Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death experienced by a young person who had contact with HSE/Tusla

Jim

Executive Summary

September 2018

Introduction

This comprehensive review concerns a young person, here called Jim, who died from a drug overdose when he was 19 years of age. His death was notified to the National Review Panel because he had been in care up to his 18th birthday and was receiving aftercare services from Tusla at the time that he died. The methods used in compiling the report were a review of records held by HSE/Tusla in two service areas, a review of an internal Tusla report and a report from the Child and Adolescent Mental Health Services (CAMHS). The review was delayed for many months while awaiting foster care records which were ultimately declared missing. It was further delayed whilst awaiting the report from CAMHS. Interviews were held with social work and child care staff as well as Jim's long term foster carers.

Background and summary of services provided to Jim

Jim was received into care at three years old because of parental substance abuse, criminality and domestic violence. He was described as an endearing young child who had a good sense of humour, but was also considered vulnerable. At six years old, he was referred to CAMHS and was diagnosed with ADHD. He had two foster placements, the second of which lasted nine years and he later spent time in a number of residential units including the Out of Hours Service and a hostel. As he grew up, his behaviour was often difficult and he abused drugs and alcohol which contributed to the termination of most of his placements. A large number of services were involved with Jim, including mental health and psychology, Gardai, youth justice and education as well as social work, crisis intervention and aftercare services. Over the years, Jim had contact with his parents and siblings but for a number of reasons, including the unavailability or ill health or his parents, this was not as consistent as he would have liked.

Jim's second foster family, with whom he appeared to be well settled, moved from one part of the country (Area A) to another (Area B) when he was 10 years of age. Up to this time, he had had regular contact with his allocated social worker but when she left, it was a year before the next social worker was allocated. The transfer of responsibility from the social work department in his original area (SWD A) to his new one (SWD B) took a long time, during which time he and his foster carers had less support than previously. Access visits with his family continued to be managed by SWD A though his parents were often unavailable. He was waitlisted for CAMHS in Area B for approximately two years. Allegations of physical and emotional abuse in relation to Jim were made against his foster family by Jim's own family members; these took a considerable time to be fully

addressed by the social work departments. Investigations ultimately concluded that the foster carers had used inappropriate methods and sometimes overused sanctions to manage Jim's aggressive and sometimes violent behaviour and recommended that they attend CAMHS for support and guidance in behaviour management. Other allegations of physical and emotional abuse were considered unfounded. Statutory Child in Care Reviews had taken place in respect of Jim in SWD A, though not in the early part of his placement. Only one Child in Care Review was held when he and his foster carers moved to Area B and the review team was told that it was never clear which social work department had responsibility for organising reviews.

When Jim was 14, his foster parents concluded that they could no longer cope with his behaviour and from that time on, he lived in one further foster placement and a series of residential units from which he was often asked to move because of his aggressive behaviour in the units and antisocial behaviour in the community. He continued to get support from CAMHS. When he was in his mid-teens, he admitted to frequent and prolonged substance abuse and his ADHD medication had to be altered accordingly. His psychiatrist was of the view that his main problem was not his ADHD but his anxiety about his placements and his experiences of loss. The CAMHS service acknowledged that it was not able to provide him with the therapeutic services he required. Jim wanted to move back to Area A to be nearer to his family. This was ultimately arranged and he continued to live in a number of residential placements, including the Out of Hours service when nothing else was available. His placements tended to disrupt because of his absconding or aggressive behaviour linked with substance use. He refused to attend mental health services and no suitable educational services were available for him. His behaviour continued to deteriorate to the point where he had criminal charges and high support was considered but he was ultimately deemed unsuitable. Ultimately, as no placement option was available for him, it was agreed that he would continue to live with his mother and receive financial support. Following a dispute with his mother, the aftercare service placed him in supported lodgings; he had to leave there because of his behaviour and eventually moved in with his father and later a homeless hostel. He was over 18 at this time and discharged from care, though the youth and aftercare services continued to work with him. He spent the next few months between his own flat, then prison and his mother's accommodation. He died aged 19 from a drug overdose.

