Review undertaken in respect of a death of a young person who was in the care of the Child and Family Agency

Kevin

Executive Summary

October 2018

1. Introduction and background

Kevin was 16 years of age when he died from suicide. He had been in foster care for two months and took his life while he was at home on a visit. His family had been known to the social work services in his area for a number of years.

Kevin was described by those who knew him as a well-mannered and quiet young man who was popular but also guarded, and did not open up easily to professionals. His family worried about his vulnerability to negative influences in the community, particularly in relation to alcohol and drug use, and were anxious to protect him. A number of universal services were involved with the family, as well as social work, child mental health, addiction and youth services. Kevin had behavioural problems as a young child. Aspects of his behaviour gave rise to concerns that he may have an underlying psychiatric condition and he was referred to child and adolescent mental health services. His attendance at appointments was initially erratic and the social work department put in extra supports to facilitate his attendance. Parenting support was provided to his parents and a family support worker was assigned to the family. She continued to work with them for many years and her input was greatly valued by them. When he was ten, Kevin alleged that he had been sexually abused by someone known to the family and a child sexual abuse assessment concluded that his account of events was credible. The allegation was investigated by Gardaí but no charges were brought and Kevin and his parents were very upset about this outcome.

As Kevin grew into adolescence, his parents found it difficult to manage his behaviour which began to include school absenteeism and misusing alcohol and drugs. He was linked with a youth advocacy programme and again referred to mental health services when he was found with a rope in his room. Kevin and his family did not avail of the appointments offered as Kevin denied any suicidal intent and said he did not want to 'dig up the past'. He began running away from home for days at a time and the Gardaí were involved in picking him up when he went missing. His mother gave up work so that she would be more available to supervise him. His difficult behaviour continued for a period, and when Kevin was a few months under 16 he was placed in the first of a number of emergency placements at his parents' request. It was agreed that a period of separation would benefit the whole family and two months before his death, he was placed through a private fostering agency with a family some distance from his home, where he settled well and had regular contact with his own family. Although the social work department had misgivings about his need to be in care, given his stable home situation and caring parents, it was acknowledged that he was more settled and happier in his foster placement and a Child in Care Review was scheduled to make further plans for him when he tragically died while at home on a visit to his family. His parents

believed that Kevin was under threat from drug dealers to whom he owed money and was anxious to be away from his home town.

2. Review findings

While the social work department was involved with Kevin and his parents and siblings, the main service offered was family and therapeutic support. Child care leaders and family support workers were assigned as the need arose, for example when Kevin and his family suffered significant bereavements. The records indicate that the family engaged well with the services that they chose to accept and benefited from the interventions of these practitioners. When a decision was made to receive him into care, a social worker was allocated. There is a consistent thread of oversight by social work management throughout.

Kevin's parents were critical of what they considered to be the lack of response from the SWD at times when Kevin would go missing, which would often be at the weekend. They were frustrated by the lack of out of hours cover at the time particularly at weekends when they needed it and by the fact that Kevin's behaviour was at that time beyond their control to manage. They were also of the view that there was an undue delay in confirming the continuation of his foster placement, caused by administrative requirements regarding private placements which had made Kevin unnecessarily anxious. While the reviewers acknowledge the frustration they experienced, it is also noted that the allocated social worker met Kevin regularly and frequently and provided very positive support to his placement.

3. Conclusions

The reviewers acknowledge the profound impact of Kevin's tragic death and extend their sympathy to his family and practitioners that worked with him. It has reached the following conclusions:

- From all the evidence available to reviewers, it appears that there was no point in time where Kevin's suicide could have been predicted.
- The social work department took the appropriate approach whereby the provision of family support and therapeutic work with child care leaders was considered the most suitable service to offer to Kevin and his family up to the time he reached adolescence. The review also notes that a number of appropriate health and mental health services were made available, some of which were availed of by Kevin and his family.

- There is evidence that the placement in Kevin he was residing at the time of his death was beneficial for him and was well supported by the social work department and the private agency providing the service
- The lack of an out of hours service at the time impacted negatively on the ability of the Gardaí and the social work department to provide a service and caused understandable frustration to Kevin's parents. This deficit has since been ameliorated.

14. Key Learning Points

14.1 Medical examinations

Two of the social work staff, when asked about their reflections on this case, put forward the suggestion more consideration might be given to the medical examination carried out when children are placed in care. It was proposed that, in cases where the examining doctor may not know a child, full background information should be provided. It was also suggested if a mental health assessment was conducted as standard, it may facilitate staff to pick up on any indicators of risk that might otherwise be missed. While such an assessment may not be indicated in every case, this appears to be a useful matter for consideration for children and young people who meet a particular profile.

14.2 Communication of decisions regarding care

Kevin's parents told us that he was extremely anxious about the outcome of a decision regarding the funding of his private placement. From a young person's perspective, uncertainty about matters like this can be difficult to tolerate and research indicates that they can feel that they have little ownership over important decisions about their lives[1]. While it is acknowledged that a number of processes have to be undergone in relation to private placements before decisions about funding can be finalised, the impact of delays and uncertainty on children and young people need to be recognised, so that delays are minimised and as much assurance as possible can be given to young people in the interim.

Dr Helen Buckley

Chair, National Review Panel

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[1] http://www.tusla.ie/uploads/content/FOSTER_CARE_PLACEMENT_BREAKDOWN-_BRIEFING_NOTE.pdf