

National Review Panel

**Review in respect of a young person who died while in the care of
the HSE:**

Luke

March 2014

Terms and acronyms used:

CAMHS: Child and Adolescent Mental Health Service. Note that services described in the report historically as Child Guidance are now part of the CAMHS service.

FLM: Front line manager. This term refers to professional staff in the SWD who carry front line managerial responsibilities, such as the direct management and supervision of professional staff

FWC: Family Welfare Conference

GAL; Guardian ad Litem

HSE: Health Service Executive

CFA: Child and Family Agency

OOH; Social Work Out of Hours service. This refers to the HSE service which provides an emergency response for young people who present as homeless. Whilst the primary aim is to enable young people to stay with parents or relatives, the service also can refer to emergency overnight accommodation in hostels

SWPM: Social work professional manager. This term refers to professional staff in the social work service who have senior managerial roles and responsibilities.

SWD: Social work department (of the HSE). Social work departments covered specific geographical/administrative areas at this time, providing a range of services for families and children which included a duty service to assess all incoming referrals and provide an appropriate response, Looked After Children Teams (LAC) to deliver social work support to children in care in the medium/long term, and Fostering Teams to recruit, assess, train , support and supervise foster homes.

USE OF NAMES

This report uses several first names to refer to key people. Whilst the general narrative and analysis is based on evidence made available to the review team, the use of the names is fictitious in order to preserve confidentiality.

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Section 1: Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care' issued in 2010. Under this Guidance, the following deaths and serious incidents must be reviewed by the National Review Team:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious incidents involving a child in care or known to the child protection service.

National Review Team

A National Review Panel (NRP) was established by the HSE and began its work in August 2010. The NRP consists of an independent Chairperson, a deputy Chair and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology social care, law, psychiatry and public policy. The Panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the National Review Panel. The National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions and recommendations. When the HIQA guidance was developed, it was envisaged that the NRP might need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a

consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

- Major review to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three team members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.
- Comprehensive review: to be held where the involvement of HSE services has been over a medium to long period of time (up to 5 years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations.
- Concise review: to be held where the involvement of HSE is either of a short duration or of low intensity over a longer period. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.
- Desktop review: to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

- Recommendation for internal local review: to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

NOTE: As Luke's life spans the periods both before and after the establishment of the HSE on 1 January 2005, the term HSE has been used throughout the report to include its previous existence as the X Health Board.

Young Adult Death: Luke

This review is concerned with the tragic death of a young adult in his late teens, here called Luke. He had been known to the HSE Child and Family Social Services since birth and was signed by his mother into the voluntary care of the HSE after the death of his father when he was nine. The review has been held because Luke, aged less than twenty one years old, died accidentally after leaving the HSE's care, to the great distress of his family and former foster carers.

Level and process of review

This was conducted as a major review. The methodology adopted was a review of available HSE written records and a number of interviews. Records included:

- Eleven Health Board/HSE social work folders pertaining to Luke containing copies of correspondence, case notes, care plans, and reports including reports to the Courts,
- One speech and language therapy file
- One Health Board public health nursing file.
- The review team also requested and received a number of complete and partial files relating to the foster carers and Luke's half-siblings from the HSE and other sources.
- Two files from an after-care agency and one file from the Probation and Welfare Service.

The review team was told that early social work records for the period up to Luke's entry into HSE care were missing. The absence of these files was noted on record soon after Luke came into care.

Interviews undertaken by the review team were carried out with the following persons:

- ten serving or former HSE staff of whom eight had direct contact with Luke or his family or foster carers during his time in care
- Cathy, Luke's half-sister and other members of Luke's extended family
- Mr. and Mrs. Jones, Luke's foster carers
- the principals and some of the teachers of the three schools and the support project attended by Luke
- representatives of three relevant services: the aftercare agency, the Probation and Welfare Service and the National Educational Welfare Board.
- one of the two Guardians ad Litem appointed to the case; the second Guardian declined to be interviewed.

Further attempts to gain information included the following:

- A discussion was held with a journalist who had relevant information as to the location of source material.
- Two members of the review team visited an emergency hostel which Luke had frequently used.
- The review team sought to interview further current or former HSE staff but they were unwilling to be interviewed or could not be traced. One member of staff who did not attend for interview provided a written note.
- The review team wrote to the disability service used by Luke's brother Sean asking it to provide a submission in relation to the family. No response was received.
- The review team wrote to An Garda Síochána asking for information on Luke but at the time of writing none has been received.
- The review team wrote to a learning disability service known to have been involved with Luke and his family but no reply was received.

Interviews were recorded with the exception of three cases where interviewees did not give their consent and one case where the equipment did not function. In this case notes taken at the time of interview were used instead. In two cases interviewees also gave a written statement. Written material was also received from interviewees and also from one voluntary agency. The timescale of the review primarily concerns Luke's period in the direct care of the HSE although his early

background and the services offered to him and his family from birth to the age of nine was also considered to be highly relevant.

The review was conducted by a three-person team, consisting of the deputy-chair of the NRP, Dr. Bill Lockhart, and two independent team members, Eamon Mc Ternan and Melanie Pine. Dr. Helen Buckley, chair of the NRP provided editorial input. Bill Lockhart is a forensic psychologist; Eamon Mc Ternan is a retired child care social worker, and Melanie Pine is a retired civil servant. None of the members of the review team had ever been employees of the HSE or had previous contact or any professional involvement with Luke or his family.

Extracts from the review team's report were sent to relevant key staff and their responses were considered in finalising the report.

Terms of reference:

The terms of reference for this review were:

- To examine the circumstances and patterns of events leading to the death of Luke.
- To examine the role played by the HSE Children and Family Services in the case.
- To identify any barriers that prevented services from working together to uphold Luke's rights.
- To determine compliance with local and national policies and procedures in the case.
- To identify elements of positive practice.
- To identify opportunities for learning arising from the review.
- To make recommendations.
- To prepare an objective and impartial report for presentation.

Overall note on HSE records

The HSE was not able to furnish records for Social Work Department (SWD) intervention in respect of Luke's childhood up to the time his father died when he was almost ten years old. Available HSE files contained contemporaneous records from the Public Health Nurse (PHN) notes and copies of psychological reports which were received at a considerably later stage. Some other information on HSE and other interventions during these years has been obtained at interview or through references in subsequent records.

The HSE was able to make files available recording SWD involvement with Luke and his family from the time of his father's death to his 18th birthday, a period of over 8 years, but these were not

comprehensive and there are significant gaps. The standard of record keeping was almost uniformly poor.

Section 2: Chronology

For clarity, the chronology is structured in five periods in accordance with the circumstances of Luke's life.

- Luke's birth to death of Mick, his father, when he was nearly ten
- His foster placement (until he was fifteen)
- First breakdown of his foster placement (aged fifteen to sixteen)
- His renewed foster placement (aged sixteen to seventeen)
- Preparation for leaving care (From seventeen to his death aged nineteen)

From Luke's birth to the death of his father (Age 1 - 9)

Note: The HSE was engaged with this family and provided a range of services in response to their additional needs, as listed below, up until Luke was nine years old. The HSE was unable to provide any contemporary records about social work input to Luke, his brother and his father for the period prior to his reception into care. The social work files were reported missing some years ago. It is not known whether the case was allocated to a specific social worker or held on the social work duty system. The following information on Luke's circumstances and needs and on HSE interventions for the relevant period has been derived from information on later social work files, on files and documentation from other services, and from evidence presented at interviews.

The following services were involved during this period;

- Luke's home was visited regularly by a public health nurse in his early childhood.
- Learning disability services were involved for Luke's sibling Sean.
- Social workers from the SWD did visit Luke's home. However, information about their level of engagement with the family is poor.
- The paediatric neurological service of the local children's hospital assessed Luke at 14 months old.

