



Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

**Review in respect of a young person who died while in the care of
Tusla**

Declan

Executive Summary

2020

1. Introduction

This review is concerned with the tragic death of a child in his mid-teens, referred to here as Declan. He had been known to HSE Child and Family Services since his birth and was admitted into the voluntary care of Tusla at 14 years old. Declan died of an accidental overdose whilst in the care of Tusla. The review was conducted by Eamon McTernan and Ciara McKenna-Keane, panel members, with oversight by the Chair of the NRP, Dr Helen Buckley.

The terms of reference for this review were as follows:

- To review the quality of services provided to Declan by the Tusla in order to determine if an act, or failure to act or to make a referral, was a contributing factor to Declan's tragic death.
- To examine and review the role played by the Tusla in the management, assessment of need, and care planning of Declan's case from his birth until his tragic death.
- To examine and review the roles played by other services, as well as the quality of multi-agency co-ordination in assessing and in planning to meet Declan's needs before and during his time in State care.
- To determine compliance with relevant national and local standards, policy and procedures.
- To identify and commend positive practice.
- To gain an understanding of the risk factors to which children like Declan are exposed.
- To identify the opportunities for learning and improvement, arising from the review, by identifying both local and system wide strengths and weaknesses. Policy and practice areas which are of particular relevance in this case include, but are not limited to:
 - a) the Social Work Department's ('SWD') threshold for child care social work intervention with the family;
 - b) the SWD's processes for matching the needs of children and young people to residential functions;
 - c) the SWD's processes for accelerating concerns regarding Declan internally and accessing Special Care provision;
 - d) the National Special Care Referral Committee's processes for managing and prioritising referrals, which are on the waiting list for special care;

e) the management of the interface between the SWD's child care services and education, youth justice, and disability services.

- To prepare an objective and impartial report for presentation to the Tusla.

2. Declan

Declan has been described as a handsome boy with sparkling blue eyes who loved animals, especially dogs and horses, sports including boxing, music especially guitar playing and writing and performing raps, cooking and DIY. He had ambitions to be a horse-racing jockey. He was willing to engage in prosocial activities, such as volunteering in animal sanctuaries. He is recounted as being a storyteller, as having a great sense of humour, and as being full of energy. He liked to dress and look well. He is also described as being capable of demonstrating physical affection, warmth and kindness. He was known to be generous and to have 'given the coat off his back to a stranger who needed it'.

However, Declan was also an extremely vulnerable young person who had a difficult start in life. His underlying communication and comprehension difficulties, and physical frailties, are addressed in detail in this report. Several interviewees noted that he was adept at masking his physical and intellectual deficits to others, leading them to believe, incorrectly, that he was more competent than he was. The report records, for example, that he was able to survive for periods of days living on the streets, in very dangerous circumstances, and could travel considerable distances by 'jumping' trains. Declan posed considerable challenges to those who worked with him, because he had such a limited understanding of the consequences of his actions. The term 'risk-taking' is used frequently in this report to refer to his lack of awareness of extremely hazardous situations. He was easily influenced by peers. He was drawn into anti-social, mal-adaptive and criminal behaviour. While he was generally well liked by those who worked with him, he could also be threatening and aggressive to those who cared for him.

3. Summary of Declan's needs

In the early years of his life, Declan's developmental needs, as well as the additional needs of other siblings and his parent's capacity to respond to these needs, required comprehensive assessment and monitoring. The inputs of the SWD and other key services, principally CAMHS, HSE Disability Services, community support services, and his school, needed to be integrated into a multi-disciplinary plan for family intervention at the point of delivery.

As Declan became older, it was vital that the generic diagnosis of ADHD and MGLD (mild general learning disability) made in his ninth year, could be supplemented by a) a full understanding of his specific communication and comprehension difficulties, b) the provision of tailored services, including speech and language therapy, to address these, and c) a greater understanding of parenting capacity, parenting style, parenting ability to change, family dynamics and associated attachment issues. The coordination of inputs from a number of services through a multi-disciplinary plan was essential.

In early adolescence, Declan required the provision of alternative care by Tusla. The selection of his care setting needed to be based on a comprehensive assessment of all of the factors outlined above, and the capacity of staff/carers, in liaison with clinical services such as CAMHS and ACTS¹, to work on his specific developmental needs. The provision of education and family contact management was particularly important in this case.

The review team was told at interview that, as Declan's maladaptive behaviours escalated, he needed to be accommodated in a structured and predictable environment where a) his specific communication and comprehension needs could be catered for in a clinically-led manner, b) his interaction with peers could be managed, c) diversionary activity could be provided, and d) he had access to education. Work in the areas of sexually harmful behaviour and attachment was also indicated. This required a high staff/carer ratio. All the indicators were that this environment had to be residential in the first instance.

