Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review of the death of Jeff, a young person who was in the care of the HSE Children and Family Services

Executive Summary

September 2015

Introduction

This review concerns the death by suicide of a young person, here called Jeff, who was placed in care when he was a young child because of family violence, parental alcohol use and neglect of the children. He remained in care until he was an adult. The review was conducted by Professor Helen Buckley, Ceili O'Callaghan and Paul Murray. The methods used were a review of the files and interviews with staff and some of Jeff's former foster carers. His mother was offered the opportunity to meet the review team but declined. The review team were unable to make contact with his father despite numerous efforts.

Background

When concerns about Jeff's family were initially reported to the local health board (later HSE), the social work department (SWD) first tried to provide supports in the home as it was considered that the children had good relationships with their parents despite the adverse factors that prevailed,. However, the situation did not improve and Jeff was placed in care first on a part time basis and later full time when he was three years old. He remained in care until he was an adult. Jeff's behaviour as a young child was difficult to manage and his first two placements broke down after a relatively short period during which he made allegations of sexual abuse against his father which were investigated and deemed credible.

Jeff's third placement with foster carers lasted for ten years, until he was 15. He did not have an allocated social worker for much of the time and there were very few case notes on file covering this period. It is evident that statutory reviews were not held as frequently as required. A child care leader was allocated to work with him when he was 15 and shortly afterwards, he moved to a different placement. Jeff made some allegations of emotional abuse in respect of his foster carers of ten years. The review team heard different versions of events from interviewees but found no evidence that the allegations were investigated. Although he settled into the next placement, it ended after six months following an incident of sexualised behaviour and Jeff went to live in a residential unit. At this point he was allocated a social worker who saw him frequently and regularly until he turned 18. Jeff had attended Child and Adolescent Mental Health Services (CAMHS) as a young child and re-engaged with the same psychiatrist at this point because of a tendency to self-

harm. He was seen regularly by this service over the next few years during which his mental health fluctuated and his tendency to self harm recurred from time to time.

When Jeff was 16, he was placed with another foster family, where he settled well and remained until he died. He completed his applied Leaving Certificate. He decided to make contact with his parents whom he hadn't seen in a number of years and met with them separately as well as some of his siblings. When Jeff turned 18, he was allocated an aftercare worker who was helping him to find a suitable course when he very sadly took his own life. Jeff's passing was a source of grief and sadness to everyone who knew him. He had become a father in the months before his death.

Findings

Jeff very sadly took his own life at 19 years of age. Staff, including care staff, who had worked with him during his last four years had been very aware of his emotional vulnerability, tendency to self-harm and suicidal ideation and had done their best keep him safe and to provide the most appropriate help for him. Mental health and psychology services were available to him at all times during this period and actively tried to engage him. He was in aftercare with his former foster carers when he died and by all accounts, he had settled well into this placement and had a very good relationship with his carers who were attached to him and made considerable efforts to help him deal with his problems and manage his self-harming behaviour. The review team finds no link between the services offered to Jeff at this time and his very sad death and acknowledges the deep distress experienced by everyone who knew him.

The review has found that Jeff 's family received a lot of social work attention when he was a young child and was provided with child mental health services when considered appropriate. The review also concludes that Jeff was left in a situation of great uncertainty for a number of years as a young child while the SWD tried to improve conditions in the family home and the court deliberated over his care status. As far as can be ascertained, once the SWD had determined that no improvements were being achieved in the home situation, they made as convincing a case as they could to achieve permanency for him and it is acknowledged that the recent implementation of the Child Care Act 1991 had created a different type of legal environment to which all involved were slowly getting accustomed. It is suggested that this situation hindered Jeff's rehabilitation from the trauma he had experienced by being exposed to neglect, alcohol abuse and domestic violence and it is likely that this delay contributed to the de-stabilisation of his early foster placements.

The review has found that Jeff was invisible to services for period of several years in foster care, including a time which he later described as unhappy. It appears that a scarcity of resources and a

culture which was non-compliant with regulations combined to deprive him of the services to which he was rightfully entitled, i.e. an allocated social worker and timely statutory Child in Care Reviews.

The review has found that for the greater part of Jeff's time in the care of the health board/HSE, management of social work services in the local area was deficient with gaps between the appointment of frontline and senior management. It suggests that the ensuing lack of accountability and poor infrastructure impacted on Jeff's welfare particularly in his late childhood and early adolescence. The review team has been informed that significant management reforms have taken place in the area in the meantime.

Recommendation

The review team have found with this review, as with others, that staff and other former carers who have been involved with a child that dies are not always aware of his or her death. On more than one occasion, staff who are invited to meet review teams have only learned of a death when they received a letter from the National Review Panel. From a staff welfare perspective, it is suggested that the area manager or a nominated person takes all possible steps to inform relevant personnel of the death of a child or young person with whom they have worked in the previous two years or with whom they had a working relationship in the past.

Professor Helen Buckley

Chair National Review Panel