Review undertaken in respect of the death of Aoife,

a young person in after care services.

August 2014

1. Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care' issued in 2010. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious incidents involving a child in care or known to the child protection service

2. National Review Panel

A national review panel was established by the HSE and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have 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 is administered by the Child and Family Agency. When a death or serious incident fitting the criteria above occurs, it is notified through the Child and Family Agency to the CEO's Office and from there to the National

Review Panel. 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

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. 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, and conclusions and recommendations. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

- **Major review** to be held where contact with the HSE services 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 three 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 review:** to be held where involvement of HSE services 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 and recommendations

- **Concise review:** to be held where the involvement of HSE 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 and recommendations

- **Desktop review** 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 the chair or deputy chair of the NRP. 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 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.

- **Recommendation for internal local review** to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Death of Young Person

This report relates to the service provided by the HSE Children and Family Services to a young person here called Aoife who died by suicide just after her 19th birthday. Aoife had been in the care of the HSE on a supported lodgings basis with a relative for four years following the death of her mother. Aoife had been her mother's main carer prior to her death. She was well liked and she was described as a very caring person who was sociable and had lots of friends; "an engaging capable and ambitious young woman". At times she

was subject to low moods and her behaviour could be unpredictable. She was very family oriented and liked to spend time with her nieces and nephews. Her plan was to train as a beauty therapist after her Leaving Cert. Aoife died by suicide. The coroner's report noted "no suspicious circumstances pertaining to death".

5. Level and Process of Review

This was conducted as a concise review. It was carried out by Helen Buckley, Chair of the NRP and Deirdre McTeigue, panel member. The review focuses on the service provided to Aoife prior to coming into care and the period in care and in aftercare.

The methodology employed was a review of the social work records and interviews with Aoife's aftercare worker, the principal social worker in the area and the foster care team leader. Aoife's relative carer was invited to meet the review panel, but she declined as she believed she would find the experience very distressing.

6. Background and reason for contact with HSE Children and Family Services

Aoife's parents separated shortly after her birth and she lived with her mother, here called Rita, and her siblings. She had regular contact with her father. Rita suffered from very poor health, which had been made worse by years of drug misuse. Aoife took a very active role in her care, often missing school as a result. The family had been referred to the HSE Social Work Department (SWD) by Rita's GP prior to Aoife's birth because of concerns about Rita's drug use and its impact on the children. There was no record of any follow up to this report. The family was referred again ten years later when Aoife was nine years old, because of neglect and the children's erratic school attendance. The case was kept open on duty for the next four years, until Aoife was received into care, at which point a social worker was allocated.

7. Terms of reference

The terms of reference are

- To examine the services provided to Aoife by the HSE and HSE funded services prior to her death.
- To identify opportunities for learning from the findings of the review.
- To provide a report to the HSE.

8. Services/ agencies involved with Aoife.

- **HSE children and family services:** The HSE SWD was involved over a ten year period due to the drug abuse /illness of the mother and the subsequent effect on the family.

- **Hospital:** Rita had many admissions to hospital and several case conferences and meetings were held in the hospital, some called by the medical social worker.

- **School:** The principal of Aoife's school attended and convened family meetings to discuss her behaviour and non attendance

- **St Vincent de Paul Society:** The same person was involved for many years helping out with financing debts he also provided great support to the family. He was particularly concerned about the neglect of Aoife and alerted the SWD to this.

- **Home School Liaison Teachers - one in primary school and another in secondary school.** The HSLTs attended and convened meetings to address concerns about Aoife caring for her mother as well as her behaviour at school

- **Extern programme for two year period, from when Aoife was 14 until she was 16.** Aoife attended Extern and benefited from the two years she spent with them. Her situation had improved as she engaged well with the service and she was discharged from the service with a positive report.

- **Psychology Service:** Aoife attended a psychologist for two sessions in the weeks prior to her death. She was offered counselling in school but chose not to avail of it

9. Summary of Aoife's needs during her contact with the HSE Children and Family Services.

Aoife's needs were never formally assessed by the SWD when she was a minor. From the time she was a young child, Aoife had adopted a parental role in caring for her mother which meant that some of her own needs were not always met. She needed space to enjoy a normal childhood, and to socialise with friends of her own age. She also required parenting that was of a more authoritative nature than was provided by her mother, as she spent a lot of time without supervision in her teens. She required counselling to help her deal with her mother's drug use and illness. She missed a lot of school, and needed to be re-integrated into education.