4. Summary of key events and analysis

Declan's physical health was fragile from birth, and he required multiple hospital admissions in his first two years of life. His parents describe behavioural management issues from a very young age. He received a diagnosis of ADHD, with noted impulsivity, MGLD and severe language and communication difficulties whilst at primary school. At that time his ability was assessed as falling within the exceptionally low range. The review team was advised that an accumulation of factors resulted in a level of functioning disability which was more significant than the formal diagnosis.

The capacity of his family to mitigate these factors was limited, and Declan's parents struggled to manage him as he became older. The family was well known to the SWD, which oversaw a number of inputs through its SWD duty service. Declan's parents had to cope with a number of adverse events over the years, involving several of his siblings. The family was allocated a family support worker to

¹ ACTS (Assessment, Consultation and Therapy Service) is a national specialised clinical service which provides multi-disciplinary consultation, assessment and focused interventions in young people who have high risk behaviours associated with complex clinical needs.

assist with practical child-minding and home maintenance, however, the majority of SWD interventions were short term responses to periodic crises. Whilst some work was done in respect of individual children, the family did not have an allocated social worker during this time.

The review team notes that Declan's parents were selective about their uptake of the services offered to them, utilising some services of a practical nature (such as respite care) but reluctant to get involved with those which required them to re-evaluate their approach to parenting (such as behaviour management). Declan was seen by CAMHS but his failure to attend appointments, which was due to a lack of parental uptake and geographic isolation, meant that CAMHS input into the case was limited. The review team concludes that both the SWD and CAMHS missed the opportunity to address Declan's communication and comprehension needs at the time of diagnosis.

As Declan approached adolescence, the social work files record the increasing concerns expressed by his school and by the Gardaí about his behaviour. Declan had, by this time, well-established traits of impulsivity, poor problem-solving and insight, limited understanding, and social naivety, which resulted in him placing himself and others at significant risk of harm. This led to his parents determining that they could no longer cope with his behaviour.

Following his placement in the voluntary care of Tusla at the age of 14, Declan experienced nine residential environments over a period of 26 months (including the Children's Detention Centre), prior to his tragic death.

The report records how the 'piecemeal' approach adopted by the SWD over the years in its work with this family resulted in a limited appreciation of Declan's underlying struggles with comprehension and communication (despite further clinical assessments in his first residential unit), and a limited understanding of family dynamics. It is not at all clear whether Declan understood why he had been first placed in care.

Declan's first residential placement required regular family contact at weekends, but contact arrangements soon broke down due to the volatility of family relationships. The review team has concluded that, whilst his parents remained committed to him and worried about him constantly, the possibility that Declan would return to live with his family was very low, and the residential care system was ill prepared to cope with his existing and emerging needs.

Following his entry into the residential care system, the SWD was unable to organise a comprehensive assessment of Declan's needs in a timely manner. His social worker attempted, unsuccessfully, to engage the Assessment, Consultation and Therapy Service (ACTS) at several points in his care career prior to his period in detention.

Declan's first placement, which was in a Tusla residential unit, ended when staff concluded that they could not keep him safe because of his increasingly disruptive behaviours, including regular absconding and his involvement in anti-social behaviour and criminality. School worked reasonably well for him. Both his parents and the Gardaí expressed concern regarding his exploitation by local drug dealers at the time. He was subsequently deemed unsuitable for Tusla mainstream residential care, with the result that he had to be accommodated in placements contracted by Tusla in the private sector.

Declan's next three placements were set up as short term 'holding' placements, pending an application for special care. These placements struggled, to varying degrees, due to limited understanding of his underlying comprehension and communication difficulties, and their inability to keep him safe. It was not possible to organize educational placements for him. Staff in all three units noted his child-like presentation and vulnerability, and very limited awareness of risk. One unit achieved a measure of success in engaging with him and reducing his exposure to risk. The containment of Declan's high-risk behaviour, rather than the management of his disability needs, quickly became the dominant consideration in planning, which was crisis-driven.

Declan's application for special care, which would have provided both containment and specialist assessment, was initially accepted by the National Special Care Referral Committee (NSCRC). However, Declan was not admitted because of a lack of available placements. After three months, Declan's place on the waiting list was withdrawn by the NSCRC as his behaviour was deemed to have improved to the degree that he no longer met the threshold for special care. The review team considers this decision to have been taken prematurely and prior to the full assessment of Declan's underlying needs. It was taken during the short 'window' in time, referred to above, when staff in one of the holding units were successful in momentarily diverting Declan from risk taking behaviour.