- The local family centre was involved, providing the site for speech therapy, from when Luke was two and a half years of age
- Luke was referred to local child guidance clinic (now referred to as CAMHS) on at least three occasions, starting when he was 4 years of age.

Luke lived with his father, here called Mick, and his sibling, here called Sean, for the first nine years of his life. His mother, here called Mary, had learning ¹ difficulties and did not live with them. Mary also had older and younger children, all of whom were in care. Most of the recorded interaction between the HSE and the family was undertaken by the public health nurse (PHN), who monitored Luke's early development weekly, from his birth. She indicated when he was eight months old, her concern about possible developmental delay. The PHN files contain a report from a neurologist in the local children's hospital, completed when Luke was 14 months old, stating that his development was mildly delayed and that he would be kept under observation. There are no records indicating whether this observation took place.

Luke regularly attended the local family centre for speech and language therapy from age two and a half. While social work files are not available, later information notes that his father resisted social work visits to family home, as siblings had been previously placed in care. The review team has concluded, in the absence of records, that the cases of the other siblings in care must have open to the social work service, albeit in other administrative areas. The minutes of a case conference held in respect of Luke's sibling when Luke was just over two years old record that the children's father refused outside help. Records show that Luke himself was involved in the daily care of his sibling. An undated note from a social worker found in a later file indicated that Mary, his mother, was not emotionally involved with the children. The file records that Luke was referred for psychological assessment to the Child Guidance Clinic (CAMHS) at a local hospital by his speech and language therapist when he was four years old because of speech and language difficulties which were associated with his home environment. A speech and language report completed when he was five years of age and forwarded to a child guidance service noted his poor attention span, disruptive

¹¹ Ireland and the UK often use the term learning disability whereas other countries, such as the USA, more usually using the intellectual disability.

behavior and speech and language delays. Appointments for assessment at child guidance were not attended and a further referral was made a year later by the speech and language therapist in consultation with his primary school on the grounds of poor academic performance, disruptive behavior, and history of learning difficulties in the family. Luke finally attended for assessment with his father when he was nearly seven years old. Completion of the report was delayed for seven months by further missed appointments. It indicated that Luke functioned within the mild learning disability range and would require special education. The psychologist noted that Luke's father had refused to enroll him in a special school and recommended a review within a year.

Luke's relatives told the review team that they had been worried about the boys at this point, and tried to liaise with the public health nurse and with the boys' schools, as best they could. They expressed frustration to the review team at Mick's apparent success in keeping social workers at arm's length from the family, although they claimed that social workers were visiting regularly. This cannot be corroborated because of absence of social work records from the time.

Luke attended two primary schools during this period. The team was told by a teacher at interview that he had difficulties with moods and mixing with others, that he was hyperactive, showed both meanness and exaggerated kindness, displayed attention seeking behaviour, was impulsive, sensitive, nervous and charming. There was a particular concern about marks on his neck and inappropriate sexual knowledge. The review team was told by a member of school staff that he spoke to the duty social worker in the local SWD who advised the school to tell his father. The school also told the review that they made a written referral to the SWD, but were not informed of any follow up or investigation. Luke's relatives confirmed to the review team that they had been aware that this referral had been made by the primary school, and that his sibling had been medically examined for possible sexual abuse. The review team would have expected that a referral of this nature should lead to a child protection assessment and implementation of child protection procedures, but could find no record of this or of any reference to a medical examination. The school informed the review team at interview that Luke had subsequently attended the Child Guidance service (CAMHS), because of his behavioural and other difficulties.

A further psychological report was sent to his primary school some three years later when Luke was almost ten years of age by the local CAMHS service, on foot of a referral by the school because of suspensions. This indicated that he had an IQ in the low 70's, with significant learning difficulties and that he displayed a range of behavioural and emotional difficulties. The report indicated that there

was little structure at home and repeated the earlier report's recommendation that a special school would be more appropriate, although it acknowledged that this proposal had been rejected by his father. It recommended that Luke should be in the special class at school, that home supports be reviewed and that he should attend an afterschool project.

In a statement made when he was 16 years old to his legal representative, Luke said he had experienced very poor conditions living with his father during these years; he was let run wild, rarely went to school and had not experienced affection. He said that Christmases and birthdays were a disaster; both he and his sibling always woke up to nothing. He never knew Easter existed when he was a child. He said he never remembered his mother living with them.

Mick died when Luke was almost ten years of age. The file records that Luke was unable to wake his father one morning and called for help. The Gardai and the SWD were alerted, and care of the children was then undertaken by Luke's relatives. Social work records from the time of Mick's death as well as evidence provided at interviews confirm that both boys were found in very poor circumstances. A social work report drawn up five years later but referring to this period indicated that while Luke was living with his father he experienced no affection or boundaries and had rarely gone to school, although it was not clear whether this report was based on contemporaneous records or on Luke's later recollection. The file records that the disability service used by his sibling wrote a week after Mick's death to the SWD Team Leader stating they had previously raised concerns about the children's welfare to the duty social worker. This letter, which is on file and which was copied to the Head Social Worker, requested an urgent case conference. There is also a letter on file from the PHN requesting a case conference on the children. The HSE was unable to provide any relevant records in relation to this to the review team.

At interview with the review team, Luke's relatives here called Annie and Betty described extreme conditions of neglect of both children which they witnessed after Mick's death. They also suspected that the boys had been shown pornography and sexually abused by their father. They also alleged that Luke had acted in a sexually inappropriate manner towards his sibling. Two care workers who worked with Luke as an adolescent informed the review team that, in their assessment, Luke was likely to have been sexually abused as a child. One told the review team of her assessment that that 'something very traumatic had happened to him'; another said that he spoke "darkly" of his early childhood.

Luke's first foster placement

Note: the HSE SWD was unable to provide comprehensive records for the period in question.

Records are as follows:

- none covering the first year of placement
- limited for the second year of placement
- none covering the third year of placement
- records covering three months of the fourth year of placement
- records covering four months of the fifth year of placement.
- patchy records covering the sixth year of placement up to its termination in the summer.
- There are no supervision records and transfer documentation was rare. At interview a Senior Professional Manager (SPM) accepted that there was no allocated social worker or care planning for Luke for long periods.

The following services were involved during this period;

- The principal service involved in the case was the SWD children and families service.
- Luke attended a community based education project for a number of months.
- The schools referred Luke to child guidance clinics (CAMHS) on at least two occasions during this placement period.
- Luke on two occasions attended hospital, once for injury after mugging, once for injury for alleged abuse.

Following their father's death, Luke and his sibling urgently needed to be cared for, as their mother could not look after either of them. The file shows that Luke's extended family was faced with a major dilemma and stepped in to try to manage a very distressing and demanding situation. One relative, here called Annie, initially took both children but another relative, here called Carol, almost immediately took his sibling for what subsequently turned out to be a stable and supportive long-term placement. Social work records show that Annie soon found it too stressful and difficult to look after Luke. Carol then arranged privately for Luke to be fostered by longstanding family friends, here

called Mr. and Mrs. Jones, whom she had approached. Mr. and Mrs. Jones readily agreed to take Luke. It appears that the SWD had very limited involvement in arranging the placement which was made without assessment or approval under Section 36 (Friends and Family scheme) of the 1996 Child Care Regulations. It was confirmed to the review team by two SWD managers (who were front-line managers at the time) at interview that Luke went to the foster parents on the recommendation of his family. It is recorded that he was formally signed into the care of the HSE on a voluntary basis by his mother about three weeks later. Evidence given to the review team about the approval process was inconsistent. One of the interviewees referred to above said that to the best of his recollection the vetting procedure had been carried out. The other interviewee recollected that the placement had been formally approved within a year of placement. The written records indicate that the placement was considered for approval by the SWD Fostering Placement Committee four years later but that this was not finalised as medical and background information on Luke was still outstanding. Mr. and Mrs. Jones stated at interview that no vetting process had been undertaken, and that they did not receive support from the SWD at the beginning. However they subsequently began to receive consistent support from a fostering link social worker, a fact which was confirmed by the SWD managers and in the files. One of these managers indicated to the review team that, whilst Mr. and Mrs. Jones could provide basic physical care and good emotional care, she believed that they were otherwise limited in the specialised task of fostering.