When her mother died, Aoife needed help to deal with her bereavement and, on a practical level, she needed to be cared for. She was received into voluntary care with her father's consent; a relative came forward and cared for her on a supported lodgings basis.

When Aoife became involved with the aftercare service, her needs were assessed by her social workers. She needed stability and behaviour management, as she was prone to temper tantrums and tended to put herself at risk by absconding from home and school. Later, she needed assistance with getting accommodation, as well as help in obtaining her benefits and placement on a course. Her aftercare worker assisted her with all these matters. She also required help with mediating her relationships with her family.

10. Chronology of contact between HSE Children and Family Services and Aoife.

Nine to ten years old

The family were first referred to the HSE the year prior to Aoife's birth, because of Rita's drug use and its impact on the children. There is no evidence on file that this was followed up. The next referral was made by the local council when Aoife was nine; once again, this concerned Rita's drug use and neglect of the children, as well as their erratic school attendance; it also noted that Rita had a history of depression and was on a methadone programme. A number of efforts were made to contact Rita, by letter and home visit and the file records that on many occasions the door was not answered, even though it appeared that someone was inside. This was a pattern that continued over the following years

whereby several social workers found it difficult to engage Rita, who appeared not to want any involvement with them at times, but at other times actively sought their assistance when she had practical needs.

Contact with the school by the SWD confirmed that the children's attendance was irregular; they were described as 'good kids' when they attended. The duty social worker made a referral to the family support service and this was eventually offered but not accepted by Rita. The case was allocated to a social worker on the duty team who advocated for the family with various charities to get them financial help, as well as with the housing authority to prevent an eviction. The social worker also requested a mental health referral for Rita who was depressed. Later that year, school reports about Aoife were positive and the case was closed to the SWD, to be re-opened if necessary.

Aoife at eleven years to twelve years old

A few months later, Rita contacted the SWD because she was concerned that Aoife had been at risk from someone who stayed in the house who later transpired to have a conviction for child abuse. The duty social worker responded promptly and helped the family deal with the matter; it appeared that Aoife had not been subjected to any abuse. A few months later, Rita again asked, via the Vincent de Paul, to see a social worker about a family matter but was unavailable when the duty social worker made numerous attempts to see her. The file records the comment from the Vincent de Paul officer to the effect that "While the family will always be chaotic, they are getting by". A closing summary completed by the duty social worker some weeks later noted that given Rita's reluctance to engage with the services and the fact that there were no current child protection concerns, the social work department could only offer support and advice which the family did not think they required at the time. Both Rita and the Vincent de Paul representative were written to and advised that the case was closed and invited to make contact again if required.

Three months later and near the end of the Christmas term, Aoife's school convened a meeting which was attended by the social worker, the SWTL, the PHN and school staff, at which they reported that Aoife had hardly attended any school since the start of term. The PHN reported that Rita was currently misusing drugs. It was noted that Aoife was spending time in her grandmother's house, where she appeared to do well. The case was allocated to a social work student on placement, who was to follow up by speaking to Rita and the

children, and linking Rita with a drug treatment service. The social work student managed to have regular contact with Rita, Aoife and Aoife's grandmother. Aoife stayed with her grandmother some of the time, particularly during a period when Rita was hospitalised. When she returned home, she took on a lot of household chores; she claimed not to mind this and said she had time to socialise in the evenings after her homework was done. However, her school attendance deteriorated again, and she got involved in some anti social behaviour. She confided in the social work student that she was being picked on and bullied at school and didn't want to go there; it was suggested by the social work student that she might stay at her grandmother's and thus avoid the school journey where most of the bullying took place but this was not possible at the time. The social work student made a referral to drug services and family support before finishing the placement, and the case was allocated to another social work student a few months later.