The review team notes that Declan's fourth private sector placement, which replaced the option of special care, was problematic in a number of respects, including poor planning, inexperienced staff, the absence of specialist assessment, and an overemphasis on incident management. This placement was unable to meet his generic need for safety management, or his specific disability needs. The review team notes that school was recognised as a stabilising and engaging environment for Declan. The SWD was unable to facilitate Declan's access to a suitable school during this placement, despite engaging in a section 29 appeals process with the Department of Education and Skills. The records show that Declan's exposure to risk remained very high during the course of this placement. His escalating criminality meant more frequent appearances before the courts, and a shift from the care system to the youth justice system in the overall management of the case.

Declan had been subject to a number of short remands to the Children Detention Centre before his eventual conviction and six month detention order. The review team notes that the Children Detention Centre provided a physical and therapeutic environment which met his needs. This was facilitated through the specialist multi-disciplinary assessment (ACTS) service which he was able to access in the Detention Centre. The ACTS team was able to draw on a number of clinical assessments already in the system, to identify Declan's specific communication and comprehension needs, and to take the lead on a structured approach to working with him (including access to school). There is a consensus amongst the professionals interviewed that he did well in detention. The review team notes the previous unsuccessful attempts by Declan's social worker to refer him to ACTS, and concludes it unacceptable that Declan had to meet the threshold for sentencing in order to access this service.

The ACTS team continued to provide support when Declan was released from detention, however, continuity planning between Tusla and the Children Detention Centre was limited. Upon his release, Declan was once again placed in short term holding placements commissioned by Tusla. This included two placements in the private sector, and a placement in an emergency hostel for young people, utilised when no other provision could be sourced. This was the most basic level of emergency care available to the SWD, albeit supplemented, in Declan's case, by an additional personalised daytime 'wrap around' service. One professional from the ACTS service described the emergency hostel as the opposite environment to that which Declan needed to build on the progress achieved whilst in detention. His behaviour deteriorated. The review team concludes that Declan's resumption of excessive risk-taking behaviour led to the circumstances of his accidental death.

Declan's risk-taking behaviour was on an upward trajectory before he entered the care system, as a result of his family's inability to manage his disability needs. The review team has considered evidence that Declan's emotional and behavioural difficulties increased rapidly after he entered the care system. A feature of this was his heightened exposure to the risk of significant harm, including his engagement in high-risk maladaptive behaviours, his vulnerability to the negative influence of peers, his drug and alcohol abuse, his involvement in anti-social behaviour and criminality, his harmful sexual behaviour, and his exposure to the physical risks associated with persistent absconding and his underlying medical condition. The late recognition of Declan's limitations as a result of his disability meant that, in the opinion of the review team, he was bewildered and vulnerable as an adolescent in the residential care system. It is easy to understand why Declan's safety became the primary consideration for residential care staff. However, Declan's inability to understand the sanctions, constraints and deterrents, which were deployed to try to keep him safe and to protect others from

the consequences of his actions, meant that these sanctions, constraints and deterrents were ineffectual.

5. Summary of findings and conclusions

Declan was a child whose complex needs were neither fully understood nor met in a coordinated way by the services he was engaged with. This review has concluded that Declan was a child, with a significant level of functional learning disability, the extent of which was masked for much of his life. Neither his parents nor Tusla, in its role as corporate parent, was able to manage his propensity to place himself at risk. Declan's complex needs profile meant that his case occupied an ambiguous policy space between services. This delayed his assessment, care planning and treatment. This review highlights the consequences of service-based gatekeeping, the lack of specialist care provision and poor inter-agency coordination. Declan experienced prolonged and repeated exposure to risk before and during his period in the care of Tusla. All of these factors contributed to the circumstances of his tragic accidental death.

The major difficulties identified in this case were caused by systemic problems within the Child and Family Agency, and by underdeveloped multi-agency working arrangements and protocols. The obstacles faced by staff were wider than the quality of day to day work with Declan. The report points to areas where practice and management must be improved. It is important also to note that the full report of this review identifies examples of very good and committed practice, in social work, youth work, in residential care and in the Children Detention Centre, including ACTS staff. In particular, one social worker's management of Declan's case is commended.

The review team's conclusions may be placed broadly into three main categories: (1) the SWD's assessment and provision of services with respect to children who pose a risk of significant harm to themselves; (2) the shortcomings in SWD service design and provision for children with complex needs who require multi-disciplinary care; and (3) the SWD's assessment and provision of services with respect to families who exhibit 'compromised parenting' but who do not reach the current SWD threshold for child protection intervention.

