National Review Panel

Review of the death of Lennie, a young person known to the child protection services

Executive Summary

September 2015

Introduction

This report concerns a young person here known as Lennie, who died just prior to his 18th birthday as. It appeared as if he may have tried to take his own life. However, the motivation behind the incident is not clear and the coroner suggested that it may not have been fully intentional as Lennie had a history of impulsive behaviour. An in-depth local review of services was undertaken after Lennie's death and forms the basis of this report, which has anonymised the family and personnel involved and has updated the key learning and recommendations in line with recent policy developments.

Lennie was a member of the travelling community and was first referred to the HSE social work services when he was almost nine years old and had recently arrived in Ireland with his mother and siblings. They had left their previous home due to domestic violence and alcohol misuse and were already known to social services in that jurisdiction.

Lennie was described by people who knew him as very engaging with numerous positive qualities. He had been diagnosed with ADHD at an early age and found it difficult to concentrate. He spent periods in detention schools and in HSE residential facilities and was living in a 'wrap around' care arrangement at home when he died. Lennie had become known to an Garda Síochána before he was 11 because of anti social behaviour. At later stages, Lennie made allegations which indicated that he may have been sexually abused by several different people during his life. He was first allocated a social worker just over two years after he was referred to the social work department in his local area but had been attending CAMHS in the interim and continued to receive services from them over many years. Getting and maintaining school placements was a recurring challenge for Lennie, and while all the evidence indicates that he had a close relationship with his mother, his behaviour was beyond her ability to manage. He spent time in detention centres and in High Support care, and made his first suicide attempt when he was 13.

Findings

Apart from an initial delay of two years in allocation, Lennie had a social worker all his life. While he had numerous assessments, it is not evident that the interventions later made were appropriate to his needs, and although his mother frequently expressed her own inability to manage him, there is no evidence that her capacity was ever fully assessed. Most interventions centered on trying to find suitable placements for him, and many options were tried but none of the arrangements made were sustainable and Lennie was returned to his mother's care on many occasions as his placements broke down. The social work department was given support to develop care packages and the last one was a serious attempt to fill the gap between the type of environment he needed and what was

available; nonetheless it was not considered suitable for the long term. The local review was critical of the lack of policy and procedural frameworks available at the time to assist social workers in the delivery of services, but also notes that that recent restructuring of services has addressed this issue. However, the main difficulty was the lack of placement options available for a child with Lennie's needs. He had done well in stable and predictable environments where he was securely held, but he was ineligible for a placement in a special care unit because he had outstanding criminal charges. Yet, most professionals working with him believed that detention in special care would meet his needs better than the criminal justice system.

There is evidence that Lennie received a very committed service from CAMHS and that his psychiatrist frequently advocated on his behalf for suitable placements.

Conclusions

Lennie was a very troubled young person with special needs and also had a long history of behavioural problems and exposure to family violence as a young child. As he entered adolescence his behaviour became more destructive. His impulsivity made it very difficult to keep him safe. This review found no direct link between the practice in this case and Lennie's tragic death. It found that staff tried over a number of years to try and find a setting that was acceptable to Lennie and in which he would thrive and develop. However, the review has also concluded that the lack of suitable placements for him added considerably to the challenge of keeping him safe. It also concludes that the lack of suitable accommodation coupled with Lennie's desire to stay at home with his mother resulted in unrealistic expectations being placed on her, despite her apparent frequent acknowledgement that she could not manage him.

Recommendation

The local review made a number of recommendations for the local area. Many of the issues raised now form part of the structure and policies that have been established by the Child and Family Agency. For that reason, they will not be replicated here with one exception, which is that the criteria for applications for special care are amended to provide more clarity on eligibility for young people with outstanding criminal charges.

Professor Helen Buckley

Chairperson, National Review Panel