reports to the court reflecting Jeff's view that he did not want to return home. At this time, different treatment services were working with the parents with regard to their relationship and alcohol consumption and reported that little positive progress was being made.

Phase 2: Long term foster care 5 yrs to 10 yrs

Jeff was subsequently fostered by family C, and this placement lasted for almost ten years, from aged five to 15. Jeff's behaviour in his new foster placement continued to be disruptive, particularly after supervised meetings with his parents, where he tended to behave in an aggressive manner. According to the file his primary school teacher reported his mood swings, stating that he often appeared confused and frightened. After the first year and a half in foster care with family C, a social work report that appears to have been prepared for case conference, concluded that, despite the problems outlined above Jeff had developed a close relationship with his foster carers and was making progress. None of the staff interviewed by the review team had a clear memory of the allocation status of the case during this decade. It is evident from the records that Jeff had allocated social workers off and on during this placement, but there were long periods of non-allocation (confirmed by staff members who attended for interview) and there are few social work case notes on the file covering this period.

Reports prepared for court and for child protection conferences during this time indicated that the situation of Jeff's biological parents had not improved, with alcohol misuse and violence still presenting difficulties. The SWD remained concerned that the welfare of Jeff and his siblings would

be put at risk should they return to live with their parents. An updated psychiatric report by Dr. P, written when Jeff had been with family C for two years described him as a 'happy, charming little boy' who was doing well in his placement. He did not wish to be moved and worried about returning home to a violent environment with his parents. The local District Court finally made full care orders in relation to Jeff and his siblings to expire on their 18th birthdays. Jeff was just over seven years old at that time, and as previously noted these orders were made four years after the initial application. Throughout this time the social work team held regular case conferences but the review team could only source evidence of two statutory Child in Care Reviews.

Once proceedings finished the files show evidence of only one further Child in Care Review being held for the duration of Jeff's placement with family C, which was held when he was 10 years old, five years after he had moved into the placement. The form completed by his foster carers for the review noted their view that the placement was working well, and indicated that any problems were discussed with Jeff to a satisfactory conclusion. It also noted that he had difficulty talking about his past. Overall, they regarded the placement as working well. In contrast, the Care Plan from this review seen by the review team outlined Jeff's behavioural problems in his foster home and at school. An educational assessment was suggested in addition to direct work at by a child care leader here called CCL1. The medium-term goal identified in the review was the promotion of contact with his siblings who were with other foster carers in the same region. The Care Plan on file is, however, incomplete and lacks detail. While there is reference to a social worker, he or she is unnamed and there is no indication that Jeff actually had an allocated social worker. There are few case notes covering this period. The name of another social worker, here called Social Worker 3, appears later in documentation during the last years of Jeff's placement with the C family although the nature or extent of her involvement with him is unrecorded. There is a note to say that no replacement was available when Social Worker 3 left.

Jeff at 14

When Jeff had been living with family C for 9 years, a child care leader (CCL1) was assigned to work with him on his social skills and self-esteem to do some work with him about the reasons why he came into care and his early life. This was because Jeff was continually asking why he had been taken into care. He also had difficulty making and keeping friends. At a meeting with CCL1 the foster carers explained the difficulties they faced with Jeff; such was his abusive and aggressive behaviour. Several staff members who were interviewed by the review team as well as Jeff's foster carers referred to an incident reported by Jeff, where he got into an altercation with his foster mother and

threw a cup of liquid at her. The review team heard different versions of the incident and the events leading up to it and at this distance is not in a position to evaluate what precisely occurred.

Around the same time Jeff was referred to a psychologist for assessment because of his low mood; the assessment concluded that while he appeared withdrawn he did not meet the criteria for a diagnosis of clinical depression. Some months later the C family reported deterioration in Jeff's behaviour. They told the review team that he became aggressive and subject to violent outbursts. The foster father was of the opinion that Jeff was in need of psychological treatment but Jeff refused to consider intervention at that time. A note on file states that after about ten years the placement with family C had ended. CCL1, who had become involved with Jeff again at this point, told the review panel that he never saw any evidence of Jeff's challenging behaviour but he believed that Jeff was not happy and a decision was made to move him. The version and sequence of events at this time was described differently to the review team by CCL1 and the foster carers and the absence of written notes has meant that it is not possible to review precisely what occurred. However, it is known that Jeff left the placement with the agreement of his foster carers and moved to Family D, whom he knew. Within a short time, Jeff began to allege incidents of what could be described as emotional abuse that occurred when he was with Family C and expressed a lot of anger against the HSE. The foster carers were aware of the allegations, which were brought to their attention by the SWD. They denied them, and told the review team that Jeff had later admitted to them that he had said them in anger because they had let him go. There is no evidence that these allegations were fully investigated at the time, though a notification of 'physical and emotional abuse' of Jeff pertaining to that time was made some time later when he was eventually allocated a social worker. The foster carers also confirmed to the review team that a social worker had visited them to discuss what Jeff had alleged. The outcome of the initial assessment was that abuse was 'suspected' and that further information was required. The foster carers retired from fostering shortly afterwards on age grounds.