Children who pose a risk of significant harm to themselves

- Neither Declan's parents nor Tusla, in its role as corporate parent, were able to understand or manage his propensity to place himself at risk, which was a maladaptive response to his cumulative disability;

- There was an avoidable delay in instigating a comprehensive assessment of Declan’s multiple needs in his early years and upon his entry into care, which led to a poor understanding of his cumulative disability and insufficient information upon which to plan adequately for his care;
- After Declan’s reception into care, the SWD complied broadly with the minimum requirements of the Child Care Regulations, but its use of Child in Care Reviews did not match the escalating circumstances and needs of the case, leading to incomplete assessment and reactive rather than proactive contingency planning;
- Declan’s needs profile required a multi-agency response and formal engagement between the SWD and disability, mental health, special care, educational and youth justice services; however, care planning, supervision and management was broadly unidisciplinary, with poor attendance by key partners at the lead planning forum, the statutory Child in Care Reviews;
- Clinical information regarding Declan’s needs profile – his cumulative disability, his communication issues, his need for a containing and predictable environment (including schooling), and his family issues - was available to the SWD within months of his entry into care but was not aggregated into a single integrated plan for his care;
- The option of special care was withdrawn from Declan before enough work had been completed to assess his underlying needs. The NSCRC (referrals committee) misread a short-term improvement in behaviour, as an indicator of underlying progress. As a consequence, the SWD lost an opportunity to assess those needs in a structured and predictable care environment, and to plan appropriately;
- The challenge of reducing the scale of Declan’s worsening exposure to significant risk was an immediate practical problem while he was in care and led to crisis-driven transitional placement planning. The absence of planning and design around appropriate residential care provision for a child with his care profile is a major systemic deficit (see further below); and
- Declan’s prolonged and repeated exposure to risk, before and during his period in care, was a contributory factor to the circumstances of his tragic death. Children with needs profiles similar to Declan, require crisis management provision precisely because the risk of significant harm as a result of their behaviours is unacceptable.

Service design and provision

- The major difficulties identified in this case were caused by systemic problems within the CFA, and by underdeveloped multi-agency working arrangements and protocols. The challenges were wider than the quality of social work practice. There are examples of very good and

committed social work practice, and other areas where social work practice and management must be improved;

- The SWD system was unable to support processes to enable social work practitioners to access and integrate clinical referrals, and referrals for services from other agencies, into their assessment of the child's needs and into the care planning process. This required individual advocacy by the allocated social worker;
- Care planning, supervision and management was unidisciplinary with inadequate levels of formal engagement between the SWD and disability, mental health, special care, educational and criminal justice services, resulting in:
 - A lack of integrated data around how to respond to the overlapping needs of a cohort of children with similar profiles to Declan known to or in the care of the State. There is evidence of a cohort of children with complex needs profiles who are disproportionately represented within the care, mental health, and youth justice sectors;
 - A divergent, inflexible and ultimately counterproductive approach was adopted by each discipline with respect to the criteria used to access their services. This excessive 'gate-keeping' includes the requirement to fit a narrow definition of disability (HSE Disability Services); the requirement for parental compliance and to be within proximity to the clinic to which one was first referred (CAMHS); the requirement to be referred to special care or to be in criminal detention (ACTS); the requirement to be at greatest need at the point at which a bed becomes available with no account taken for temporary behavioural shifts and cycles (special care); the requirement that educational facilities must meet the needs of a child referred during the school year, within their existing resource allocation, and can refuse a referral on that basis (education); and the temporary severance of the care relationship between the child and the SWD while the child is in detention (youth justice); and
 - A general lack of, or delayed access to, special care beds, and a lack of alternative specialist residential provision;
- The dearth of residential care units within the community designed to meet the needs of this cohort of children, and the failure of the Tusla central referral system (CRC) to make provision for these children, led to an overreliance on private placement providers. The system became immobilised, since the type of placement assessed to meet Declan's needs was not available; and

- The systems for the escalation of individual cases, including ‘missing from care’ and need to know notifications, are ill-defined and do not necessarily trigger or require further action by senior management, or address the underlying paralysis in the care system.

