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

Executive Summary

April 2016

Introduction

This review concerns the death of a young person, here called Adam, by suicide. He had been in the care of the HSE at different periods including a period in special care, since he was 13 years old. He regularly absconded from home as well as from care settings, and at the time of his death, he was due to enter special care for the third time.

The review team comprised two members: Dr Declan Bedford and Dr Ann McWilliams with oversight by the chair, Professor Helen Buckley. The methods used were a review of the files from social work, residential care settings and Child and Adolescent Mental Health Services (CAMHS). Interviews were held with Adam's family, social work staff, a Guardian ad Litem and a professional from CAMHS.

Background

Adam's mother and stepfather found his behaviour very difficult to manage, and he was referred to both the Child and Adolescent Mental Health Services (CAMHS) and the HSE SWD when he was 13. A social worker was allocated to the family, and other referrals were made for family support and the Educational Welfare Service, as Adam was declining to attend school. As further tensions developed between Adam and his parents he was placed first in a residential youth service for respite and assessment for a short period, after which he was referred to, but not accepted by, a residential mental health service. His home situation became more difficult and his behaviour became more risky; he had a short foster placement and this was followed by a period where he spent some nights with a relative and others sleeping rough. Supports were provided to assist his family to care for him, but ultimately a placement in special care became the only option to keep him safe. It took some time to satisfy the requirements for this placement but once Adam had settled, he reportedly did well in special care where he stayed for three and a half months. In the meantime, his parents started to engage with services to help them resume their care of him. Problems arose with the availability of an onward placement for Adam which delayed his discharge from special care. When he eventually moved to a step down placement, he absconded almost immediately and spent the next few weeks sleeping rough, staying with a relative, or living in the house of a woman in the neighbourhood who befriended him. His parents and the professionals involved with him were very concerned for his safety and it was agreed that a readmission to special care was the best option available. However, his application was rejected on the grounds that it was not in his best interests. The refusal was appealed and in the meantime Adam spent periods living rough, or staying in the house of the person who had befriended him. He remained in intermittent

contact with his mother and with the SWD. Adam's Guardian ad Litem brought his case to the High Court because of concern about his safety and wellbeing, after which a special care place was offered but was not immediately available. Adam turned down the offer of an interim placement. The CAMHS service offered both Adam and his parents appointments but they all declined to attend, his parents stating that they had lost confidence in the services. Adam's chaotic lifestyle continued throughout the month prior to his placement becoming available. This included alcohol misuse, stealing and getting involved in rows. When the time came to return to special care, Adam went missing; the gardai were contacted and revealed that they knew where he was and would pick him up and bring him to the special care unit when backup was available. The following day, Adam arrived at this mother's house and agreed to go to the special care unit, but abruptly left the house and drove away in the family car. When he was found a few hours later he had taken his own life.

Findings

On the basis of the facts presented to it, the review has found that neither action nor inaction by the HSE services involved with Adam contributed to his death. The review found that while Adam's family did their best and were offered a number of services, Adam was disinclined to avail of most of them. Ultimately, no person or service in his life was able to provide the constant secure base and the authoritative caring that he required. A lot of time and effort was given to Adam and his family by the professionals involved in different services. 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.

The review also found that while the SWD responded to each of the crises emerging in the case, a more strategic, holistic and long term approach based on a comprehensive assessment of his needs would have been required. Ultimately, 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 living in a situation that could not be classified as approved placements.

The review has identified a failure by the HSE to provide adequate care placements for a child with Adam's requirements, and has noted that lack of a suitable school placement. Adam had particular needs that were untypical of many of the children referred to the service; he was unable to fit into the existing system and required a unique response.

The review team have found it difficult to understand why the second application for a special care placement was rejected, and is of the view that the grounds for refusal should have been made more explicit. The delay which ensued when the refusal was repealed highlights once again the great difficulties presented to the SWD in managing children such as Adam when the required resources are not available.

The review has also concluded that the SWD response to the allegations of child sexual abuse was not totally adequate and that the delay on the part of the Gardai in executing the second special care order was not in Adam's best interests.

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].

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.

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

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.

Recommendations

The review 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 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

Chair, National Review Panel

[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.*