As outlined, the lack of case notes made it difficult for the review team to get a sense of what was happening for Jeff over this period, but it appears that access with some, though not all, of his siblings had ceased at this point and it is not clear if he was seeing his parents.

Placement with D family

Jeff had no allocated social worker when he was with the D family but he was still receiving support from CCL1. Mrs. D met with the review team, and confirmed that Jeff had made allegations about his previous foster carers. She described Jeff as a 'lovely gentle person' who became more cheerful

when he came to live with her. She told the review team that she discovered that he had been self-harming for some time, with old scars which suggested that it had started in his previous placement. He continued to cut himself, and arrangements were made for him to attend the psychiatrist whom he had seen previously who was familiar with his case. Jeff's placement with the D family ended very abruptly when it was discovered that he had inappropriate sexual contact with another foster child there. From accounts provided to the review team by different interviewees, the move was very upsetting and traumatic for all concerned.

Residential care: Jeff at 15 - 16 years

After two days in an emergency placement, Jeff was removed for a couple of days to a temporary foster placement and then to a low to medium support residential centre. The referral form for the residential centre noted that the main areas of concern for Jeff were self-harming as a method of coping, little or no knowledge of family of origin, no sibling contact and remorse about the incident that caused a termination of his placement with family D.

The residential unit kept excellent records of Jeff's time there with regular reviews and updates about his activities, his progress and his general welfare. He was allocated a social worker, here called Social Worker 4, who saw him frequently and regularly. He continued to receive support from CCL1. He also had the support of two identified key workers. A Child in Care Review was held. He was described as very quiet initially, but also subject to outbursts of temper. As part of the residential programme, young people were encouraged to write down their feelings; notes made by Jeff revealed a troubled person with thoughts that could be described as suicidal. In discussions with a keyworker, Jeff disclosed that he felt depressed, often thought about killing himself and had already made attempts. He continued to self-harm and explained that it gave him relief. The staff did their best to deal appropriately as incidents occurred, getting him medical treatment when required, monitoring him and encouraging him to talk to them about his feelings. He was referred to a HSE community psychologist, who administered a test that showed Jeff scoring high on the scales of many negative issues, including depression, self-harm/suicide risk, impulsivity and poor self-esteem. Staff who knew him told the review team that he appeared to be extremely angry about the way he had been treated in the past. It also was noted that he had a close circle of friends, including a girlfriend, and that his personal care was good. Staff continued to be extremely concerned about his mental health and his frequent self-harming. A move to a high support unit was carefully considered but not judged to be the best intervention for various reasons.

Jeff attended six appointments with the psychologist, but was reluctant to engage and the sessions were ultimately terminated as he appeared to be getting no benefit from them. The psychologist considered that he needed further psychiatric intervention because of his suicidal tendencies and referred him to CAMHS on the grounds that a multi-disciplinary team would provide options to see both psychiatry and psychology. Contact was renewed with Dr. P, the psychiatrist in the CAMHS service, whom Jeff had being seeing off and on since he was a young child. Dr. P saw him regularly, weekly at times, and told the review panel that as Jeff was resistant to psychological therapy, he prescribed anti-depressants on a trial basis but later took him off the medication as it appeared he was abusing it (trying out an overdose to see its effect). It was recognised by all concerned that Jeff's mood was low, he had emotional and behavioural problems; he had suffered a lot of trauma in his early life, he had suicidal ideation and that he required help. From the evidence available to the review team, it appears that support was readily available to him from all the services involved and the residential staff did a lot of direct work with him. His mood appeared to lift after a few months and his mental health treatment was paused for a while with an invitation to return if he required it

After a few months, a foster placement was considered for Jeff, with newly approved foster carers who, in the view of all the staff involved with him, appeared to have the capacity to meet his needs. Introductions were made gradually and Jeff was initially resistant but began to view the prospect of a move more positively.