There are no social work case records for Luke pertaining to the first year of his placement. Nor is there any record of the allocation of a social worker to his case. There is very little specific reference to Luke in the fostering social work records.

Mr. and Mrs. Jones told the review team that they had only met Luke once, for about five minutes, before he was placed with them. They described him as very withdrawn at first; he was bedwetting and unable to carry out basic tasks such as flushing the toilet and washing himself. He did not talk to them for a few weeks. They noted that he was defensive about his father but had no mourning period after his death. They told the review team that they raised the possibility that Luke had been sexually abused by his father with a social worker quite early in the placement; but that the social worker had advised that there was no need for further action now that Luke was safe. There is no reference to this discussion in the available records.

Luke went to a new primary school near his foster home, from where he was referred to a full-time community-based educational support project. This was to prepare him for re-entry into the mainstream school system, as he had been out of school for some time before his father's death.

This was a pilot community based project (established with funding from the Department of Education and Science in 1998/99 which targeted children who were at risk of disengaging from school, and which worked closely to integrate them with local schools and community services. The review team considered that this project which was subsequently brought under the remit of the Education Welfare service, to have been a model of good practice. Staff from the project described Luke to the review team as “a lovely little boy basically” and noted that he had been quite anxious and was apprehensive about being in a big group. They also commented that he engaged well with the project which provided intensive, often one-to-one, support to him, although they were not able to resolve his difficulties with literacy, numeracy and social communication. The review team would have expected social work involvement in Luke’s referral to this project, as Luke was a child in care, but this is not evidenced in the record. The project head told the review team that they had not initially been briefed on Luke’s background by the SWD although a social worker subsequently convened an inter-disciplinary case meeting at their request. The review team has concluded that this social worker is most likely to have been from the fostering team as there is evidence that Luke had an allocated social worker (from the Looked After Children service) at this time. There is no record of the inter-disciplinary meeting in SWD files, but a copy of the minute was provided by the project, which describes Luke as having ‘huge’ fears about the security of his foster placement. The head of the community education project told the review team that the foster parents had needed a great deal of support and guidance.

The new primary school reported that Luke was in the bottom third in terms of academic achievement but did not consider him to be learning disabled. They believed that his academic level of achievement did not warrant learning support, though he was assigned to small group work. They noted good attendance and good input from his foster parents.

Records in respect of the second year of Luke’s placement are very limited, covering only a 3 month period and do not contain any record of either assessment or of reviews. The records indicate that Luke still did not have an allocated social worker. Luke’s relatives told the review team that when Luke had been placed initially, they were able to see him every week but contact became more infrequent after a period and became monthly or bi-monthly. They felt that he was unhappy then, and saddened by irregular contact with his siblings. His relatives told the review team that they began to feel unwelcome and worried that their visits only made it harder for him. Nonetheless, the review team also heard from one social work manager that Luke was very attached to his foster parents, a fact that was confirmed by educational staff who worked with him and by his aftercare worker.

The review team has been unable to ascertain if these concerns expressed by the family were communicated fully to the SWD or were addressed. The file does show that Carol discussed her concerns about the placement with a social worker from the fostering team after the first year. Social workers, presumably from the fostering team, visited the foster carers for a general discussion on the concerns but no formal action was initiated. The records indicate that Mr. and Mrs. Jones were receiving regular support from the fostering link worker at this time and this was confirmed at interview.

There are no social work records for Luke in respect of the third year of his placement with the Joneses when he was aged between 11 and 12, nor any record that he had been allocated a social worker. Information from other files shows that a new born half sibling of Luke's was placed with the Joneses at this time. There is no evidence on file that the baby's placement was assessed or approved, and no record of the placement in Luke's file. The foster carers told the review team that there were differences of opinion between the social workers involved as to the suitability of the baby's placement, and legal action had been initiated by Luke's mother to have the child removed but was discontinued because of a legal technicality. The review team was able to confirm from the fostering files that the final decision was to leave both children with Mr. and Mrs. Jones, subject to regular review and intensive support. Luke was apparently very upset by the episode and the prospect of losing his sibling, as he saw it.

The review team was told of growing tensions between Luke's extended family and his foster carers, with differing accounts from each about the degree to which contact with his family was encouraged or discouraged by them. The file records further allegations made by Luke's relatives about the placement when he was almost 14 years old, which were investigated by the SWD and refuted by Mr. and Mrs. Jones shortly afterwards

Records in respect of the fourth year of Luke's placement, when he was aged 12 to 13, are also very limited. They do not include any case conference records or supervision records. There is evidence that a social worker was allocated to Luke, here known as Social Worker 1. She met Luke early in the year and reported him to be 'assertive', 'talkative' and 'sociable'. This is the first reference on file to the allocation of a social worker from the Looked After Children Team to the case.

The foster care files record Luke's foster carers' concern about his difficulties in accepting limits and his behaviour, especially at school, which included poor concentration and an inability to keep quiet or refrain from interfering in situations which were nothing to do with him. The fostering social

worker recorded a discussion with them about the results of Luke's previous psychological assessments. This was the first indication that the SWD had access to the earlier psychological reports. The review cannot establish from the record whether this information was shared between the fostering team and the Looked After Children Team.

Luke was then re-referred to the CAMHS service at the instigation of his foster parents. The record does not show how the referral was made, but it is noted that Mr. and Mrs. Jones were offered support from the CAMHS service at the inter-disciplinary meeting held sometime previously (referred to above). The psycho-educational assessment carried out at this time, which is contained in a report dated one year later, described Luke as a "happy, open 13 year old who worked rather slowly but carefully" and said he functioned at the borderline range of general learning difficulties. The report concluded that he would find the educational process somewhat difficult and stated that he found it hard to structure himself. The review team was told at interview that the primary school that he was attending at the time had not received this assessment.

Luke started secondary school some months before he turned 14 years of age. His class teacher and the current principal of the school told the review team that assessments showed Luke to have difficulties with literacy, numeracy and social communication. They considered him lacking in coping skills and recalled that he got into an awful lot of scraps and arguments. They told the review that Luke was placed in a small class with two teachers and had access to extra learning support and to special needs assistants, in recognition of borderline general learning difficulties. In late autumn Social Worker 1 referred on file to Luke's suspension from his new secondary school. The family and foster carers said that he began to run away to his family at this stage. Social work records state that Luke's relatives once again expressed verbal concerns about his foster-placement. They raised issues about the limited contact they were allowed to have with him, the lifestyle of the foster parents, including the nature of their relationship and alleged alcohol abuse. They also expressed concern about Luke's well-being. They were asked by the SWD to put these in writing.

Luke's records for the fifth year of the placement when he was aged 13 to 14 years are very limited in number and cover only a four month period. They do not include any review records or supervision records. The file records outline growing concerns about Luke's difficulties in secondary school from which he continued to truant. The delayed CAMHS psycho-educational assessment report was made available to the foster carers and to the school in the spring. The file indicates that the SWD Looked After Children Team knew of the contents of the report and were aware that Mr. and Mrs. Jones had found it very helpful. A summary by Social Worker 1 noted that Luke had started

to get into trouble at school a month after starting secondary school (in the autumn of the previous year) and indicated that he found it difficult to make friends at school and could not come to terms with being in mainstream foster care while his sibling was fostered by his relative. The file records that social workers met at the beginning of the year to assess the allegations made by the relatives and that they addressed them with the foster carers three months later. The allegations were denied by the foster carers. The Gardai were notified but did not take any action, according to the record. The review team understands that Luke effectively ceased to attend school from late spring onwards, although he may not have been formally discharged until a year later (the school underwent a major restructuring at that period which disrupted administrative systems, and they explained to the review team that they did not have good records).

