Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of the death of a young person who was in the care of the Tusla

Lisa

Executive Summary

June 2022

1. Introduction and background summary

This review concerns a young girl, here called Lisa, who was in the care of Tusla when she took her own life at fourteen years of age. Lisa lived mainly with her mother, her parents having separated when she was a small child. She had contact with her father until she was eleven years of age at which point, she refused to see him any more. While Lisa had complex needs, she was also described as smart and creative with a great sense of humour. From all accounts given to the review team Lisa was well liked, yet professionals were left with a feeling of being unable to reach her.

Two referrals were made about Lisa to the SWD during her early years, neither of which indicated ongoing risk or harm. As she grew older, it became evident that Lisa had a number of complex needs including a tendency to act aggressively. She became involved with CAMHS after a serious self-harm attempt when she was eleven years old. She was not diagnosed with a mental illness, but CAMHS observed relationships and attachment difficulties between her and her family. She was offered ongoing appointments but despite her mother's encouragement, she was unwilling to engage any further with the service. Not long afterwards, a referral was made to the SWD following an incident where the Gardai placed Lisa in emergency care as her mother found that she was unable to keep her safe. Lisa subsequently had four foster placements over a four-week period. She was unable to settle, and her foster carers were unable to deal with her behaviour so it was decided that residential care would be a more suitable option for her. At the time, Lisa's father had wanted to care for his daughter, but this option was not taken up by the SWD because Lisa did not want it.

Lisa initially settled into residential care, but her behaviour became challenging. She was unable to regulate her emotions and displayed a high level of aggression including assaulting staff and destroying property. A psychologist contracted by her residential unit assessed Lisa and recommended a transitional return to her mother's care, supported by family therapy and individual counselling. However, Lisa was opposed to this and to placements with extended family members. Lisa's father again requested that she come to live with him but acknowledged that it was not going to be possible. Although her family did not want her to stay in residential care, they deferred to the professionals' ultimate recommendation that she remain there.

Ultimately, due to Lisa's high risk behaviour, it was decided to pursue special care and a placement was found for her. At this time, she had no allocated social worker due to staff shortages in the area and the principal social worker kept oversight of her case, attending meetings and keeping contact with unit staff. A new social worker was allocated six months after she entered the special care unit. She settled reasonably well, though her behaviour and assaults on staff continued to be problematic. She had a pattern of making allegations against staff, all of which were investigated, followed by

incidents of self-harm. She began to make relationships with some members of staff, and despite her challenging behaviour she had an overall positive experience in special care and was reluctant to move on. The SWD became under pressure to move her as her stay had considerably exceeded the recommended three-month period. it was very difficult to find an appropriate step-down placement for her but ultimately it was agreed that she would transfer to a private residential unit which was considered suitable to meet her needs.

Lisa's transition to her final placement was protracted and the reviewers became aware of some differing views as to how it should be handled. These were ultimately agreed between the special care unit, her Guardian ad Litem, the SWD and her new unit. Lisa found the move to be difficult and she seriously assaulted a staff member at an initial stage in her placement. As time went by, the number of assaults diminished considerably, and she seemed to settle. She engaged with staff, personalised her bedroom and seemed to be able to focus on some of her difficulties. Staff made efforts to encourage her to be less controlling and allow herself to be parented. She liked to stay up late talking to staff but adjusted to regular routines.

Lisa's tragic death took place following an incident whereby she seriously assaulted a staff member and the Gardai had been called. An emergency staff meeting decided to postpone any further interventions until the following day and let everything rest for the night. Lisa subsequently appeared to settle in her room. The staff member that was due to call Lisa in the morning found that she had taken her life.

During the eight months that she was in her first residential placement, efforts had been made to transfer Lisa's mental health care to the local CAMHS team but a six month delay ensued. Overall, Lisa had a total of three psychiatric assessments. All three psychiatric assessments noted that she did not suffer from any major mental illness but had poor impulse control and self-harming behaviour. While in care Lisa met with three psychologists in her different placements and, in addition, attempts were made to support her through the services of a counselling psychologist and art therapist in her final placement. Lisa was diagnosed with attachment difficulties and with Oppositional Defiant Disorder at different points in her care

From reading the reports on file and from interviews made Lisa would not or could not always engage in therapeutic supports.

2. Review Findings

The review found that the social work services responded to all the referrals made about Lisa although no adequate assessment of her needs was made until she was received into care. Due to her escalating

needs and sometimes unpredictable episodes of aggressive behaviour, many interventions were made on an emergency basis. However, Lisa's welfare was monitored regularly, and her safety reviewed in terms of her behaviours. She often refused to see her social workers and seriously assaulted one of them as well as many residential staff. It was evident however, that staff were able to persist and develop relationships with her, and many of the accounts in the records about Lisa describe her in terms that reflect very positive aspects of her personality. There is evidence that there were periods of settled behaviour in her last two placements that were beneficial for her and allowed her to address some of her difficulties.

