Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Composite review report on the deaths of five young people who were known to child protection services

July 2016

1. Introduction

This overview report presents the main issues, key learning points and recommendations from reviews conducted by the National Review Panel relating to the very sad deaths of five young people who were known to the HSE/Tusla child protection services. It was decided not to publish these reports separately and in full in order to protect the welfare of family members and communities of the young people who died. None of the reviews that were undertaken found a direct link between the very said deaths of the young people and the actions or inactions of the services provided by Tusla. The reports highlighted a number of factors, some of which were common to more than one case, which will be elaborated on in this overview.

2. The young people

The five young people who were the subject of these reviews ranged in age from 14 to 21 years at the time of their deaths. Three of them had spent time in care. One young woman had been in foster care from the time she was one year old to the age of 18, and in aftercare for a further two years. Another young woman had been in care intermittently from the age of 14 and was in aftercare at the time of her death. A third young woman was 16 at the time of her death and had been in care for a brief period up to that point. Four of the young people died by suicide and the fifth person was found dead with a high level of toxicity in her bloodstream, indicating a drug overdose.

In one case, a desktop review, i.e. a review of social work records only, was carried out as the involvement of the SWD had been relatively brief. In the other four cases, comprehensive reviews were carried out. Case records were reviewed, including material from adult mental health services and child and adolescent mental health services, social work departments and residential care facilities. Interviews were held in respect of these cases with a range of professionals, including social workers, care staff, school staff and practitioners from mental health services. Submissions were received from other health professionals. Meetings were held with the young people's families and in two cases with their former foster carers. Staff and family members were given opportunities to comment on the reports in draft format and their comments were considered when finalising the reports.

3. An overview of the needs of the young people.

While their individual family situations differed, the young people who were the subject of these reviews had all experienced difficulties at various times in their lives which had led to their referral to services. Two of them had been diagnosed with serious mental illnesses and had been hospitalised for treatment. One of these young people also misused drugs and alcohol. Two other young people had been referred to community mental health services because of attempted self-harm. A fifth young person had a disability which meant that he had special educational needs.

Two out of the five young people had experienced bullying at school to such an extent that it was regarded in each case as a serious stress factor. In one of those cases, the bullying only became known after his death. Two of the young people had grown up in situations where they witnessed domestic violence and substance misuse and had experienced a lack of stability in terms of parenting and housing. All of the young people needed support in dealing with family relationships and two of them needed assistance with finding accommodation when they reached 18 years of age. The needs of all these young people became increasingly complex as they grew up and the pressures on their carers became more intense.

4. Quality of social work services provided to the young people.

One of the young people was known to social work services for all of her life up to 20 years old. Another young person had been known for over ten years, and the other three for under two years. The reviews indicated that in three out of the five cases, the HSE/Tusla child protection and welfare services provided to the young people and their families were timely and consistent. These services included the initial response, care planning and statutory reviews as well as specific interventions and general support. In the two other cases, initial referrals received what the reviews described as slow or blurred responses, but when subsequent concerns were reported the responses became more focused and thorough.

The quality of social work assessment varied from case to case, and the impact that environmental factors had on the young people was not always fully explored. This resulted in missed opportunities for timely intervention on occasion. In two of the cases, suspicions of child sexual abuse were reported although they were not the primary reason for social work involvement. One incident involved an allegation of sexual abuse and the other involved a report of sexualised behaviour on the part of a young person. Although the SWDs responded to each report, the

reviewers were not satisfied that their assessments were sufficiently thorough and comprehensive. In one of the cases, an investigative interview had been planned for over a year and ultimately did not take place and in the second case, an incident was not explored as fully as the reviewers considered necessary.

In four of the five cases, there were no gaps in social work allocation to the young people and statutory reviews were held where relevant. While there was a certain amount of staff turnover as might be expected over an extended period, there was reasonable stability in the provision of social work services, with one young person having the same social worker from the time she was first allocated until her 18th birthday. In a fifth case, the family met ten different social workers in an eighteen month period while the case was managed by the duty service. Once the case was allocated, the same social worker stayed involved but her contact with the family was very intermittent. This made it difficult for the young person and their carer to form a trusting relationship with the service and undermined the potential for effective intervention.