Luke's placement with Mr. and Mrs. Jones broke down in its sixth year, when he was aged 15. Social work records pertaining to six months prior to the breakdown of the foster placement are scant and do not include any review records or supervision records.

There is evidence from Mr. and Mrs. Jones and from relatives that Luke absconded frequently prior to the placement breakdown, although this is not recorded in the files. Social Worker 1 recorded a conversation with Luke who said his father Mick had 'fondled' him when he was a young child. She also noted a possible eating disorder. Relatives told the review team that, in their view, he had been very withdrawn at this time. The fostering files indicated in spring that Luke had become more settled, working well at school, but within two months the situation had deteriorated and Mr. and Mrs. Jones reported their suspicions that Luke was smoking hash and was lying and fighting a lot. An undated unsigned note made the first social work reference to a possible learning disability and raised the possibility of alternative placement if Luke was unhappy. There is a HSE payment record for two new beds, stating that at some stage this year (date not recorded) Luke broke his and his half-sister's beds at a time when he was allegedly using drugs.

In the early autumn, Social Worker 2 accompanied Luke to hospital after he had been allegedly assaulted by Mrs. Jones. The hospital report could not confirm whether the injuries had resulted from an assault, but stated that they were not inconsistent with the allegation. There is a report on file of a Garda investigation which did not result in prosecution. The placement broke down when Luke subsequently refused to return to Mr. and Mrs. Jones. The file indicates that he stayed with a friend's family in the immediate aftermath of this event.

Foster Placement Breakdown

(Note: From this period onward, the HSE were able to provide the review team with detailed records).

The following services were involved during this period;

- The principal service involved in the case was the HSE children and families service, through the Looked After Children team.
- Short term residential care (x 2)
- Social work Out of Hours and Crisis Intervention service (x 3)

When the placement broke down in early autumn, Luke, then in his 16th year, got a place in an HSE-funded mainstream residential unit on a medium term basis. The record covering the months after he left his foster home indicates that he was hugely vulnerable at this time. His relatives told the team that they felt that he was “very messed up” and in a “deplorable” state and expressed alarm at his deterioration at this time. There is evidence that relatives continued to be pro-active in supporting Luke in his residential placement, sometimes providing missing background information to residential staff and to social workers. The record shows that social workers were active on his behalf on the immediate priority of getting him a placement. The file notes that Social Worker 2 believed that the breakdown of the foster placement was irreversible and reported growing concerns about Luke’s health, including substance abuse and suicidal thoughts. He was brought to a GP who recommended practical work and cognitive behaviour therapy to change his destructive and irrational behaviour. A care plan was drawn up although not completed. There is no record of a statutory Child in Care review or of consultation with Luke or his family/foster family or with the residential unit. The plan focused on returning Luke to foster care and to education, linking him with counselling for anger management and contacting with his half-brother Sean and his relatives.

The file shows that the residential unit made almost daily reports to the social worker of Luke’s increasingly violent and risky behaviour, involving violence, fighting, stealing and absconding. The social worker’s responses to these reports were by phone and the contents of the conversations are not noted. Gardai were called on more than one occasion. The residential unit sought full background information and a ‘move-on’ plan but there is no evidence that this was provided.

Indeed written evidence from the residential unit, supported by evidence at interview from the family, indicates that it was Carol who provided information on Luke's background and circumstances. His relative Annie told the review team that the family constantly had to brief incoming social workers because of the poor or missing file records. She and another relative told the review that Luke was becoming dependent on tablets and urgently needed counselling. They said that both they and Luke were frustrated at the inability of social workers to deliver services.

In mid-winter, the SWD was informed by the residential unit that Luke had been begging in the city centre. It was also reported that he was having a sexual relationship with a female resident (both under 16) and it was alleged he had attempted to sexually exploit her. According to the record, the Gardai were informed of this by the residential unit. Their response is not recorded. There is no evidence of any child protection response by the SWD to this serious reported incident. According to the file record Luke then left the residential unit to stay with a relative, here called Margaret, and remained with her over Christmas. After the New Year, Luke returned to the residential unit. The file records that the SWD linked him with a youth diversion programme but after three days he refused to continue with it. When he returned to the residential unit the social worker was told that he appeared quite "manic". A week or so later, the unit reported to the social worker that Luke was missing.

Luke was discharged from the mainstream residential unit at the end of the month and referred to the Out of Hours (OOH) social work service which provides support to homeless young people. This service placed him in an emergency hostel for young people. He was also referred to the Crisis Intervention service.² A care worker in this service told the review team that they were unable to get a social care report on Luke from the relevant SWD which impeded their ability to identify which services would be appropriate to his needs. The emergency hostel, which was located in the inner city, indicated concern that Luke would become quickly immersed in the street scene. Care Worker 2 told the review team that he presented as defiant, un-cooperative and 'frightening'; he was an "extremely broken child..... there was no evidence of any sensitivity or conscience... he was obviously a very hurt child, full of revenge". (These descriptions should be understood as illustrative

² The Crisis Intervention Service, established as part of the social work Out of Hours service, to provide an emergency service to children and young people who present as homeless.

of the difficulties with which Luke was struggling and not pejorative criticisms of him). His social worker sought a psychiatric assessment at this time, which he refused to attend. It was evident that Luke had established a pattern by now of refusing services from social workers.

A family welfare conference (FWC), the first to be convened in this case, was held several weeks later. The record of this meeting refers to a family plan which recognised his need for a new residential placement which would enable his care to be shared with the family. A rural mainstream residential centre was suggested, which would require to be supplemented by week-end care by a relative. Other elements of the plan included return to education, daily structure and boundaries and health and emotional stability. According to the record, a schedule of week-end placements with relatives was to be set up the following month. The plan was to be reviewed after three months.

Evidence of Luke's situation as the month progressed is somewhat contradictory. The social work file contains incident reports made virtually every day detailing his difficult and disruptive behaviour in the emergency hostel, with Garda involvement and at least one arrest, but the review team was told by his relatives that he was also living with Annie at this time. Records show that he was formally placed with her the following month, on a trial basis and on condition that counselling was provided. During this time Luke attended a youth programme for a week before he was suspended for inability to manage his anger. According to the file, his placement with Annie lasted for just over a month, at which point Annie refused to have him back. According to the record, her children had been upset by the placement. Luke returned to the same emergency hostel, where staff reported increasing aggression and arrests. He was arrested for breach of public order. Luke was not allocated a social worker for two months during this critical period. His next social worker, here called Social Worker 3, told the review team that when she took on the case, Luke was impulsive, angered easily and had a chaotic life style. She made daily contact with Luke but he refused all interventions (e.g. weekday placement centre, counselling and youth advocacy). She also called to the foster carers to discuss Luke's allegations of mistreatment.

The file shows that the Luke's relatives sought legal advice at this time, and wrote to the SWD through their legal representative, expressing their view that he was very much at risk and requesting an immediate investigation. This led to an application by the family for the appointment of a Guardian ad Litem (GAL) a month later. The family stated that they were subsequently in court in excess of 20 times. A child protection plan was drawn up by the SWD, although there is no

indication on file as to how it was agreed or what kind of assessment was involved. The evidence on file indicates clearly that the SWD was fully aware that Luke was increasingly abusing alcohol and drugs, was well known to Gardai, was unsafe and very vulnerable and was no longer using the emergency hostel because he was being threatened. The record is not clear as to where exactly he was living when this happened; the review team surmises that he was either with Annie or was living rough on the streets, or possibly both. The review team was told by his relatives that Luke really wanted to change at that time.

