Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of death of a young person known to the child protection system: Hugh

Executive Summary

January 2018

Introduction and background

This review concerns a young man here called Hugh, who died when he was 16 from a suspected accidental drug overdose. Hugh lived with his mother and had frequent contact with his father. He had been known to the Tusla social work department (SWD) from the time he was 12, and had spent a period in residential care. Eight referrals were made about him to the SWD, mainly about his poor school attendance, his use of illegal substances and his associated involvement with theft and anti-social behaviour. He came into contact with the Gardaí as a result of break-ins, assaults and drug use. He also had mental health difficulties and was diagnosed with ADHD and Oppositional Defiant Disorder and Conduct Disorder. A family welfare conference was convened with the aim of helping himself and his family to manage his behaviour. Although earlier referrals received a limited response from the Tusla SWD, a social worker was allocated at this point and provided a regular and consistent service Hugh and his mother from the time he was in his fourteenth year. Hugh was admitted to voluntary foster care for a short period following drug use and absconsion from home. Hugh's mother and father were both extremely concerned about him, and wanted to have him home as soon as his behaviour settled down. It was agreed that he would have regular respite care.

When Hugh was 14, a number of further concerns were reported about him including school dropout and substance use. A child protection conference concluded that he should be admitted to care on a voluntary basis initially and be referred to mental health services. His parents were offered parenting courses and his mother availed of one. The CAMHS service expressed the view that Hugh's substance use needed to be addressed as a priority prior to treatment for his mental health. He went to stay in a private residential service, where he was assessed as vulnerable to drug use and criminal behaviour. He did well in the residential unit at first but later became involved in destructive behaviour and had to leave for a period, after which he was allowed back under certain conditions.

Hugh received home school tuition in the residential unit and passed a number of subjects in his Junior Certificate. Due to his poor level of cooperation with services, a care order was sought by Tusla and a number of interim care orders granted by the court. However, in line with his mother's wishes, the aim was for him to return home as soon as his behaviour became more manageable and this occurred a few months later after he turned 15. He agreed to cooperate with his parents and the social work services. The SWD kept in touch with him over the following months; his mother found him more manageable but reported his ongoing substance misuse. He attended Youthreach and was linked with a mentor and a drugs outreach worker but was reluctant to engage and found it very difficult to give up taking drugs. Over the next year, numerous concerns were expressed in

relation to Hugh's behaviour, his attitude at home and in Youthreach and his drug use. He had numerous appearances in court with regard to criminal matters. Gradually, his behaviour and attitude appeared to improve and he claimed to have limited his drug use. He volunteered with a local charity and seemed motivated to sit his Leaving Cert. The SWD decided to close the case. Sadly, Hugh died shortly afterwards. His autopsy showed a fatal level of different illegal drugs in his system.

Findings

The review has found that Hugh's parents and the SWD, together with the other services involved, did their best to support and guide him during the last three years of his life. It has concluded that earlier intervention could have been achieved if the numerous referrals made about him when he was younger were followed up appropriately. The review notes that Hugh was left without treatment for his ADHD and conduct disorders because of his drug use, due to a CAMHS policy whereby young people who are using drugs are not eligible for a service. The review panel concludes that such policies leave children and young people, especially those with diagnosed conditions, extremely vulnerable.

Key learning

The review has identified the following learning points:

- It has been a feature of a number of NRP reviews that initial child protection referrals have received incomplete screening and assessment when received by SWDs. This has most frequently been the case when a number of referrals have come in from a range of different sources in a comparatively short period of time and for a range of behaviours. This appears to be what occurred in respect of Hugh and his family. It was clear that Hugh, at an early age, was experiencing a number of behavioural problems which should have triggered concern for his welfare. A careful analysis at this stage would have revealed a number of risk factors and the need for a timely intervention. Instead matters were allowed to drift for around 18 months and matters had escalated significantly before action was taken.
- It is understood that Tusla now have a policy for such early interventions to take place and have put resources into such initiatives. For example, *Children First: National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs, 2017) contains at Appendix 4: 'Pathway of a Child Welfare or Protection Concern Reported to

Tusla'. This highlights the importance of screening and preliminary enquiry, initial assessment and then, at Pathway 2 a Child Welfare Assessment and Response which is to be led by Tusla. This in turn could lead to a strategy meeting which could initiate a Child Welfare/Family Support Plan. Had such a pathway been in place when the first referrals came in on Hugh in relation to his behaviour then a much needed Family Support Plan could have been put in place.

- Hugh had complex needs and a number of different agencies and persons worked with the family. It must have been difficult for him to understand the different roles and be able to negotiate such complexity. Bevington and Fuggle (2017) refer to the "Tower of Babel" effect whereby young people fall into the spaces between services, or are offered multiple assessments that result in little effective action. They suggest that sometimes engagement is 'nominal' because the confusing effect of numerous operational models used by a range of professionals with different backgrounds from social care, mental health, youth offending and educational services and more which makes it difficult to integrate interventions. This matter will be developed in the following learning point.

- Evidence based models or frameworks which integrate services around hard-to-reach young people and their families would be useful for Child and Family Agency staff. Frameworks such as AMBIT (see: www.tiddlymanuals.com) have shown promise. Similarly interventions like multisystemic therapy (MST)[1] and multidimensional family therapy (MDFT)[2] are providing a solid research evidence for effective outcomes. The Child and Family Agency could consider setting up pilot trials of one or more of these models/interventions and report on effectiveness in engaging hard-to-reach young people and families within a three year period.

[1] Swenson, C. C., Schaeffer, C. M., Henggler, S.W., Faldowski, R., and Mayhew, A. m. (2010) " Multisystemic Therapy for child abuse and neglect: A randomized trial". Journal of Family Psychology, 24 (4), 497-507

[2] Liddle, H. A. , Dakof, G.A. Parker, K., Diamond, G.S. Barrett, K., and Tejeda, M (2001) "Multidimensional family therapy for adolescent drug use: Results of a randomized clinical trial". American journal of Drug and Alcohol Abuse, 27(4), 651-688.

Recommendation

The NRP understands that policies made by CAMHS are outside the remit of Tusla. However, it recommends that Tusla use any possible opportunity to highlight situations where policies operated by CAMHS may ultimately result in young people who have clinical diagnoses being left vulnerable and without services.

Dr. Helen Buckley

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