Aoife at 13 years old

Over the following months, Aoife started secondary school which was initially better for her, but her mother's health deteriorated and she began to miss days. Aoife confided in the social work student about some of her problems, including issues about some of her friends. The student engaged a family support worker to do some work with Aoife, and kept in close contact with Aoife and Rita. As Rita's condition worsened, Aoife missed more days though it transpired that she was mitching as well as caring for her mother. Her school became very concerned about her absenteeism. The file records that Rita was reluctant to see social workers as she feared that Aoife, who was her only carer, would herself be taken into care. She became more dependent on Aoife, but also expressed concern about her behaviour: she suspected that Aoife was sexually active and having inappropriate relationships with older boys. Aoife was refusing to engage with social workers at this time, and the SWD gave consideration to placing her in care because of the inappropriateness of her care arrangements and lack of supervision at home. This plan was changed when a relative of Aoife's, here called Diane, moved into the family home and took over the household duties and most of the care responsibilities for Rita. The student finished her placement and a duty social worker took over from her.

Aoife at 14 years old

When her relative moved into the family home, Aoife's caring responsibilities lessened and her school attendance improved, though she was prone to walk out of school if

reprimanded. She was, at this point, working with Extern, which she continued for two years, and was involved in a juvenile diversion programme, but as the year progressed her behaviour became very challenging, including stealing, absconding, spending time with older teenage boys and engaging in anti social activities. Another social worker took over the case, and had frequent contact with the family although Aoife was reluctant to speak to her. Other services actively involved at this time were a counselling service based at her school, the PHN service (for Rita), the Vincent de Paul and the hospital where Rita attended. Aoife had occasional contact with her father during this time. Her behaviour became very challenging for Diane to manage and there followed a few unsettled months, where she spent some time with her father and with friends. A number of meetings were held, including one in Aoife's school, a conference in the hospital and a strategy meeting in the SWD, prompted out of concern about Aoife's behaviour and welfare in the context of her mother's deteriorating health and her relative's ability to care for her. The SWD considered placing her in a residential setting, as there were few family options open to her.

Aoife at 15 years old

Rita died shortly after Aoife's 15th birthday; she initially stayed with her grandmother and father for short periods afterwards and there was some uncertainty about her future accommodation. Diane then agreed, somewhat reluctantly, to become her relative carer. She was very attached to Aoife and her reluctance stemmed from concern about Aoife's behaviour and her own ability to manage it. Aoife's father gave consent for Diane to be appointed as Aoife's guardian, and she undertook a parenting course. The placement with Diane was made on a supported lodgings basis[1]. Aoife was allocated a social and Diane was allocated a fostering link worker.

Over the next few months, Aoife continued to work with her Extern worker; the file shows that she settled down somewhat, though stayed out overnight on one occasion with older

[1] A supported lodging is the provision of accommodation, support and a family setting to young people who cannot live at home, but are not ready to live independently. The provided of SL will work in partnership with the young person, and the young person's social worker in preparing them for independent living at a future date.
SL should only be considered for young people aged 16 and above, who are deemed, through a thorough assessment process capable of living independently without a full range of supports. It is not suitable for young children under the age of 15 years.
As each young person in SL is in the care of the HSE, they will be subject to the normal care planning and review processes.
Those wishing to become providers of SL will undergo a competency based assessment focusing on their capacity to work with teenagers as part of a team. The assessment will include medical clearance, Garda clearance and the checking of references. Approval will be made at LHO level. Each placement will be subject to an individual contract.
A daily allowance is paid to the carer. In addition to covering out of pocket expenses for the carer, the allowance should be used for the care and upkeep of the young person, including for example, school expenses, pocket money, after school activities, lunch, bus fares etc. (HSE.ie accessed 27th February 2014))

adults. She returned to school, and a review carried out by the Extern worker noted that she was making excellent progress. She was reported to be getting on well with her relative carer, despite the occasional row.