The Court appointed a Guardian ad Litem (GAL) for Luke. The GAL told the review team that she had been very frustrated with the level of co-operation from the SWD, and their inability to provide her with “a context or framework” for the work with Luke. The review team understands that the GAL was looking for evidence of prior assessment and care planning on which to base her involvement. According to the file, the Court directed that Luke was to be given bereavement counselling, that the SWD was to assess Mr. and Mrs. Jones, the former foster carers and, that the SWD must report any threats to him to the Gardai. The rationale for the reference to Mr. and Mrs. Jones at this time is not clear to the review team from the available record.

The social work file records that, at this stage, Luke was so unsafe on the streets that the SWD had to transport him by taxi to various locations. There is also evidence of discussion about referring him to a special care unit which could provide secure ³care for a time limited period. An application was to be considered at the next available referral meeting. There is an undated request for an emergency child protection case conference by Social Worker 3 and Team Leader 2 on file, but no evidence of how it was processed. The report for the second Family Welfare Conference (FWC) notes that Luke had in fact returned to live with Annie a couple of weeks previously. It makes reference to the frustration and anger of relatives at the lack of follow up by the SWD of decisions taken at the previous FWC (where it had been agreed that Luke would commence a new residential placement in a rural mainstream residential unit from Monday to Friday with weekend care to be provided by Annie). The plan was to assess Annie as a relative foster parent under Sect 36 of the

³ Special Care is a locked facility where the person is often detained against their will for a period of months. Special care can only be accessed through a court order and is subject to regular review by the court.

Child Care Regulations 1995. The social work file notes a request from two of Luke's relatives for provision of anger management, bereavement counseling, assessment re cognitive development, a care plan and ongoing professional support for both Luke and for Annie, the appointment of a counsellor/key worker and updated reports on all of the above from his file.

At this time Luke made a written statement to his legal representative about his life, which is on the social work file. In summary, Luke described very unhappy experiences at home with his father. He also made a number of allegations about his foster home which were investigated and by the HSE and not confirmed. He claimed that he had received little service from social workers, and that he had been unfairly treated by the HSE.

Luke went to the rural mainstream residential unit, but tried to abscond to England two weeks later. The social worker succeeded in having him intercepted at a port trying to board the ferry. He returned to the rural mainstream residential unit and despite difficulties, including a reported assault by another young person, remained there until the placement finally broke down after a total of two months. The unit subsequently advised that the placement had been unsuitable as Luke needed more support and structure.

At the same time, the weekend arrangement with Annie disrupted, according to the record, because of Luke's drinking, criminal behaviour and sexualised behaviour. Annie wrote to Luke asking him not to contact her again. A report on file from a care worker in the Crisis Intervention Service referred to his involvement in violence on the streets and to 'vigilante' threats made against him, which his relatives had already attempted to avert by paying the people who threatened him.

Luke returned to the emergency hostel, which continued to make daily reports to the social worker about his violence, aggression and arrests for suspected criminal behaviour. Social worker 4 was allocated to the case at this time and referred Luke to a youth diversion programme which provided some overnight accommodation. In the referral, Social Worker 4 described Luke as being at 'medium' risk but confirmed that no comprehensive assessment of his needs had been carried out. She also stated that he had no record of aggressive or violent behavior (which is contradicted in other, existing, records). Shortly afterwards, it was agreed by frontline and senior management, together with Luke's GAL that an application to a special care unit should be made on his behalf. This was supported by his relatives. The application, which took several weeks to complete, detailed the many risks to which he was currently subject including threats, nine criminal charges and multi-substance abuse. In the interim, Luke had returned without the agreement or sanction of the SWD,

to live with his former foster carers, Mr. and Mrs. Jones who had bailed him out when he was under arrest.

Second placement with Mr. and Mrs. Jones

Note: Social work records were limited for some of this period and the following information is largely derived from reports drawn up for court proceedings in respect of Luke, following the decision to appoint a GAL to review his case and a subsequent legal challenge by his relatives.

The following services were involved at this time;

- The principal service involved in the case was the HSE Children and Families Service (Looked After Children Team).
- Luke was arrested by An Garda Síochána on a number of occasions and also attended Court.
- Luke used teenage counselling services from time to time.
- An after-care worker from an HSE-funded agency was appointed to support Luke some 6 months ahead of his 18th birthday, in preparation for his leaving HSE care.
- Luke was offered respite accommodation in residential centre
- The Probation and Welfare Service
- The courts / GAL

The evidence on file establishes that the SWD was not actively involved in setting up Luke's second placement with his previous carers. It had been seeking a place for him in a special care unit. The social worker is on record as advising Luke that it would be very difficult to have him officially returned to the foster carers; she asked him to write to her requesting to return. He did so, saying he was happy to be back with his sibling and that Mr. and Mrs. Jones were treating him 'like an adult'. The review team notes that the plan to place Luke in special care which was presented to the District Court at this time made no mention of his second placement with the Joneses.

Luke was described as happy to be back with Mr. and Mrs. Jones and with his sibling, away from the chaos of the streets. The social work records indicate that Mrs. Jones started a formal training course in parenting. There is reference on file to a 'professionals' meeting of the Children in Care social work team the status of which is unclear, which considered the placement safe and suitable. However, a contemporaneous file note by the team leader doubted its long-term sustainability.

Luke's GAL was changed, and a statutory Child in Care review, convened early in the placement, concluded with a plan for Luke to remain in foster care despite other evidence on file to suggest that his social worker, the team leader, and the fostering social worker already had serious misgivings

about its sustainability. The review was attended by social workers, Luke and by Mr. and Mrs. Jones, but with no outside agency representation. It confirmed the placement as suitable and planned for Luke's needs, which included respite care, drugs counselling and psychiatric assessment. This was the first statutory Child in Care review convened in respect of Luke since his admission to care some seven years previously. The record does not refer to the need for formal fostering assessment or approval and there is no indication on the record that this was undertaken by the SWD.

Family members opposed Luke's second placement with Mr. and Mrs. Jones, instigating a legal challenge within weeks of him going there. Luke's extended family told the review team that the reason that Luke settled initially into the placement was probably because he had manipulated Mrs. and Mr. Jones into letting him do what he liked.

An unsigned care plan dated some two weeks after the review foresaw Luke's remaining in care with Mr. and Mrs. Jones and noted that he was now receiving counselling for his drug problem. While the plan was positive in tone, it noted that he was on probation and recorded concern about the negative company he was keeping. Another review was not scheduled for ten months, according to the record. The record indicates that the District Court had misgivings about this plan (which was revised some weeks later). The report of the GAL to the Court at this time called for measures not addressed in the care plan, specifically a comprehensive assessment of Luke's relationship with Mr. and Mrs. Jones and the circumstances of his allegations against them, and for urgent access to psychological, psychiatric and mediation services. The Court acted on her recommendation and directed immediate psychiatric evaluation and a comprehensive assessment and mediation to reconcile Luke with his maternal family. The social work records note that it was Mr. and Mrs. Jones rather than the family who became active in supporting planning for Luke at this time.

Despite the fact that Luke had gone back to his previous foster placement, Social Worker 4 continued to pursue the option of a special care placement until it was turned down a month later by the (special care) Admissions and Discharge Committee for three reasons: that Luke would be 17 years old shortly; that he had recently achieved some stability with his foster carers; and because there was no clarity regarding his current level of functioning. The committee raised the question of

whether a RACS (Risk Assessment and Consultancy Service⁴) assessment had ever been considered. The review team could find no evidence of any SWD response or reaction to this query. According to the record, Social Worker 4 kept in very regular contact with Luke for the following months, during which he experienced stability in his foster placement, was apparently not abusing alcohol or drugs; was behaving well and was spending a lot of time at home. He was described in the record as being in 'survival mode'. In response to the Court instruction, the social worker tried to source an appropriate psychiatric assessment but found it difficult to get a psychiatrist to assess a young person between 16 and 18 years old. Luke was effectively ineligible for both child and adult mental health services⁵. He was eventually assessed by a psychiatrist from the adult service just before his 17th birthday. The psychiatrist diagnosed no formal mental illness and recommended psychotherapy but did not feel qualified to administer an IQ test or perform a child psychiatric assessment or child psychological assessment. The GAL noted the absence of any family history of learning and intellectual disability in the psychiatric assessment and brought this omission to the psychiatrist's attention. This led to referral to a consultant psychiatrist from a learning disability service, which was declined by Luke who did not accept that he had a learning disability.