Placement with family E: Jeff at 16 – 19 years

After seven months in residential care, Jeff moved in with family E not long after his 16th birthday. He settled well despite what was described as some very testing behaviour and the review team were told that he developed a good relationship with his carers, particularly his foster mother. In view of the sexual incident that terminated his placement with family D, he was assessed by a psychotherapist to assess whether he might pose a risk to other children or young people. The assessment concluded that he did not require specialist therapeutic intervention and the risk of him committing acts of sexual abuse was low. However, Jeff was considered to be at continuing risk of self-harm and making suicide attempts and it was suggested that he would benefit from ongoing therapy in that regard. His self-harming continued for a while and he went back to see Dr. P again, but overall his mental health was considered to be better. His psychiatric file was closed as he decided to discontinue treatment.

Jeff's foster mother also attended a course in self-harm in an effort to help her deal with Jeff's behaviour and evidence suggests that she showed great patience and perseverance with him. By the end of that year, she reported his behaviour as improving. There is evidence that Social Worker 4 was in frequent contact with him and his carers during his placement and that his foster carers were supported.

Early in the second year with Family E a statutory Child in Care review was held. Self-harm, while improved remained as a concern. It was also recorded that Jeff had difficulty with school attendance and could, at times, be abusive towards his foster mother. The records show that Jeff did well his applied Leaving Certificate and began to attend a special education project. He had reported being confused about his identity but was reluctant to discuss it.

When Jeff turned 18 years, he stayed in aftercare with his foster carers by mutual consent and was allocated an aftercare worker; Social Worker 4 also remained in contact for a few months after his 18th birthday. He sought and obtained his personal files under FOI. He was offered counselling to support him while he was reading the records but he declined it, pointing out that he had his foster mother for support. He made efforts to renew contact with his parents, whom he hadn't seen in a number of years. He met both parents separately and saw them from time to time. Whilst in this placement, Jeff also renewed contact with some of his siblings whom he hadn't seen in a number of years.

Jeff became a father at this time. He was no longer in a relationship with the baby's mother, but she indicated her willingness to have him involved. His social worker brought him to a FAS office where he registered. Towards the end of the year, Jeff began to get stressed and showed inclination to self harm. His aftercare worker contacted a counselling service and made an appointment for Jeff on the following day. Three weeks later the child care manager received a call from the Gardaí advising that Jeff had been found dead by his foster carers and the Gardaí were treating the death as suicide.

11. Analysis of the services provided to Jeff by the HSE

11.1 Initial response and early protective action.

The initial response of the SWD to concerns about Jeff and his sibling was timely and appropriate and a social worker was allocated to the case. The SWD initially attempted to work with his family in the community by offering various supports including respite care. After approximately a year, they revised their view and decided to apply for care orders, initially on a temporary basis but later on a

long term basis as home circumstances had not improved and they were concerned about the disclosures of sexual and physical abuse. The review notes that it took five years from the time the case was first referred to the SWD for the courts to grant full care orders, despite the presentation to court by the SWD of evidence about sexual abuse and neglect. During that time the files record eight case conferences in respect of the family and it appears that workers with the family met approximately every three months to share information and plan.

The review notes the considerable efforts made by the SWD to improve the children's situation while still at home. It also notes that the delay in securing permanent care arrangements, which was outside the control of the SWD for a time, must have had a very unsettling effect on Jeff and the different foster carers who were looking after him at the time. The role of the health board and the court in the applications for and granting of care orders has to be considered in light of the recency of Child Care Act 1991 which had only just been implemented when orders were being sought for Jeff and his siblings. It appears that no clear process was in place for social workers to follow in the operation of the relevant sections of the Act and no consensus existed with regard to appropriate timeframes for the assessment of reunification. Likewise, as full hearings did not always take place the amount of evidence presented to the court was limited, and on that basis it would appear that the court did not always have complete information, for example with regard to outcome of the assessment of child sexual abuse.

11.2 Assessment

Individual assessments were not carried out on the children prior to their placement into care, which meant that their needs were not clarified at the time and it was not possible to measure how well they were met. When the children were received into care, the court directed the health board to conduct assessments following allegations made and behaviours exhibited by the children in placements. However, aside from psychological and psychiatric reports there are no individual needs assessments of the children. The review team acknowledges that the period in question was prior to the publication of Children First and there was less clarity or consistency of practice at the time in respect of responding to child protection concerns.