Families who remain on the margins

- The SWD’s lack of capacity and resources had a knock-on effect, including an extremely high threshold for social work intervention, which meant that a family identified as having a multiplicity of needs (children with complex needs, compromised parenting, concerns about physical and sexual abuse and neglect, a fear and reluctance to engage, and trauma) was never comprehensively assessed and remained unallocated;
- The SWD was not compliant with its statutory duty to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to be able to give, adequate protection and care.² The SWD failed to assess parental capacity and family functioning for most of Declan’s childhood, despite the accumulation of specific and general concerns. This resulted in the case being categorised as ‘child welfare’ in the absence of a family assessment;
- Staccato interventions were crisis-driven and not based on social work assessments of the individual child or the family as a whole, as per Children First;
- An over-reliance on the SWD Duty Service meant planning for the family, and for the individual children, lacked coordination, structure and consistency, and the resulting supports and services could be opted out of by the parents; and
- The SWD, as the lead agency in planning for Declan’s care, was unduly optimistic in its management of the case by virtue of its insufficient assessment of, and engagement with, the family. This meant that there was insufficient family contact planning and a very little realistic chance of Declan returning home after his first admission to care.

6. Summary of learning points

In addition to reaching conclusions on the quality of practice and policy in this case, the review team has identified the following points for learning.

Cumulative referrals of compromised parenting

² Section 8(2) of the Child and Family Act 2013

Declan's family were well known to the SWD for some 17 years before he came into care. The SWD operated a high threshold for access to its child care social work service at the time, and episodic social work inputs were short and very limited in scope. Families with consistent low to medium level visibility require assessment. Evidence from Serious Case Reviews in the UK, and other research concerning the needs of children who do not reach the threshold for a statutory child care response, indicate that the risks to children from 'compromised parenting' can be as severe as the risks to children who are in the formal child care system.³ These families tend to be characterised by emotional abuse or neglect and, while they appear on a surface level to cope, the children are very vulnerable to the long term effects of this abuse. Such cases rarely receive intensive or coordinated interventions. Domestic violence, mental health and alcohol/substance abuse are typical contexts (see also Recommendations).

Assessing the child and the family

The review team has noted two instances where allocated social workers reported that their work briefs were to focus on the needs of individual children and not on the needs of the family as a whole. In the first instance, there was reluctance on the part of the SWD to engage with the whole family because the family did not meet their allocation threshold. In the second instance, the Children in Care Team policy at the time, which has since changed, did not encompass a whole-family approach. Opportunities were missed, in both instances, to trigger an assessment of the whole family context. One of the principles underpinning the Children First guidelines states that intervention should not deal with the child in isolation, and that the child must be seen in a family setting. This case highlights the need to further develop SWD's understanding of 'seen in a family setting'.⁴

Family support programmes – measuring change

Declan's parents were offered a number of family support services over the years. The report indicates that they accepted those which they perceived as practical (for example, respite, a family support worker, and a youth support worker) but were not motivated to engage with those which required self-reflection or a change in parenting style (for example, the Incredible Years and CAMHS parenting

³ Morrison T et al

⁴ Children First 1999; Principle (vii) and Children First 2009 5.27

programmes). The deployment of these family support services was largely uncoordinated, and no overview of the overall effectiveness of family support provision was undertaken. There is a need for Tusla to develop a consistent practice-based framework to assist practitioners, managers and service-providers to review the effectiveness of family support services. This should draw upon a 'mixed methods' approach to evaluation, incorporating service user experience, existing outcome measures, and clinical evidence.

Understanding cumulative disability and maladaptive responses

This report has highlighted the differential between Declan's diagnosed level of MGLD, and his actual level of functioning. Declan's developmental trajectory featured a cumulative overlay of factors, including comprehension and communication issues, which pointed to a greater level of disability than was formally scored. His adaptive functioning was, therefore, lower than that of a MGLD, and resulted in a pattern of high-risk and anti-social behaviours. A consequential mismatch between his diagnosed and functional disability resulted in a lack of access to key services, inappropriate care placements, crisis-led planning, and criminality, which eventually shifted focus from the care to the youth justice system.

Communicating with children with learning disabilities

This report has demonstrated Declan's inability to make sense of the environments in which he found himself. He was unable to comprehend the consequences of his actions, to understand warnings around his behaviours, or to comprehend the meaning and purpose of deterrents. The constraints, which were placed upon him, were destined to fail since he could not understand them in order to respond positively to them. This highlights the need for front-line staff in both community and residential settings to have access to a repertoire of communication tools, such as visual and activity-based programmes of work, when working with children with a learning disability.

Accountability for integrated care planning for children with high levels of need

Declan's case fell into the gaps between services and agencies. This fundamental service deficit was recognised by both practitioners and managers, who felt powerless to do anything about it. It is essential that practitioners are enabled to draw attention to children whose care is jeopardised in this way, and that pathways for the design and implementation of individualised multidisciplinary care

plans are strengthened and developed. There needs to be greater professional accountability by the SWD in relation to the planning of comprehensive assessments within the care planning process. This needs to be supported by guidance and multi-disciplinary protocol on how to undertake commissioning and implementation. This report identifies a number of specific areas for action (see also Recommendations).