Aoife at 16 and 17 years old

A Child in Care review the following year recorded that Aoife was doing well in all areas except school, which she claimed to dislike. She had another change of social worker and was again allocated to a student, to whom she confided that she didn't trust social workers. The review noted the rate at which her social workers were changing and recommended continuity. She was allocated a new social worker, here called **Social Worker 1**, just before her 17th birthday. At her next review, held when she was 17 years and seven months, a remarkable change was noted, it was considered that her placement was stable, her behaviour and attitude had improved, she was happy and mature and hoping to train as a beauty therapist after her Leaving Cert. She was reported as having friends, and close relationships with her family including regular contact with her father.

Despite her reservations about social workers, Aoife appeared to engage very well with Social Worker 1; the file records frequent contacts between them including visits, phone calls and texts. She returned to school to study for her Leaving Cert, and made plans to apply for third level courses.

Concerns arose later that year when Aoife began to go missing from home, and it was revealed that she had been having a relationship with a person that her family considered to be very unsuitable. Aoife was also very friendly with this person's sibling, here called Rose. The relationship ended, though Aoife remained friendly with Rose and tension between Aoife and her own family receded.

Aoife at 18 years old

Aoife was referred to the aftercare service on her 18th birthday, and started working with her aftercare worker, here called ACW1, who had already attended the final Child in Care Review. Aoife sat and passed her Leaving Cert, and started a Post Leaving Cert Course (PLC). ACW1 maintained regular contact with Aoife, meeting and texting over the next few months. Aoife found the course she was doing to be very difficult and started missing days, spending them with Rose and Rose's other friends. At one point, Aoife contacted ACW1 to

say she had had a row with Diane, who had asked her to leave. Aoife told ACW1 that she had been staying with a friend, they had been drinking and she had cut herself, but gave no further details. ACW1 was very concerned at this and advised her to see her GP as soon as possible. ACW1 subsequently spoke to Aoife about that incident on a number of occasions; Aoife had assured her that her actions were out of anger and that her self-harming behaviour had passed. ACW1 then contacted Diane who confirmed that the quarrel had been serious and that she wanted Aoife to move out.

At a review meeting attended by Diane, Aoife, ACW1 and her line managers a few days later, Diane outlined the only conditions on which Aoife could return home, which were not acceptable to Aoife. With ACW1's help Aoife subsequently applied for and was offered accommodation in an emergency hostel where she remained for nearly four weeks, spending some time with her friend Rose. She told ACW1 that she liked the hostel. ACW1 was still concerned about Aoife's recent attempts at self harm and advised her to see a psychologist. Aoife took her advice and had two sessions with a psychologist in the hostel where she was residing. She considered various accommodation options and it was reported that she was going to return to live with Diane. Sadly, however, she died by suicide shortly after this plan was communicated to her aftercare worker. The record indicates that her aftercare worker had been concerned about her in the days leading up to her suicide and had made frequent contact with her. However, in general, Aoife had been considered to be upbeat about life in general and had been making plans for her future. Her friends and family were very shocked at her suicide.

11. Analysis of the services offered to Aoife and her family.

11.1 Initial response of the SWD to referrals concerning Aoife

There is no record of the response from the SWD when the family were first referred prior to Aoife's birth, because of concerns about Rita's drug misuse. It is not clear from the records why this referral received no follow up even though the GP had identified her concerns about neglect of the children. Although the Child Care Act 1991 had not been fully implemented at this time, Part II, which compels the health board to 'promote the welfare of children in its area who are not receiving adequate care and protection', was in force. In the opinion of the review team, an opportunity for early intervention was missed at this point, and Rita's drug habit was later to worsen. When the next referral came almost ten years later, Rita's drug use was seriously compromising her ability to adequately parent her

children. Aoife was the one most at risk due to her age and the fact that she was already acting as a carer to her mother was causing her to miss school.

The SWD responded quickly to this referral, and made numerous efforts to contact Rita and her children but were often unsuccessful. The case was held on duty over a six year period and allocated to different practitioners including social work students. Each time it was closed the option to re-open was made clear to the family and to other services who were involved. There was good liaison between services. However, the fact that responsibility for the case was transferred so frequently, with the choice left up to the family as to whether or not they wished to engage, resulted in a number of limitations in the service offered. The family were difficult to motivate and constant change did little to build their trust. No assessment of Aoife's needs was comprehensively conducted, which meant there was no continuity in meeting them, or re-evaluation of what was required.