11.3 Interaction with child and family by the SWD and other services

While Jeff and his siblings lived with their parents, there was frequent involvement from services but the lack of a recorded assessment makes it difficult to evaluate what means was being used to measure progress and decision making appears to have been incident led. As outlined above, the management of the case was court led for a number of years and the long drawn out process of securing permanency for the children was difficult as a result. A number of case conferences were held both before and after the children were placed in care and these were the main decision making fora. From interviews, it appears that the standard of teamwork and support was high during the period in which court proceedings were active. It is also apparent that even though the area was relatively understaffed, a lot of resources were allocated to this case, including therapeutic services and child care workers to support the foster placements and supervise access.

Jeff was placed with Family C when he was five and remained there for ten years. He apparently settled in well initially. He was seen in the early stages by Dr. P as part of a review for the court and was considered to be happy and attaching well to his foster carers. However, there is a dearth of information for the following years as only one Child in Care Review seems to have been held and it has been difficult for the review team to get a clear picture of Jeff's childhood and early adolescence during which he claimed to have been badly treated and unhappy. Most of the staff that were interviewed by the review team and had earlier involvement had moved to different posts by that time, and neither Jeff nor the foster carers had allocated social workers for periods over a number of years. Case notes are scarce and the records were poorly kept and very difficult to follow. There is little evidence of contact between Jeff and his siblings during that time. A child care leader here called CCL1, who knew Jeff for most of his time in care became involved with him in the final period of his placement with Family C. His involvement, however, did not compensate for the lack of an allocated social worker. In the opinion of the review team, the gaps in allocation of a social worker to Jeff represented a very significant omission, not only in regulatory terms, but because it meant that the problems emerging in his foster placement went unaddressed for a long time. From comments made to the review team by staff who were interviewed, it appears that it was not unusual at the time in that area for a child in care to remain without an allocated social worker once their placement appeared to be 'settled' and this was the rationale used to explain why Jeff was a low priority in terms of allocation.

A social worker was allocated to the case when Jeff was 16, after the breakdown of his placement with Family D. This worker, known here as Social Worker 4, appears to have provided a very consistent service to Jeff who, at that point, was allegedly feeling very angry with the HSE services and had become difficult to engage. The review panel were told by Jeff's later foster carers and also

by care staff in the residential unit that Jeff was sometimes very abusive to Social Worker 4, refusing to see her and behaving in a hostile manner, but that she managed to persist in keeping an open relationship with him.

11.4 Focus on child and family:

Social Worker 1 acknowledged to the review team that in Jeff's early years, she was working with all the children together and was not necessarily aware of Jeff as an individual until his behaviour in foster care became very challenging and his need for attention was observed. At different points in his life, Jeff received a child/young person focused service from social care and residential staff, from psychologists and mental health staff, CCL1 and from Social Worker 4 as well as his foster carers, but during the long lacuna where he was with Family C he was virtually invisible to services until near the end. This appears to have been the time when he began to self-harm. A psychologist who treated Jeff while he was in residential care told the review team that, in her opinion, Jeff had been deeply traumatised by his early life experiences and that his self-harming behaviour was symptomatic of this. The review team believes that opportunities to continue the therapeutic interventions that had been available to him earlier were lost during his period of unhappiness in his third foster home.

There were numerous references on file to the relationship between the parents and children and the fact that Jeff's mother loved them. This was one of the motivations for the SWD to continue trying to work with the family in the community. However, it was not balanced by an equal focus on the children's own wellbeing and the impact that the parental behaviour was having on their development.

While in residential care, and in his last placements with Family D and Family E, Jeff's behaviour was very challenging but there is evidence that he was responded to with firmness and kindness, that therapeutic services were available to him and that staff and foster carers made considerable efforts to inform themselves of the best way to deal with his self-harming.

11.5 Foster care

Jeff's early foster placements broke down due to what is described as his challenging behaviour which became too much for his foster carers to cope with. Staff who met with the review team confirmed that foster carers at that time did not receive any specific training or preparation to deal with challenging behaviour. It also appears in hindsight that the full range of Jeff's needs was not known at the time he was placed. The review team understand that in the early placements Jeff had

the support of a play therapist and child care worker but it is not clear if their input benefited his carers or enabled them to cope better. The dearth of supervision and management over time of Jeff's placement with Family C meant that support needs they or Jeff required as the placement progressed were unmet. Jeff's later foster placements were better supported and considerable preparation went into his final placement.