The review found that Lisa's mental health care was disjointed due to her different placements, which meant that she was unable to make a trusting relationship with a mental health clinician. It was noted that the way in which mental health services are structured meant that there was little flexibility in the way they are delivered.

Lisa's time in care was negatively impacted by a shortage of social work staff and by difficulty in accessing a step-down placement that was suitable for her needs. It was noted that her difficulties with self-regulation meant that she was often unable to participate in meetings that were held about her. However, the reviewers also found evidence that her views were regularly ascertained by staff and did impact on plans that were made for her.

The review found differing levels of interagency collaboration during Lisa's care career. The break in the continuity of her mental health care was disruptive and the difficulties that arose in relation to her transition from her second to her third placements were unhelpful. However, there was evidence of good collaboration in other instances between the social work department, CAMHS and Lisa's placements.

3. Conclusions

The review acknowledges the sadness expressed by all involved with Lisa in response to her untimely death and it also acknowledges the profound grief of her family.

On the basis of the evidence available to it, the review has reached the following conclusions:

- Lisa's tragic death was not predictable on the night that it occurred. Records indicate that apart from two assaults on residential staff, her behaviour in the months prior to her death was relatively calm and less impulsive in comparison with previous years. People who spent a lot of time with her, including residential managers and workers and her Guardian ad Litem felt that she was able to come through difficult times. On the night that she took her

life, staff responded to the incident that had occurred earlier and had carefully considered how to deal with it in her best interests.

- Although Lisa had little personal contact with her parents during the last two years of her life, her mother and father demonstrated ongoing love and commitment to her, and her extended family also remained involved and concerned. Their goal was to have her back to live with them.

- Lisa's behaviour became significantly problematic when she was about 11 years of age. As time passed her behaviour continued to escalate out of the control of her mother who was her main carer. She was diagnosed with several psychological difficulties. Whilst professionals offered a number of services and interventions, it would appear that no person or service was able to provide the secure base and consistent caring required. Lisa could not engage and could not accept care of therapeutic support when offered to her.

- Lisa was diagnosed with attachment problems and other psychological disorders which impacted on her self-esteem and her ability to self-regulate and had a profound effect on her life. The delivery of her mental health care was fragmented, partly because of staff changes in the first CAMHS service she attended, but also because her placements were spread between different areas and there were unacceptable delays in the transfer of her care between CAMHS teams. For a child who already had difficulties relating to professionals, this fragmentation meant that she gained very little from the formal mental health service.
- Lisa's reception into care occurred in a crisis following a cluster of referrals. The escalation in her behaviour and circumstances appeared dramatic and left services in many respects challenged. Initially, the focus was on safety and behaviour management as services tried to a make sense of her high level of need.
- Lisa was unable to manage in foster care and the decision to move her to residential care was appropriate. The review team has found evidence of considerable effort and dedication by staff teams in the three residential units in their efforts to meet Lisa's needs. Despite the challenges presented by her psychological difficulties and concurrent behaviours, staff in all the units were sensitive to her needs, aware of her strengths and optimistic about her future.
- Lisa had extremely violent outbursts on occasions. While in special care, she assaulted almost every one of the staff, some quite seriously and committed serious assaults against her social worker and two staff in Residential Unit 2. Because of her physical strength, her assaults sometimes resulted in sick leave, injury and hospitalisation of staff members. By all accounts,

staff handled assaults in a consistent and proportionate fashion whilst remaining committed to her.

- The absence of a national policy on transitioning between care placements caused difficulties in this case. The NRP understands that Tusla has implemented a protocol in the interim.

4. Learning points

- **Post discharge contact following special care**

The process of children transitioning from one placement to another needs to be carefully managed, particularly when they have attachment difficulties. Tusla's policy document 'Effective Care and Support Services Policies and Procedures' acknowledges the significance of relationships developed by young people in special care and points out that follow on contact from staff members is approved by the social worker and the young person. It notes that 'it is important for the contact to be purposeful and appropriate in terms of the needs of the young person'. It outlines the importance of full transparency in relation to post-discharge contacts between young people and staff members and provides guidance on how this may be managed.

- **Engaging fathers**

Low engagement with child welfare services from fathers has been identified in studies as an issue resulting in limited resources for children's care and possibly poor assessment and management. Whilst there is limited evidence about what works in engaging men, there are some encouraging pointers from family support and child protection practice contexts. These include early identification and early involvement of fathers; a proactive approach including insistence on men's involvement with services and the use of practical activities[1].

5. Recommendation

Tusla, in conjunction with the HSE and other relevant parties, should develop a national policy and strategy to address the mental health needs of children and young people in care. This should include **c**onsideration to the development of a dedicated mental health service for children in care

[1] Maxwell, N., Scourfield, J.,Featherstone, B.,Holland, S. and Tolman, R. (2012) Engaging fathers in child welfare services: A narrative review of recent research evidence. *Child and Family Social Work*, 17 (2): 160-169. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2012.00827.x/abstract

that can provide a holistic and therapeutic attachment-informed work which should not be merely based on service provision to children with a diagnosis of mental illness.

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