11.2 Assessment

There was no assessment of Aoife's needs prior to her reception into care. As outlined above, this seemed to be partly due to constant changes of social worker. Initially her needs were assessed through communication with her mother and not with Aoife directly. Given Rita's dependence both on drugs and on Aoife as a carer, she may not have always been a reliable person to decide on her daughter's care. Aoife's needs were ultimately comprehensively assessed by her aftercare worker when she was nearly 18.

11.3 Compliance with regulations

From the time Aoife was received into voluntary care, with the consent of her father, the required standards were complied with. She was placed with her relative in a supported lodgings arrangement. Her relative applied to be her guardian and this was supported by her father. A care plan and after care plan were formulated for Aoife. There were three reviews held and documented during her time in care and after care. Aoife participated well in issues related to her care and it seems from the files that her wishes were listened to and respected. The support offered by the fostering link worker to Diane was well up to the standard required by the regulations.

11.4 Quality of practice

During the years prior to her reception into care, the social work service provided to Aoife was managed by the duty social work team. The records indicate that some social workers found it extremely difficult to get into the house or get any response when they called. Both Aoife and her mother were mistrustful and suspicious of social workers, fearing that Aoife would be taken into care while her mother was alive. The rapid turnover of social workers made it difficult for them to get to know individual workers and did little to alleviate their mistrust. Whilst the case was held on duty, no comprehensive assessment of Aoife's needs was carried out, there was no overall plan and the case was not reviewed. In the opinion of the review team, the frequent changes of social worker added to the challenges posed by the family's reluctance to engage (see Key Learning Points at the end of this review). It is notable that two social work students were allocated at different times and both appear to have been able to engage quite well with Aoife, seeing her frequently. In addition, eighteen social workers were involved during the six year period before Aoife was received into care.

Aoife was allocated a social worker after she entered care and the service was more consistent though there were still frequent changes, as noted in one of her Child in Care Reviews. She had two allocated social workers and a social work student for the three years after she was received into care and an aftercare worker once she turned 18. The record indicates that the social workers had frequent contact with Aoife, either in person, by phone or by text and she engaged well with them most of the time, though still expressed mistrust from time to time. Her aftercare worker gave her considerable practical assistance as well as support.

11.5 Child and family Focus

The difficulties establishing a relationship with a family who do not wish it must be acknowledged. As outlined, Rita treated social workers with suspicion but would engage when she required practical help. The social workers who were allocated to Aoife, and the social work students who worked with her, developed good relationships with her, met with her on her own, gave her a lot of practical assistance and showed concern for her safety and welfare. However, the fact that she had no allocated worker in the earlier years meant that the same level of child centeredness was not applied.

11.6 Quality of recording

The records and case notes were typed signed and dated and recorded the frequent contact with the various services involved at different times. A transfer summary report was recorded and signed by the team leader. Supervision notes were signed by the social worker and the team leader.

There are also records of text messages between Aoife and her after care worker which shows the ease of communication that developed between them.

11.7 Management

11.7.1 Allocation.

As outlined above, the case was held on duty for six years, during which time 18 social workers were involved with Aoife and Rita. The earlier sections have outlined the review team's view about the consequences of the rapid turnover. However, it is also noted that the duty social work service responded promptly when concerns arose or when the family requested contact.

11.7.2 Interagency co operation

The information provided to the review team shows good evidence of co operation and communication between the various disciplines and agencies working with this family, including the hospital where Rita was being treated.

11.7.3 Case conferences and inter agency meetings

Eight interagency strategy meetings were held between the time Aoife was 12 and 15. Two were convened by the school, two by the medical social work department in the hospital where her mother was being treated and the remaining three by the SWD of the HSE. Each was attended by the five disciplines attending the family including the Society of St Vincent de Paul.

11.7.4 Supervision

There is good evidence of supervision once the case was allocated. Notes were signed and included on the file. Actions were agreed each session reviewed whether previous actions had been addressed.