Consistency in models of care used by residential providers

Declan passed through nine residential environments over a period of 26 months. The review team acknowledges that the challenge of matching a care model to Declan's needs was compounded by limited assessment, and the crisis-driven selection of residential placements. The team was told that some units applied specific care models to their work with Declan, whilst others appear to have adopted a more reactive approach. This meant that Declan had to negotiate multiple care regimes. The review team has reflected on the need for consistency in the care models adopted by the different units for children who experience 'transient' multiple placements. The care models that worked best for Declan were those which included resilience-building through activity, an emphasis on communication, and an emphasis on 'buy in' by the child.

Reporting systems - over emphasis on behaviour or incident management

Declan presented a very complicated profile of need, which was dominated, in practice, by his need for safety and which obscured his cumulative disability needs. The review team accepts that staff tasked with his day-to-day care were extremely conflicted, and that Declan's safety was their paramount concern. However, Declan's safety could not be delivered through an emphasis on his maladaptive behaviours but had to be balanced with responsiveness to his communication, comprehension and problem-solving challenges. Tusla's formal residential care reporting system was dominated by the reporting of discreet individual incidents. There was a poor level of SWD data analysis, or commentary, with respect to the residential units' reports. An uninterrogated emphasis on incidents and events can feed into crisis-led planning, which is ineffective in delivering either child safety or enhanced wellbeing.

Advocacy for children in care – the role of independent youth support services

Two community-based youth support providers delivered personal independent support to Declan. Staff from these agencies were able to add value to the work with him in ways which were difficult to achieve for staff in his regulated care environment. There is evidence that Declan perceived this

support as an independent resource for him and that he engaged very positively. Towards the end of his life, the work undertaken by one youth support worker across several placements, became a valuable resource for other professionals in planning for his care.

Role of child in care reviews

The review team has identified three areas where the role of Child in Care Reviews requires further guidance and strengthening (see also Recommendations):

- a) **Commissioning comprehensive assessments.** The consequences of a prolonged delay in accessing a multi-disciplinary assessment for Declan were significant. The review team has concluded that a key weakness in the commissioning of comprehensive assessments is a lack of accountability;
- b) **Complex 'unsettled' cases.** The frequency of Child in Care Reviews should be determined primarily by the needs of the child, and not by a requirement to adhere to the minimum statutory time frames. In cases, such as Declan's, the Child in Care Reviews process needs to be responsive to all significant changes in the circumstances of the child; and
- c) **Managing time-limited high intensity placements.** This report has shown that Child in Care Reviews did not feature in the decision-making in relation to two high intensity placements i.e. special care (not accessed) and the Children's Detention Centre. Major decisions such as seeking a special care placement or determining that a special care placement was no longer necessary, are not discrete or separate events and need to be considered within the statutory Child in Care Review process.

7. Recommendations

The review team recognise that Tusla, as the Child and Family Agency, will not be able to action the inter-agency and inter-departmental recommendations set out below, without a whole of government commitment and, in particular, leadership from the Department for Children, Disability, Equality and Integration. These recommendations are not novel, and the reforms proposed have been highlighted in previous NRP reports on children in care, for example, Ben (2013) and Luke (2014).

Recommendation 1: Review of the operation of thresholds for service allocation

The extremely high threshold for social work intervention in this case meant that a family identified as having a multiplicity of needs (children with complex needs, compromised parenting, physical and

sexual abuse, neglect, a fear and reluctance to engage, suicide and trauma) were never comprehensively assessed and remained unallocated for prolonged periods of time.

It is recommended that Tusla develop a consistent practice-based framework to assist practitioners, managers and service-providers to review the effectiveness of family support services where these are provided to support families characterised by compromised parenting. This should draw upon a 'mixed methods' approach to evaluation, incorporating service user experience, existing outcome measures, and clinical evidence.

It is further recommended that Tusla develop a framework for estimating unmet need in the community and risk assess its threshold policy for allocating social workers to child care cases.

Key aspects on this project should include:

- a. An international literature review on threshold management in childcare systems;
- b. Quantitative and incidence data in Ireland (including regional variations);
- c. Policy assessment (including Signs of Safety, Meitheal, and HIQA);
- d. Sample risk assessments; and
- e. Proposals for monitoring and review.

Recommendation 2: Accessing multi-disciplinary assessments

There is a need for greater professional accountability by SWDs in relation to the planning of comprehensive assessments within the care planning process.