Social work records for the winter months after Luke turned 16 years of age are not comprehensive but indicate very regular contact between him and Social Worker 4 against the background of his continuing criminal activity and ongoing concern about drugs. The first record of involvement with Luke by the Probation & Welfare Service was in mid-winter. This followed criminal charges heard at the end of the previous year. Luke's GAL noted his lack of concern at the number of cautions he had amassed. The record shows conflicting views between the GAL and Social Worker 4 in respect of Luke's relationship with his extended family; the GAL felt he should have contact with them but his social worker advised him that he needed to acknowledge that his foster parents were now his family. The social worker also recorded that she had identified a potential aftercare placement for Luke.

⁴ The Risk Assessment and Consultancy Service is a service attached to the CAMHS service which provided psychological and developmental assessments of children and young people designated to be vulnerable or at risk

⁵ ⁵ The upper age limit for access to Child and Adolescent Mental Health Service was at age sixteen, whilst access to Adult Mental Health service did not begin until age eighteen.

Luke had another change of social worker a few months later, when Social Worker 5 was allocated to him. It appears from the record that Luke's continuing criminal activity put untenable strain on his placement, undermining its stability. Although Social Worker 5 had been initially optimistic about the placement, she quickly became concerned about the impact of Luke's behaviour on its durability. The next few months were difficult for the Joneses; Luke was robbed and assaulted, requiring hospital treatment and at one point the placement appeared very vulnerable.

Luke's mother died some eight months after Luke had returned to the Joneses. Luke was very upset by this event; he had seen her only briefly before she died. His extended family managed the tension between themselves and Luke's foster carers at the time of the funeral, but told the review team that they were unable to see enough of Luke to assess how he was coping with the loss of his mother. The fact of his mother's death led to contact between Luke and his half-sister, Cathy who had hitherto been unaware of his existence. She subsequently kept in touch with him.

The file indicates that Luke's mental health and behaviour deteriorated after his mother's death, putting his placement under strain. Social Worker 5 continued to be optimistic about the placement for a period, noting that the carers were supportive and that Mrs. Jones was attending courses to help her cope with Luke's behaviour. She did not initially consider that an after care plan would be necessary, but within weeks she became concerned that the placement was at risk and began to seek a residential placement for Luke. An aftercare worker was subsequently appointed, seven months before Luke's eighteenth birthday.

Social Worker 6 took over the case at this time. A 'professionals' meeting was held and chaired by an acting team leader, at which an aftercare plan was formulated. The meeting was attended by social workers, Luke, Mr. and Mrs. Jones, the GAL, a social worker from the proposed respite placement, aftercare worker, Juvenile Liaison Officer, psychiatrist and a CAMHS psychiatrist and psychologist. This plan noted that Luke was still being supported by his foster parents and that that his needs assessment had not been completed. It also outlined the impact of the negative company that he kept, his criminal activity, his 'fragmented' health needs, the need for a comprehensive psychiatric assessment; ongoing contact with his relatives. It noted that he was attending counselling. The review team has noted that much of the content of a care plan formulated some eight months previously was reproduced in the record of this meeting.

According to the file, the foster placement finally broke down shortly afterwards and Luke became homeless. He was once again referred to the Out of Hours service. The following week the GAL was discharged. No rationale for this was provided in the records but the review team presumes that the

decision was linked to the status of the case in the Courts. It appears that the SWD did not follow up the GAL's suggestion to try and reconcile Luke with his extended family. Although the family was very active in Court proceedings on Luke's behalf, there is little evidence of personal contact between them and Luke at this time.

Planning for leaving care and aftercare

The following services were involved at this time:

- The principal service involved in the case was the HSE Children and Families Service (Looked After Children Team), until shortly after his 18th birthday.
- The after care agency key worker was in regular communication with Luke before and after his 18th birthday
- HSE social work Out of Hours Service (until 18th birthday)
- Adult homeless hostels (after 18th birthday)
- A respite accommodation centre was involved in planning for the future
- Luke was referred to a GP for health issues related to substance abuse.
- Luke needed psychological services but had difficulty, because of his age, accessing child mental health services and had to go to an adult psychiatrist for assessment.
- On one occasion Luke was admitted overnight to the local hospital
- The Gardai were regularly involved with Luke because of his criminal behaviour.
- Probation and Welfare Service
- The courts
- A week after the placement breakdown, the GAL was discharged by the court but was reappointed in mid-winter
- The prison service

There is evidence that Luke was at heightened risk self harm, offending and substance abuse when he became homeless for the fourth time. According to the records, he used different emergency hostels, presenting as chaotic, agitated and uncooperative but also constantly anxious about his safety. When Social Worker 6 met the panel, she reflected that his cognitive ability at this time had probably been impaired by drug use. The record shows that Social Worker 6 made numerous efforts to secure a placement for Luke, but was unable to access any whose criteria he met. She also tried to source placements in private child care organisations although funding for private care had been explicitly refused. The file records that Luke regularly came to the SWD office in an agitated state, demanding money which was given to him in small amounts by Social Worker 6. He refused other offers of service, and was becoming increasingly embroiled with the law. He was described by a worker from a voluntary agency as 'ingrained' in street society.

Three psychiatric reports were produced in respect of Luke over the following month, all of which highlighted his drug misuse with related conduct and other psychological and emotional disorders and indicated the need for a suitable placement. The review team could find no evidence that the multiple concerns recorded about his safety and behaviour at this time triggered any emergency Child in Care review or a child protection case conference.

At the end of the summer, Social Worker 6 reported to the SWD Placement and Discharge Committee (whose role was to oversee the movement of children in and out of residential care placements) that Luke's behaviour "continues to be erratic and dangerous to himself and others.... he appears increasingly lost and directionless". His behaviour had become intermittently threatening to her and she had had to withdraw from meeting him on more than one occasion. One of the emergency hostels carried out an assessment of the risk to which Luke was subject, the only one which was ever conducted on the record. The seriousness and urgency of his needs was such that staff there believed they were unable to meet them, and they indicated he was in danger of being barred because of his behaviour. According to the record, he was not engaging with his Probation & Welfare Officer and was in breach of his bail conditions.

A statutory Child in Care Review was held ten weeks after the placement breakdown, involving Luke, relatives Annie and Betty, the emergency hostel, the Out of Hours social work service the after care agency, the social worker and the team leader. The unavailability of a local residential placement was discussed and it was noted that Luke was not prepared to go outside the area. Annie and Betty reminded the review about his terrible abuse as a child and the need for him to get therapeutic help. The review made a number of recommendations about teenage counselling and youth training. It did not make a specific recommendation about accommodation. A revised care plan, which contained significant additional information on Luke's early childhood, recommended residential placement until his 18th birthday, to be followed by supported lodgings. However, according to the records, Luke remained in either emergency accommodation or sleeping rough and a report from the hostel raised concerns that he was being sexually exploited, later denied by Luke. A document entitled Initial Child Protection Conference Assessment and Plan, notes the risks presented to Luke by his drug use and homelessness. Social worker 6 requested a child protection case conference at this time but there is no evidence that it took place.