12. Conclusions

The review team acknowledges the sadness experienced on Aoife's death by her family and friends, and all the professionals who worked with her. The review has reached the following conclusions, on the basis of case records and interviews.

- No action or inaction by the HSE Children and Family Services contributed to the death by suicide of Aoife. Her aftercare worker exhibited a lot of concern for her during the period prior to her death and made sure that she was in contact with appropriate services.

- While Aoife's welfare was negatively affected by issues in her family and some of her needs remained unmet during her childhood, the review acknowledges that her close family members were attached to her and concerned about her. Her relative carer in particular showed a high level of commitment to her welfare and the success, while it lasted, of the supported lodgings arrangement compensated in part for some of Aoife's earlier unmet needs.

- An opportunity for intervention with this family was missed at an early stage. Concerns were expressed at different stages that Aoife and her siblings were being neglected because of her mother's drug abuse and ill health. Aoife also adopted the role of a young carer while she was still quite a young child. There is evidence that both these factors can be detrimental to children and young person's development, but their impact was not fully assessed.

- The fact that the case was held on duty for long periods meant that opportunities to build up trust between the family and the SWD were missed. It is also the likely reason why no assessment was conducted, no child protection plan was developed and case reviews were not held prior to Aoife's reception into care.

- After Aoife was received into the care of the HSE, the service received by the family improved and complied with the regulations. The record shows a commitment on behalf of her social workers and prompt responses to any concerns that arose.

- Aoife's aftercare worker (ACW1) showed a high level of commitment to her welfare and managed the delicate balance which is required with young people in aftercare, to offer guidance and support but appreciate their independence.

- The good inter agency co working and communication in this case is acknowledged.

13. Key learning points.

No direct link has been found in this case between the quality of service delivery and Aoife's death by suicide. However the review has highlighted a number of learning points.

- Aoife was the youngest in her family and became a young carer to her mother who suffered from poor health. Research has found that young carers can experience positive impacts such as earlier maturity, life skills and a close and loving relationship with their parents. However they can also experience stress, depression, restricted social and educational opportunities and impaired psycho-social development which affects their transition into adulthood (Deardon & Becker, 2000; Gilligan and Halpenny, 2004)[2]. Research on the perspectives of young carers was conducted by Thomas et al (2003)[3] and found that even though some of them were emotionally needy, they had no desire to be rescued from their caring roles. What these findings indicate is, essentially, that a number of complex factors may combine to determine the ultimate impact of being a young carer. Thomas et al. recommend that social workers should weigh up the risks of intervention and non-intervention in such cases and should take a lead in the planning and provision of services for young carers and their families. The point here is that Aoife was never assessed in her role as a young carer, and consequently its impact on her could not be appropriately addressed.

[2] Deardon, C & Becker, S. (2000) Young Carers: Needs, Rights and Assessments n J. Horwath (Ed) *The Child's World: Assessing Children in Need,* London: Jessica Kingsley; Halpenny, A.M Gilligan and Gilligan, R.. (2004) *Caring Before TheirTime? Rsearch and Policy Perspectives on Young Carers.* TCD, Children's Research Centre, https://www.tcd.ie/childrensresearchcentre/assets/pdf/Publications/caring_before_their_time.pdf

[3] Thomas, N., Stainton, T., Jackson, S., Cheung, W., Doubtfire, S and Webb, A. (2003) 'Your friends don't understand': Invisibility and unmet need in the lives of 'young carers'. *Child and Family Social Work,* pp. 35-46.

- There is a large body of research on the impact on children of parental drug use as well as parental illness. It shows that children whose parents misuse drugs are at higher risk of a range of negative outcomes in all areas of health, safety and emotional and social development. Families where one or more parents abuse drugs are less cohesive, with higher levels of unresolved conflict and arguing. Cleaver et al (2011)[4] detail these impacts but also make the critical point that while a single issue may not detrimentally affect parenting capacity, the 'multiplicative' impact of combinations of factors may increase the risk of harm to children. To reiterate an earlier point, the impact on Aoife and her siblings of Rita's drug using behaviour and the added complication of her ill health was not specifically assessed. Opportunities for early intervention when she was a young child and later in her early teens were therefore missed.