The National Standards for Children's Residential Centres 2018, refers to having an appropriate evidence-based assessment of a child's needs, and providing effective interventions to meet these needs, in order to enhance the lives of children in care.

It is recommended that Tusla, as the lead statutory agency for planning for children in care, develop policy and managerial guidance on how practitioners can access/commission timely multi-disciplinary assessments. This guidance needs to be backed by protocols with other services to ensure responsiveness to assessment requests and swift interventions.

Recommendation 3: Quality of care planning in complex cases

This case demonstrates why care planning needs to be a more influential and robust process, and why Tusla must have more effective management and accountability frameworks in place to ensure that

it is fully implemented for every child. This is required in order to adhere to both national⁵ and UNCRC⁶ guidelines.

It is recommended that Tusla review the procedural guidance for Child in Care Reviews, to account for the escalating circumstances and needs of more complex cases. In particular, the review team considers that the chairing arrangements for complex cases should be set at a higher managerial level than social work team leader, as these cases require both a greater degree of detachment from practice, and a higher organisational profile, to appropriately address risk, service coordination, and resourcing requirements. Practice in care planning should be benchmarked and monitored against this reviewed procedural guidance.

It is further recommended that this review include the development of practice guidance on care planning for children with disabilities as well as protocols for ensuring multi-agency inputs, and the timely implementation of comprehensive assessments, as stated above.⁷

Recommendation 4: Special care provision and management

Tusla, along with the Department for Children, Disability, Equality and Integration, need to review urgently the level of provision of special care placements in the State, and the process for accessing special care placements, so that children who require special care can access it when they need it most.

It is recommended that special care provision is expanded, and therapeutic step-down placements are developed in order ensure a continuity of care for these children and young people. Once a child is approved for special care, decisions in respect of special care should be transparent and should be taken at a formal Child in Care Reviews.

Recommendation 5: Needs profiling of children in care

⁵ Tusla has a statutory duty, as lead agency, to ensure that care planning is implemented. Standard 3:2 of the National Standards for Children's Residential Centres 2018, requires that children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability. Care planning is the formal vehicle through which an assessment of need can be convened, and planning measures reviewed, with partner agencies. This needs to be understood as an open, on-going, creative and accountable process.

⁶ The State is obliged to implement the rights of the child. Article 25 of the UNCRC states that 'State Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement'.

⁷ See also NRP Annual Reports 2018 & 2019

There is a lack of integrated data regarding the overlapping needs of a cohort of children with profiles similar to Declan, who are disproportionately represented within the care, mental health, and youth justice sectors.

It is recommended that Tusla, in partnership with other key agencies and departments with responsibilities for children, develop a comprehensive national database, which aggregates the needs profile of the care population to facilitate strategic planning, including models of care and specialist provision, for children in care with a multiplicity of needs.⁸

A common multi-agency, multi-departmental database would:

- a. Be child centred, based on children's needs and rights;
- b. Identify cohorts of children whose needs require specific multi-disciplinary responses;
- c. Facilitate recognition of patterns of need for children in care and the responsibilities of different agencies;
- d. Facilitate protocols & shared statistical profiling between key agencies within Department for Children, Disability, Equality and Integration, the DOH, the DES and the DOJE to track the trajectories of children in care who traverse through and across systems; and
- e. Provide a consistent baseline for measurements of outcomes for children in care.

This case has once again raised the issue of the lack of hard information about the prevalence of learning disability in the care population. It is recommended that Tusla address this question within the above action and develop its policy accordingly.

Recommendation 6: Children in care at risk of significant harm

Tusla has a responsibility to recognise that some children in care remain at risk of significant harm, irrespective of where or how harm is inflicted, and do all in its power to mitigate such risks. Further guidance is needed from Tusla, specifying how Children First principles for protective action should be implemented for children in care who place themselves at risk of significant harm.⁹

⁸ At present, Tusla captures quantitative activity and performance metric data on children in care by area, by placement type, by age & gender, by reason (under the Children First definitions of abuse), by legal status, by length of time in care (including the number of placements/out of State placements/private providers/special care), by whether they are in education, and by whether there is an allocated social worker and written care plan, as per its requirements under section 8 of the Child Care Act 1991.

⁹ Tusla informed the review team that it has since selected the Signs of Safety as their national approach to child protection casework practice. The Signs of Safety is an innovative, strengths-based, safety-organised approach grounded in partnership and collaboration with children, families and their wider networks of support. While the review team recognise that this approach may have assisted Declan when he was on the edge of care, it is not clear to the review team how this approach

Tusla has a responsibility to review each serious incident involving children in care.¹⁰ The review team considers that Tusla's Need to Know process for alerting senior managers to adverse incidents, and its Organisational Risk Management Policy are insufficient in responding to the level of risk that some children in care pose to themselves.