Findings

The review team acknowledges the loss that has been experienced by Jim's family and the professionals that worked with him and extends its sympathy to everyone that knew him. It has reached the following conclusions:

- From an early age, Jim faced a number of challenges due to his family circumstances and his complex needs and the breakdown of his first two foster placements had major implications for him.
- The management of the case including the planning and implementation of interventions was inadequate at times. Statutorily required reviews were not held in the early days and later, suitable placements and education were unavailable to meet Jim's needs. This led to crisis management at the expense of a more strategic approach. Furthermore, the initial transfer between the two SWDs was poorly planned and implemented and resulted in Jim and his foster carers receiving a deficient service at a critical time. The allegations made by Jim's family about his care were handled inadequately.
- SWD A tried to do the best for Jim and there was evidence of good work on the part of several professionals especially Jim's aftercare worker. However, the service provided by SWD B was limited and the NRP understands that this was largely due to pressure on resources.
- The review has noted a discrepancy between the expectations held by Tusla of CAMHS, and the perception of the latter in relation to its remit and its inability to provide a generic mental health service or long term psychotherapeutic services.

Key Learning Points

This report has attempted to reflect on the challenges faced by Jim and those who worked with him and his family. It has identified areas where lessons can be learned.

- Prior to the placement of any additional children in a foster family (even in the case of siblings), careful consideration and a full assessment of the implications both in the short and long term in respect of all parties is required. In addition, the ability of the foster carers to meet the needs of all the children in their care must be continuously supported and monitored[1].
- The impact of the lack of an educational/ training placement on Jim's wellbeing cannot be underestimated. Besides offering a daily schedule and structure, education enhances the development of young people. The literature demonstrates that the educational difficulties that are experienced by children in care are more likely to be grounded in the care and

[1] Zeijlmans, K., López, M., Grietens, H., & Knorth, E. J. (2016). Matching children with foster carers: A literature review. *Children and Youth Services Review*, 73, 257-265.

education systems than in the children themselves (Jackson and McParlin, 2006)[2]. It is the responsibility of the Department of Education and Skills to provide educational placements for children.

- It is essential that young people in care have direct work completed with them on a regular basis by the SWD. Tusla's (2014) 'Alternative Care Practice Handbook' highlights the importance of direct work and the importance of having a meaningful relationship with young people and how this requires both consistency and commitment. Workers need to be given time in their caseloads to achieve this. In addition, the SWD should ensure that young people in their care who have a need for more intensive therapeutic work are referred to appropriate services at the earliest opportunity.
- In the later years, Jim's needs were too complex to be met by any one agency or setting. In the absence of the necessary resources and placements, the work became increasingly reactive and driven by crisis management when a high degree of shared assessment, planning and co-ordination was required. Furthermore, many of Jim's behaviours clearly illustrated that a number of high risk factors were at play. Risk factors comprise static (e.g. gender, age) and dynamic (e.g. drug use, employment status and traumatic events) circumstances that may be outside the control of the individual. Managing risk is an ongoing process and having a risk management plan in place assists professionals to make informed judgements about the risks and the actions required. Guidance provided by Tusla on working with children in out of home care points out that 'Those working with young people who present with 'risky' behaviour must develop transparent ways of working with and recording risk which clearly demonstrates the approach in dealing with the risk and the rationale for it' (Tusla, 2014, p. 185)[3]
- In the interests of all parties, complaints must be fully addressed in a timely manner so as to limit unnecessary stress and loss of confidence in any party. Good communication is an essential component of such a process[4]. Front-line responsibility for complaint handling is seen as the most crucial aspect of complaint systems[5].

[2] Jackson, S. and McParlin, P. (2006) Education of children in care. *The Psychologist 19*(2): 90-93.
[3] Tusla (2014) *Alternative Care Handbook.*
[4] Tusla *Complaints – 'Tell Us'*.
[5] Lister, G., Rosleff, F., Boudioni, M., Dekkers, F., Jakubowski, E. and Favelle: H. (2008) Handling Complaints in Health and Social Care*: International Lessons for England.*. https://www.nao.org.uk/wp-content/uploads/2008/10/0708853_international_review.pdf

Recommendation

Given the current concern about lack of mental health services for children and young people, it will be essential for Tusla to clarify the role and function of CAMHS so that gaps in the services required are highlighted and referrals are appropriately made.

Dr Helen Buckley

Chair, National Review Panel