- There is an emerging body of research on the effect of cumulative harm on children. The comment made when Aoife was young by the Vincent de Paul representative that '"While the family will always be chaotic, they are getting by" was quite telling, and was indicative of cumulative harm. Robyn Miller[5], the Principal Social Work Practitioner in the Department of Human Services in Queensland has defined cumulative harm as 'patterns of circumstances and events in a child's life which diminish a child's sense of safety, stability and wellbeing. She describes how the unremitting daily impact of 'layers of neglect' can be profound and exponential, covering multiple dimensions of the child's life. She recommends that workers should assess each notification as bringing new information, which needs to be carefully integrated into the history contained in previous reports. This case was held on duty for six years. While each concern received a response, there is no evidence that the cumulative impact on Aoife of living with an ill and drug using parent, being a young carer and in her case, missing a great deal of school, was subject to an overview and a plan of action until her mother became extremely ill and died. The point here is that repeated referrals which appear to fall below the

[4] Cleaver, H., Unell, I. and Aldgate, J. (2011) *Children's Needs – Parenting Capacity.* 2nd Edition, London: The Stationery Office.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

[5] Miller, R. (2007) *Cumulative harm: a conceptual overview.* Best interests series: Every Child Every Chance, Department of Human Services, Melbourne, Victoria, Australia
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

threshold for a child protection response need to be recognised as symptomatic of cumulative harm even if the family appear to 'get by'.

- There is evidence that this family, while not outwardly hostile, were resistant to social work intervention and hard to engage for many years. The resistance was manifested mainly in their unavailability to social workers calling. Research by Tuck (2013)[6] suggests that social workers, out of a concern to avoid labelling families and anxious to use a strengths approach sometimes fail to make a realistic view about parental deficits and can be misled by occasional episodes of disguised compliance on the part of parents. Tuck goes on to point out that family non engagement must be recognised as a significant obstacle to assessment and planning, and that practitioners should prepare for resistance by fully familiarising themselves with case histories, reflecting on the situation from the child's perspective, and examining parental motivation for avoidance. In this case, Rita was motivated by fear that she would lose her carer and Aoife had colluded with her. Motivational interviewing using the Wheel of Change (Buckley et al, 2006; Morrison 2009)[7] can be a useful strategy in a case like this. The HSE Child Protection & Welfare Handbook also provides useful guidance on dealing uncooperative behaviours. It is notable that the two social work students who were allocated the case appeared, from the record, to have a lot of contact with Aoife and Rita in the limited time they had available.

- Aoife was one of a number of young people who tragically took their own lives in recent years. Suicide prevention programmes are now provided to all HSE and Child & Family Agency staff, and can be availed of by everyone. In response to earlier National Review Panel reports, the Child & Family Agency has now committed to paying particular attention to this area. Practitioners in this case, reflecting on what happened, suggested to the review team that as well as trying to prevent what is normally considered to be risk behaviour, i.e. alcohol and drugs, practitioners working with young people should also sit down with them and go through very

[6] Tuck, V. (2013) 'Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy. *Child Abuse Review,* 22: pps 5 – 19.

[7] Buckley, H. , Horwath, J. & Whelan, S. (2006), *Framework for the Assessment of Vulnerable Children and their Families,* Children's Research Centre, Trinity College; Morrison T. 2009. Assessing parental motivation for change. In *The Child's World: The Comprehensive Guide to Assessing Children in Need* (2nd Edition), Horwath J (ed.). Jessica Kingsley: London.

basic facts, such as who their supports are, who they could contact if upset, and how they manage if they are lonely.

14. Recommendations

- The Child and Family Agency should implement one standard assessment framework that is sufficiently comprehensive to encompass the child's unique circumstances and do this in conjunction with primary care professionals and be reviewed regularly to ensure compliance with an agreed plan.

- In revising the Child Protection and Welfare Practice Handbook (HSE 2011) the Child and Family Agency might usefully incorporate guidance to the effect that repeated referrals that fall below the threshold for a child protection response need to be recognised as symptomatic of cumulative harm.

Dr. Helen Buckley
Chair, National Review Panel
21st August 2014