In one case, the foster carers of a young person were critical of the SWD, commenting that they could not get support they required when their foster daughter's mental health deteriorated rapidly. They described the social workers as 'out of their depth… like rabbits caught in the headlights'. However, the review team found sufficient evidence to show that a high level of support was available to the foster carers and the young person, and suggest that the practical difficulties in accessing a psychological intervention exacerbated their stress. In the same case, the young person's birth parents felt that insufficient attention was given to their own needs. However, the review team while sympathetic to their perspective, ascertained from the evidence that the SWD had appropriately prioritised their daughter's needs.

It was notable that in one case the young person and in another case, their carer, showed a lot of resistance to social work intervention or to engagement with other services that they were recommended to attend. In the first case it was clear that efforts were consistently made to engage the young person in counselling and community mental health services. However, she resisted and it was difficult to see what other methods could have been tried to assist her. In the second case, however, it could be inferred that frequent changes of worker, gaps between contact and the sheer number of social workers involved in the case contributed to the resistance of the family concerned.

5. Provision of mental health services

Both the adult and child and adolescent mental health services were centrally involved with four of the young people. While the services, once secured, were attentive and consistently available, access to them varied between areas. In one case, the young person and her carers spent an upsetting and frustrating period waiting for an in-patient service after the psychiatric team had decided to admit her. The family had to return to the hospital each day for three days and wait in the Emergency Department until a bed became available. The young person was very unwell and agitated at the time which added to the distress that she and her carers were experiencing. Her carers described the service provision in that area as 'very poor' and this opinion is upheld by the reviewers. The SWD had been trying unsuccessfully to get a psychological evaluation of the young person's mental state over the previous weeks but had great difficulty getting the appropriate service for her because of her age as she was on the cusp of adulthood. When she was finally admitted to hospital, she was diagnosed with a specific disorder was prescribed a treatment programme which was not available in the area. Once she moved to a new address, however, she was provided with what was regarded as a very good quality area based HSE service.

Another young person, also with a diagnosed mental illness, requested a transfer from one inpatient mental health service to another because she had very negative associations with the psychiatric hospital to which she had been referred. She was over 18 at the time and asked to transfer her treatment to the mental health section of a general hospital but she was told that she had to remain within her catchment area. Given her vulnerability and her psychological state at the time and the very valid reasons put forward by her for wanting to change, the reviewers in that case felt her request warranted consideration.

In another case, it was noted that a poor information system within one area based mental health service meant that significant information was not picked up by staff in the same service at a different location. This information, had it been known, might have expedited interventions.

Overall, however, the reviews acknowledge that the mental health services once engaged with the young people, were responsive to their needs and in one case in particular, the CAMHS showed an impressive level of commitment and flexibility in their urgent response to a crisis.

6. Individual and shared responsibility for child protection

As expected, all of the cases required multi-disciplinary and multi-agency responses Experience has shown that while specific responsibilities for responding to vulnerable young people are held by different professional services, it is important that at least one agency has oversight in case there is any slippage. This is particularly pertinent where multiple agencies are involved and particularly where young people are referred to a SWD because of actual or suspected self-harm and the need for additional services. In one of the cases reviewed here, a young person was referred by the Gardaí because of a belief that she had attempted, or was planning an attempt, to take her own life. The duty social worker quite appropriately advised the referring Garda to request the young person's carer to bring her to her GP for an urgent referral to CAMHS. However, apart from one phone call to see if an appointment had been made (it had not) the SWD did not pursue the matter and it transpired that the young person was not referred to CAMHS for a further two weeks. This underlines the responsibility of the statutory social work services to follow up referrals to alternative services if a child is considered to be at risk.

Education services were also involved with some of the young people. In one instance, a school reported a concern about suspected child sexual abuse but seemed unclear about its precise remit under Children First in terms of investigating and sharing written information with the SWD. In contrast, there is another example of positive collaborative work where a joint response to an incident of self-harm was made by education, mental health and social work services.