It is recommended that Tusla review and refine its Need to Know process, and its Organisational Risk Management Policy by:

- Registering cumulative referrals concerning individual children at risk of significant harm, which require immediate action;
- Creating a distinct profile for such children on the corporate risk assessment register;
- Giving guidance on and monitoring such action at senior management level; and
- Giving guidance on crisis action to other agencies involved with the child via protocols with multi-agency endorsement.

A clear recommendation from this case is that guidance on crisis action in these cases must be multi-disciplinary, requiring a protocol with multi-agency endorsement (see further below).

Recommendation 7: Models of care and residential provision for children with complex needs

Following his placement in the voluntary care of Tusla at the age of 14, Declan experienced nine residential environments over a period of 26 months (including the Children's Detention Centre). Children like Declan should not have to navigate different models of care in each placement experienced.

There needs to be greater consistency between service providers in relation to the model of care engaged with children with complex needs. Tusla needs to develop and publish an integrated model of care and a plan for implementation based upon analysis of the needs profile of this population. This must be done in close collaboration with mental health, disability, education and youth justice services, and NGO providers.

In particular, there needs to consistency between the model of care experienced by a child with complex needs in detention and that provided in post detention step down provision. Even when

would have kept Declan safe once reunification with his family was no longer a possibility and he was exposing himself to increasing risk.

¹⁰ Standard 2:11 of the National Standards for Children's Residential Centres 2018 requires that serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels.

Declan's needs were assessed by ACTS whilst in detention, there was no specialised placement for that work to continue upon his release.

After Declan's first placement broke down, he was deemed unsuitable for Tusla mainstream residential care, with the result that he had to be accommodated in placements from the private sector. The de facto policy of utilising short-term private sector provision for this group is wholly inadequate. Children with complex needs should be visible and accounted for within Tusla's Alternative Care Strategy and across the other State agencies and departments with responsibilities for children.

It is, therefore, recommended that Tusla develop specialist residential care provision to meet the complex needs of this population. This is a major systemic deficit and constitutes a 'missing pathway' available to social work teams within alternative care. The current cost to the agency of failing to make provision for alternative specialist residential care is reflected in The Tusla Business Plan 2020. It states that 'The impact of increased complex needs of children in care has also created an increase in demand for specialist residential care placements for children. Numbers in both private residential and private foster care placements have remained high in 2019. An increase in the contract rate for Private Residential placements from October 2018 onward, delays in HSE taking over placements and costs relating to Disability clients who have passed 18 years of age and on-going significant investment in arrangements to provide local alternative support to residential care for children have all contributed to a cost pressure across this area of €30.408 million in 2019.'¹¹

Recommendation 8: Review of inter-agency working and strengthening protocols for children in care

Children with complex needs require a range of services from different agencies and disciplines to be integrated at the point of delivery. The excessive gatekeeping experienced by Declan in this review requires immediate remedial action. This has been a recurrent theme in NRP reports.¹²

It is the opinion of the review team that agencies and departments with responsibilities for children are not clearly mandated, or held to account, by government to coordinate their work effectively.

¹¹ Tusla Business Plan 2020, page 16/52

¹² The NRP has recently recommended that "formal channels" for communication between Tusla and other agencies serving children are established and maintained. The NRP Annual Report 2018 called for a review of the 2017 Protocol Promote the Best Interests of Children and Families in order to clarify the roles and responsibilities of different agencies. A recently published NRP review recommended that Tusla develop a multi-agency policy response when dealing with complex child abuse cases (Review of a serious incident: abuse of children in a family setting, published August 2020). A previous NRP report also called for the need to develop coordinated policy, protocols, working arrangements between Tusla and the Dept of Education and Skills, and Tusla and the Dept of Justice and Equality (Simon, published July 2019).

It is recommended that Tusla review joint working with partner agencies and departments to raise the priority levels of services to children in care:

- HSE: a more structured partnership with CAMHS is required to provide for the mental health needs of children in care. It is understood that Declan would still not qualify for HSE Disability Services support, if this was sought today. A child's functional level of disability must be taken into account in their consideration for services;
- Dept of Education and Skills: There needs to be individualised educational plans for children and young people with needs profiles similar to Declan, to ensure that the systemic failures illustrated in this case are not replicated; and
- Dept of Justice and Equality: There is statistical evidence of a common constituency between the populations of children who come within the remit of the Children's Detention Centre and those who are known to Tusla but there was poor coordination in planning in this case.