11.6 Residential Care.

Jeff's entry into residential care was inevitably traumatic and upsetting for him and his self-harming behaviour during his stay there was a cause of great concern to the staff. It appears from all accounts, including the very detailed records maintained by the unit that the staff were competent and committed to helping him. Staff at the centre assisted Jeff to deal with his emotions and feelings and made an appropriate referral to the community psychologist who in turn referred him to CAMHS where he saw Dr. P again. There was regular exchange of information between services. Staff ensured Jeff's education at a local school continued with as little interruption as possible. He was visited regularly by his newly allocated social worker and by CCL1. He was well prepared for his next placement and introduced gradually to his next set of foster carers.

11.7 Psychiatric and psychological interventions.

Jeff was referred to a child psychiatrist (Dr. P) at an early age and saw him over a three year period during which he was placed in three separate foster families and while child care proceedings were still going on. Jeff was re-referred to him after a period of nine years, during which his placement with Families C and D ended. He was at that time in residential care and seriously self-harming. Jeff saw Dr. P and for a time he was treated by his senior registrar. Even though Jeff was difficult to engage, he was seen frequently and it appears to the review team that mental health services were flexible and available to him as he needed them. Jeff also received psychological services from different child and clinical psychologists from an early age. There appeared to be excellent communication between the mental health and psychology services and the residential and child protection services.

11.8 Management of child protection and children in care services

The review team have noted the noncompliance with statutory regulations in respect of Jeff's earlier foster placements. It was also made aware of the casual attitude to children in care and foster carers who appeared to be 'settled' and, in a time of scarce social work resources, were not provided with support or regular contact. Interviews were held with a former child care manager and principal social worker who had been appointed within the last six years, around the time that Jeff was moved to residential care and prior to his final placement. Both of these managers confirmed to the review team that when they started working in the area, a culture of noncompliance with national regulation and poor accountability had prevailed there for several years, underpinned by a scarcity of resources and gaps between the appointments of frontline and senior managers. They reported that systems, record-keeping and databases, particularly in respect of children in care, had been extremely weak, and that supervision had been practically non-existent. They also commented that there were some good frontline practitioners whose work was undermined by a very deficient structure.

The review team was informed that the area had been allocated extra staff in the past few years, new systems had been put in place to standardise and formalise business processes and that statutory Child in Care reviews were held regularly. The system for recruiting, training and supporting foster carers was reformed. While the number of priorities and various pressures facing the team continued to be a challenge, these managers, who have since left the area, were satisfied that practices and local policies had vastly improved and that the culture had shifted to a point where regulations became embedded in practice and lines of accountability were clear.

The review team concurs with the view of these former managers in respect of the supervision practice operating in the area, which appears from the evidence to have been unstructured and informal with no supervision records maintained.

11.9 Quality of Record Keeping.

The review team received a total of 24 files from the residential centre and the SWD, including RAISE (computerised) Records. The early records of case notes and preparation for court hearings were of good quality, appropriately signed and dated. The records of Jeff's time in the residential centre were excellent and provided a full account and understanding of Jeff's time there. The qualities of the remainder of the SWD files varied from good in parts to poor, with large gaps, and were presented in a way that made the preparation of a chronology difficult. Documentation covering the period of Jeff's placement with Family C was particularly scarce.

11.10 Inter-agency cooperation.

Cooperation between the SWD and other relevant agencies appears to have been good and all persons concerned generally attended case conferences. In particular, all allegations of sexual or other abuse were dealt with promptly with the Gardaí being informed in accordance with national policy.

12. Conclusions

Jeff very sadly took his own life at 19 years of age. Staff, including care staff, who had worked with him during his last four years had been very aware of his emotional vulnerability, tendency to self-harm and suicidal ideation and had done their best keep him safe and to provide the most appropriate help for him. Mental health and psychology services were available to him at all times during this period and actively tried to engage him. He was in aftercare with his former foster carers when he died and by all accounts, he had settled well into this placement and had a very good relationship with his carers who were very attached to him and made considerable efforts to help him deal with his problems and manage his self-harming behaviour. The review team finds no link between the services offered to Jeff that time and his very sad death and acknowledges the deep distress experienced by everyone who knew him.