7. Provision of out of home care.

Three of the young people were in care, one since she was an infant and two others since their early to mid-teens. In one case, what had been a very stable placement became strained by the young person's deteriorating mental health and her frequent attempts at self-harm. The SWD sourced an alternative placement for her that seemed to meet her needs at the time and continued to provide support to her when she reached adulthood until the young person herself decided to terminate social work contact.

One of the other young people, who was later diagnosed with a mental illness and also misused drugs had four separate placements between the ages of 14 and 18, most of which were in hostel type accommodation. She found it difficult to settle and tended to go back home after periods in care, only to return to the SWD requesting further placements when her relationship with her carer

deteriorated again. At her fourth admission, she was placed in a long term residential unit where she did well for a number of months but left after a year and a half. When in aftercare, she was assisted with accommodation and her aftercare worker advocated strenuously on her behalf to get funding for housing. She was assisted to move into a flat, but was unable to manage on her own, and other options were very limited. She spent some time in a women's refuge and ultimately was offered a place in a unit that was part of the homeless service which was the only option that the housing department could offer her. This service, while supportive to her, was not entirely appropriate for someone with her level of need and dependency.

The third young person was in care for a very short time before she took her own life. The reviewers were satisfied that her carers were adequately prepared for the placement and that everyone involved did their utmost to keep her safe. Tragically, her own determination to end her life thwarted their efforts.

Some issues about family contact arose in respect of two of the young people in care. In one instance, the young person had a number of siblings in different care settings. Contact was difficult to manage for a number of logistical and child protection reasons and the reviewers were impressed at the level of detailed planning that took place both before and after each family access meeting. In another case, the young person who was 16 years old and in foster care wanted to have contact with a particular family member but her birth parent would not permit it. This caused the reviewers to raise the issue of consent for young people in care in respect of family members whom they wanted to meet.

Statutory Child in Care reviews were held regularly in respect of two of the young people in care. The third young person was only in care a short time before she died. A review had been planned to take place six weeks after the start of the placement and while the timing was within the regulatory requirements, the reviewers suggested that given the circumstances in this case, where the placement was made with some urgency, it would have been better to convene the review within days rather than weeks.

A particularly sensitive issue arose in one case which highlighted the need for a protocol in the event that a child or young person over 18 who has been in care dies so their own wishes with regard to communication of information and other arrangements are known and respected. A recommendation was made accordingly and is included at the end of this report.

8. Aftercare

Two of the young people were over 18 at the time of their deaths. Although the handover process from mainstream social work to aftercare was less than adequate in one case, the reviewers in both cases found evidence that the young people each received very consistent, regular and supportive social work services in aftercare. The aftercare workers in both cases appeared to be skilled in negotiating the changed relationship between state services and young people once they reached 18 years and each seems to have forged a trusting connection with the young person concerned. One of the young people chose to terminate her relationship with the aftercare service when she was 20, as was her right, but she was assured that the service would be available to her should she decide to engage with it again.

There was, however, a shortage of appropriate accommodation for young people who are leaving care and have mental health difficulties. This caused a lot of stress to the young people concerned and affected their confidence. Neither of them was really competent to live on their own but found themselves very isolated at different times even with the supports available in the community.

9. Summary of key learning points from the reviews

The review reports identified a number of learning points from the different cases which are summarised below

- Central to good practice is the need to complete a comprehensive assessment of the child and family in a timely manner. This should take account of the multiple adversities such as domestic violence, substance abuse, poor mental and physical health, that can impact on parenting capacity. It must be recognised that inadequate assessment undermines the potential for effective planning.
- Schools should not have any ambiguity about the process to be followed in relation to the immediate transfer of relevant information to the SWD where there are issues of child protection. Children First (2011, 5.2.2) guidelines are clear that, whilst issues relating to child protection may be initially followed up by another agency or professional closely involved with the child or family, the outcome of such inquiries must always be reported without delay to the SWD. The SWD cannot discharge one of its core statutory duties to establish whether a child is receiving adequate care and attention, without access to this information.