According to the file, the situation remained the same for the next few months. The SWD Admission and Discharge committee were unable to find a suitable placement and his GAL questioned the lack of urgency employed in addressing Luke's needs. His drug use and criminal behaviour continued and

his family refused to accommodate him over Christmas. However, his GAL, who reported her concerns about non action by the HSE to the Court at this time, noted that he was 'holding himself together' and was open to support.

Luke was by now over 18 and an aftercare plan had been developed for him. Social Worker 6 was authorised to continue working with him and it was proposed by the aftercare agency that the HSE would continue to support him in dealing with his homelessness. Social Worker 6 arranged B & B accommodation for him over Christmas. Luke left however before the agreed time and returned to sleeping rough before being remanded to prison on serious charges. An aftercare review was held early in the New Year and it was agreed that the aftercare service would manage his case from then on, following the formal withdrawal of the SWD.

Luke's aftercare worker described him as "an extremely vulnerable lad... when he was in good form and calm and collected, he had great ideas for himself; he was good to work with. But unfortunately he was very ... inconsistent." His aftercare plan identified his need for health care, addiction treatment, contact with family, practical life skills; stable accommodation, training and employment as well as help with literacy. The plan noted his reluctance to engage with services and his refusal to leave the immediate locality for housing, although he missed an appointment with a relevant possible provider. His independent living skills were judged inadequate as he had no experience of taking care of himself and had difficulty with literacy and completing forms. The need to try and resolve the "turbulent" relationship with his extended family was considered important as he lacked other social supports.

The aftercare worker's case notes were maintained regularly and illustrate Luke's sporadic interaction with the service and continuance of negative behaviour and self neglect. This pattern was corroborated in the records of the Probation and Welfare Service, which described his appearance as "shocking". His life was punctuated by increasing periods in prison, culminating in five admissions during the first six months of that year. The aftercare worker constantly reassured him that support was available and continued to make determined efforts to get him accommodation, ultimately referring him to a residential unit that provided training. However, Luke refused this, opting to use emergency accommodation. In late summer of that year he was again imprisoned. He left there just prior to his 19th birthday and went to an emergency hostel from which he was soon barred. His behaviour was described by staff there as more 'chaotic' than previously; he was often affected by drugs, was aggressive, used weapons, and appeared suicidal at times. He was imprisoned again within a few months.

The available record strongly suggests that Luke's prison experiences were very negative, as he was subjected to incidents of serious bullying and had to spend periods in 23-24 hour detention for his own protection. The review team was given some contradictory evidence about Luke's contact with his family while in prison. Family members told the review team that they visited him regularly once they were aware that he was in prison. However, the aftercare service told the review team that he received no visits from his relatives. They said he valued the contact that he had with his foster carers and this was confirmed by the fostering social worker who said that Mr. and Mrs. Jones visited and telephoned him in prison.

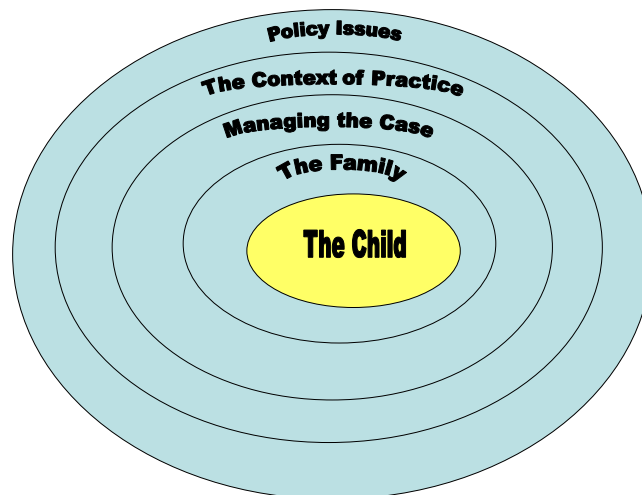
Luke was due to go to a rehabilitation centre on his release from prison, but decided to defer this and returned instead to a hostel. He was found dead two weeks later. The closing summary in the social work file refers only to the transfer of his care to the voluntary aftercare organisation and to his date of death. There are no further details of the circumstances of his death on file.

Section 3: ANALYSIS

In presenting the lessons, conclusions and recommendations in this case, the review team has adopted an ecological approach. This framework places the needs of the child/ young person at the centre, and then works outwards, to consider the child/young person's family and environment, the management and governance issues highlighted by the case, the context of child care practice, and any national implications for practice and policy. This approach is based on the contention that the outcome in any case is influenced by the interaction of all of these systems.

This chapter provides a narrative summarising the review team's assessment, based on the information available to it, of the key issues in Luke's case from the perspectives of:

- the child/ young person
- the family
- managing the case
- the context of practice
- policy issues



3.1 Luke

The review team was given many glimpses, often contradictory, of Luke that have been sketched in the chronology. He was a challenging young person to engage, was prone to swings of mood, was undoubtedly difficult to manage, was heedless, could be aggressive and was at times manipulative. He was also capable of presenting well, and could participate when motivated. He could be observant and reflective. Several people described him as 'charming', with what one worker referred to as a 'quirky' sense of humour. Another worker said that he wore his 'disturbance on his sleeve'. He had conflicts with his family and with his carers that were never resolved. He did not trust the services that were offered. He was described as resilient, but with 'huge emotional baggage that was 'palpable at times' and a 'depth of distress'. It was commented that he had a low opinion of himself and 'wanted to make changes'.

There is little record of Luke's own words on file except for a statement made when he was 16 and a copy of his self-assessment of capacity for independent living which he completed before leaving care at eighteen. In his self-assessment, he admitted to getting upset and "going off the head" when stressed or worried but claimed to have good practical skills. He identified his strength as 'caring about his family'. He felt his needs were for a roof over his head, clothing and a job.

All of the information available to the review team suggests that Luke's needs, whether emotional, developmental or educational, were inadequately met during the years when he was at home in the care of his father. There are ample indicators on file that Luke presented as a child with developmental problems and significant and increasing behavioural difficulties at that time. One of the GALs who worked with him later described his home situation during these years as 'untenable'. Suspicions that he was being sexually abused, later confirmed by Luke himself, do not appear to have been followed up when raised by his school (the absence of social work records means that there is no evidence to show what action was or was not taken). Basic needs for safety and nutrition appear to have been unmet on occasion. Despite the recognition of his primary school teachers that he needed additional help with education, the refusal by Luke's father of a place in a school for children with learning difficulties meant he received less support than he needed. Luke's learning disability was recognised by some services including the PHN service, a speech and language therapist, Child and Adolescent Mental Health (CAMHS), his various schools and the education

support project that he attended. However, it was not sufficiently considered by the SWD when planning his care until he was in mid-adolescence.

The review team has noted the extremely traumatic circumstances of Luke's father's death and its impact on both him and his sibling, both of whom had complex needs. At nine years old, Luke's world was turned upside down; he had to adapt to the loss of his father, the continuing disengagement of his mother and separation from his sibling. Additionally, he had to get used to living with foster carers who were strangers to him when he was placed with them. In the opinion of the review team, he needed a very intensive and sustained care plan at that time. The factors which needed to be specifically addressed in care planning between the ages of 10 and 12 included the emotional, psychological and developmental impacts of long term neglect and possible child sexual abuse; separation and loss; attachment (to family and to foster carers); family history of learning disability; educational delay; family contact needs and impaired social development. The team has also reflected on the possible adverse emotional consequences for Luke of the attritional relationship between his family and his foster parents which was evident at this time.

There is no clear record of how Luke's troubled behaviours manifested themselves or were managed during early teenage years. The review team has heard evidence that his foster carers maintained good contact with his school, and that this was a source of positive support for them. However it has not been possible to get a picture of how they managed him at this time; how, for example, boundaries were negotiated, how they responded to his moods, how they encouraged him to think about the future. There is little reference to his social or emotional development. The lack of detail or analysis in the file record of his absconding is a major gap. Luke's need for family contact was constrained by an on-going conflict between his foster parents and his extended family; the review team could find little evidence that important attachments were recognised, developed or encouraged. There is no assessment of the significance for Luke of his reference at this time to sexual abuse by his father.