The review has found that Jeff 's family received a lot of social work attention when he was a young child and was provided with child mental health services when considered appropriate. The review also concludes that Jeff was left in a situation of great uncertainty for a number of years as a young child while the SWD tried to improve conditions in the family home and the court deliberated over his care status. As far as can be ascertained, once the SWD had determined that no improvements were being achieved in the home situation, they made as convincing a case as they could to achieve permanency for him and it is acknowledged that the recent implementation of the Child Care Act 1991 had created a different type of legal environment to which all involved were slowly getting accustomed. It is suggested that this situation hindered Jeff's rehabilitation from the trauma he had experienced by being exposed to neglect, alcohol abuse and domestic violence and it is likely that this delay contributed to the de-stabilisation of his early foster placements.

The review has found that Jeff was invisible to services for a period of several years in foster care, including a time which he later described as unhappy. It appears that scarcity of resources and a culture which was non-compliant with regulations combined to deprive him of the services to which he was rightfully entitled, i.e. an allocated social worker and timely statutory Child in Care Reviews.

The review has found that for the greater part of Jeff's time in the care of the health board/HSE, management of social work services in the local area was deficient with gaps between the appointment of frontline and senior management. It suggests that the ensuing lack of accountability and poor infrastructure impacted on Jeff's welfare particularly in his late childhood and early adolescence. The review team has been informed that significant management reforms have taken place in the area in the meantime.

13. Key Learning points

This review raises a number of points for reflection and learning, as follows:

- Professionals who worked with Jeff were of the opinion that he was deeply traumatised by the neglect he suffered and the domestic violence and alcohol abuse that he had witnessed in the family home while still a baby and young infant. There is increasing evidence that trauma can have an adverse impact on a child's emotional, social and intellectual development[1] and many of the behaviours that Jeff exhibited, including difficulties with self-regulation, aggression and self-harm conform with this theory. It is therefore imperative that children exposed to such trauma receive a sense of safety, stability and therapeutic services as quickly as possible. In hindsight, it may be inferred that Jeff and his siblings should have been removed from their family home earlier once their situation had been identified and that they should have had very specific therapeutic interventions over a long period. The review acknowledges that the staff involved did the best they could with the knowledge and resources available at the time and that their interventions were dictated by the court for a considerable period, but nonetheless raise this issue as a learning point.

- The review has noted that despite Jeff's difficult history in care, the foster care team in the area were prepared to place him again in foster care during his late teens, an intervention that would generally be considered quite risky but which was successful in this case. It also notes that in planning the placement, Jeff's needs and the abilities of the foster carers to meet them were carefully considered and his transition to the placement was, according to evidence given in interview, gradual and well planned. Jeff was a much damaged young person and it was agreed by all who were involved with him that this placement gave him a

[1] (see, for example, Cook et al. 2003 *Complex Trauma in Children and Adolescents: White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force*).

period of stability and happiness, notwithstanding the very sad outcome. The learning point here is that calculated risks are worth taking to promote a young person's welfare when all possible aspects are considered and addressed.

- Jeff sought to read his own social work records and exhibited a sense of needing to establish his identity which he took further in his late teens when he re-contacted his parents and siblings. When he entered residential care at 15 years, the staff noted his need for information about his family of origin. The review team were told that the children had wanted to be placed together in foster care but that this was not possible both for logistical reasons and because of challenging behaviour would have been too much for one family to manage. While this is understandable, it appears that very little effort was made to keep all of the children in touch with each other once they were in permanent placements. Jeff was, at one point, in school with a sibling whom he hardly knew and for a considerable period he and his sibling would only nod at each other in the corridor. His sibling was in foster care nearby and the review team could identify no reason why sibling access could not have been arranged and maintained. The learning point here is that while parental access can sometimes be problematic for children, it is important to maintain their sense of identity in feasible ways and sibling access should be supported.

Recommendation

The review team have found with this review, as with others, that staff and other former carers who have been involved with a child that dies are not always aware of his or her death. On more than one occasion, staff who are invited to meet review teams have only learned of a death when they received a letter from the National Review Panel. From a staff welfare perspective, it is suggested that the area manager or a nominated person takes all possible steps to inform relevant personnel of the death of a child or young person with whom they have worked in the previous two years or with whom they had a working relationship in the past.

Professor Helen Buckley

Chair National Review Panel