- Suspected sexual abuse or sexualised behaviour involving children requires a proportionate response. Sexualised behaviour is viewed along a scale from normal/healthy to problematic to harmful (Boyd and Bromfield, 2006)[1]. Research has shown that adolescents who abuse other children are likely to be isolated and to suffer from anxiety, depression and suicidal thoughts (Pritchard, 2004)[2]. They are also likely to have problems in school both in terms of attainment and behaviour as well as poor attachments. Inappropriate sexual behaviour by teenagers involving younger children needs to be thoroughly assessed. If it is considered to be problematic, early intervention is essential in order to prevent fixed patterns of behaviour becoming established and to reduce the risk to both the adolescent and younger children.

- Bullying can have a serious impact on a young person and can lead to depression, anxiety and aggression in young people. Research undertaken by Katz et al., (2002)[3] has shown that some young people can misuse drugs and alcohol as a response to bullying.. The point at which bullying arises in a school environment requires a response beyond the normal procedures operated in the education setting needs careful consideration. Its impact needs to be understood and judged within the context of the child's experience which includes both their personal vulnerability and their resilience.

- Research indicates that physical and mental health problems can increase on leaving care[4]. This highlights the need for a comprehensive handover process to be in place between mainstream social work and aftercare services and for communication of full information about a young person and any risks to which they are exposed to.

- The concept of resistance from young people and families to social work intervention has been the subject of research, a key message being that workers need to understand that they themselves may be contributing to the process of resistance, and that the development of certain communication styles can be very effective. For a useful briefing

[1] Young people who sexually abuse: Key issues by Cameron Boyd with Leah Bromfield http://www.aifs.gov.au/acssa/pubs/wrap/w3.html
[2] Pritchard, C. (2004) *The Child Abusers: Research and Controversy*. Maidenhead: Open University Press
[3] Department for Children, Schools and Families (2009) *Safe from Bullying of Children's Homes*. London: HMSO.
[4] Tusla (2014) Alternative Care. *Practice Handbook*

document on meeting the challenge of resistance, see *Resistance, a complex challenge for practice* by Lindsay Robb[5].

10. Recommendations

The reviews which are the basis for this composite report have made a number of recommendations which are summarised below

- When a referral is made to the SWD of a child who has self-harmed or is likely to self-harm, the child or young person should be considered to be at risk until the case has been assessed by CAMHS. The SWD have a responsibility to check that, following referral, contact has been made with CAMHS. It should also check that any relevant information from SWD or other agency sources has been accessed (as would be the case with any referral of a child at risk), and that any necessary follow up by the SWD has been discussed with CAMHS.

- It is recommended that the foster care training and foster carers' contracts should include a section on the appropriate steps to take if a child or young person in care or aftercare dies. This should include a protocol for communication with the child or young person's birth parents and other family members. It should also cover communication with staff that have currently or recently worked closely with the child or young person and may be involved with their siblings or other family members. The option of nominating a liaison person to manage the process of notifying relevant parties of the bereavement should be considered. It is also recommended that this matter is included the Tusla practice guidance on working with children in out of home care when it is being reviewed.

- It is recommended that young people leaving care are helped to understand the advisability of documenting their own wishes regarding the arrangements they would like to see in place if they are no longer able to manage their own affairs, or in the event of their deaths.

- While Tusla has no jurisdiction over the provision of mental health services, this composite review has highlighted some difficulties, particularly for young people suffering from diagnosed mental illness who are about to enter, or have entered aftercare. These include the dearth of suitable accommodation, inconsistent access to mental health services and

[5] http://withscotland.org/exchanging-withscotland-briefings?utm_source=WithScotland+Newsletter&utm_campaign=85e82bc54b-October_201410_7_2014&utm_medium=email&utm_term=0_9c936327ef-85e82bc54b-412073733

limited treatment options. It is recommended that Tusla, through the Children First Interdepartmental Committee or another suitable channel, continue to press for a resolution of these matters'.

Dr. Helen Buckley,

Chair.