Overall, the evidence in respect the period prior to the first breakdown of the foster placement points to Luke's disengagement from foster parents, school and from social workers and to a sense of increasing anger and defiance. The absence of care planning would have meant that he had little idea about his future, and little sense of his own involvement in planning it. The review team affirms the view expressed to it by a GAL that he was running away from an environment that was better than that in which he had lived when at home, but which still had limitations in respect of his needs. In the assessment of the review team, the 'fall out' from the foster placement represented a second

major traumatic transition for him, precipitating a period in his life of heightened uncertainty and acute risk. There is minimal assessment of this significant event on file, and Luke's rationale about where he was running to at this time is a matter of speculation.

The review team has deliberated on how Luke made sense of the environments in which he found himself in the 11 months after leaving, and before returning to, his foster home. He experienced at least six changes of placement during this time including two in mainstream residential care, one with a relative, and, at 16 years of age, three in emergency accommodation. It is likely that he also spent periods living on the streets. The exact record of how much time he spent with his relative Annie cannot be established. The record confirms that he had major difficulties in adapting to the group settings in residential care, and in negotiating boundaries for behaviour. He spent three periods (an estimated time of some 16 weeks) in the largely unstructured environment of the emergency hostel. He struggled to adapt to living with Annie and her family. He was, according to the record, constantly and increasingly involved in drugs, criminality and was subject to threats of violence on the streets. Relatively little is known about how Luke saw himself or his situation at this time. One care worker suggested to the panel that he was not street wise when first referred to the emergency hostel; that he associated himself with an older group of young people who were involved in criminality, but felt safer with younger people; he was not liked or trusted, got regular beatings and was vulnerable to sexual exploitation. Whilst relatives made considerable efforts to advocate and intervene on his behalf during this time, Luke's relationships with them appear to have deteriorated, and his experience of family contact, on his terms, ended in rejection.

There is some divergence of opinion on file as to why Luke chose to return to his previous placement. There is no sense in the record of if or how he and Mr. and Mrs. Jones dealt with the very acrimonious circumstances of the placement breakdown the previous year, including serious allegations about their treatment of Luke and about their lifestyle.

The review panel has concluded that Luke's fourth placement in emergency accommodation, which lasted for some five months until his 18th birthday and discharge from care, thrust him back into a hazardous environment from which he was never likely to recover. As before there is little sense in the record of how Luke saw this period in his life. By this time he had effectively cut ties with his foster carers and relatives, who were important to him but whose combined support he had never been able to draw on. Despite the best efforts of the social worker and the voluntary after-care agency staff, it is clear that his engagement with the belated care planning process was at a low level. Social Worker 6 told the review team that Luke had no primary attachments, nowhere to live

and that his life style was chaotic. The review panel acknowledges that he had more consistent social work input than before during this period, but has concluded that he was functioning at such a basic level of survival that his ability to engage with the services that were offered was minimal.

What followed over the remaining 18 months of his life was a succession of prison terms for sentences related to offences such as burglary, stolen property, possession of weapons and public order offences, interspersed with residence in homeless adult hostels. Records note that at times he could appear to be polite and interested but, at other times, chaotic and disruptive. The review team was told that he was bullied in prison and also suffered burns injuries as the result of an assault. The exact nature of his contact with his family and with Mr. and Mrs. Jones could not be evidenced, and the review team received conflicting accounts. He was reported to be drug free in prison and towards the end of his life and the record indicates that he was due to attend a drug treatment programme, which he then postponed.

3.2 Luke' family circumstances

The level of care provided for Luke by his parents and immediate family was very limited. The first nine years of his life, when his main carer was his father, was characterised, according to the record, by considerable neglect. His mother, vulnerable because of her disability, was largely absent in his life. Most of his siblings grew up in care. He knew two of them, one of whom had severe disabilities, and valued what contact he had. His contact with the others is unclear from the record, although he did establish contact with one of them in his mid-teens, following the death of his mother. The relationship between Luke and his extended family went through different phases as he grew older. Family members were concerned about his care when Luke was very young, but remained at a distance. They did not have the ability to care for him when his father died. They did not cope well with the consequences of their own decision to place him in foster care with friends. The difficulties were likely to have been amplified by the low levels of engagement by the SWD in the early years of the foster placement. In the assessment of the review team, any opportunity that may have existed to address the difficulties between the extended family and foster parents (and to influence what happened later) probably occurred at this time. The extended family succeeded, through direct representation in raising the profile of SWD involvement in the Courts when Luke was in his teens. Their attempts to offer direct care were frustrated through poor SWD support and because of Luke's very challenging behavior. When Luke returned to the foster placement, they stood back from him, but remained vigilant, pointing to the extreme deterioration in his well-being after the second

breakdown. Whilst the quality of SWD input improved, Luke, given his circumstances and demeanour, was well beyond the capacity of family members to manage in the final phase of his life.

Luke's extended family raised a number of specific questions at interview with the review team, and these have been answered insofar as possible on the information available, where the questions and answers fall within the remit of the NRP and of this review. Issues such as the precise circumstances of Luke's death and the address provided by the Gardai as regards the locus of his death, which were raised by the family, are not within the ability of the review team to address.

3.3. Managing the case

Luke's infancy to the death of his father

Although there was significant evidence of Luke's vulnerability as a young child, the review team could find no indication as to whether this case was allocated to a social worker at any point prior to the death of his father. As already outlined, the HSE was not able to provide contemporaneous social work records for this period, although they did make PHN records available and some information was contained in later files, family centre reports, child guidance reports and reports from the school. Had an assessment been carried out at this period of Luke's life, risk factors such as his mother's learning disability, his additional developmental needs, the effectively single parent situation, the presence of another severely disabled child, the isolation of this family and the very poor home conditions would have been quickly visible. The claims made to the review team about the exclusion of social workers from the home, although not corroborated because of the absence of a written record, indicate that the family came to SWD attention, and a later file note confirms that they were 'well known' to the SWD.

Staff members from Luke's primary school told the review team that they reported, by direct referral and in writing, concern about sexual abuse to the social worker when Luke was almost seven and there is hearsay evidence that they also notified alleged neglect. In the absence of SWD records and without oral evidence from any staff dealing with Luke at the time, serious questions remain unanswered about how the concern about sexual abuse reported by the school was managed by the SWD. The HSE had a statutory duty at this time under Section 3 (2) of the Child Care Act 1991 to assess the needs of children who were not receiving adequate care and attention. The procedural guidance in place at this time was the Department of Health (1987) document 'Guidelines and

Procedures for the Identification, Investigation and Management of Child Abuse'. These procedures provided guidance on signs and symptoms of physical and sexual abuse; outlined the roles of different agencies, with emphasis on the importance of inter-agency collaboration; established the need for initial and comprehensive assessments; and identified specified action to be taken by community care social workers and public health nurses. They also identified the role of GPs, hospitals, child psychiatrists and 'others' including teachers, and day care staff. The review team has been unable to establish whether there was any risk or other assessment of Luke's circumstances carried out by the SWD, and whether there was any collaboration with other services or within the HSE, pursuant to the above duties. The refusal of Luke's father to agree to special education is an example of one point in time when it would have been appropriate for the SWD to consider the available circumstantial evidence of neglect alongside what was known to learning disability services and child guidance service (CAMHS) and the school. The available evidence about neglect indicates that, at minimum, action should have been taken to assess the concerns about standards of child care. This, allied to the issue of the sexual abuse concern, has led the review team to query whether the threshold for social work child protection intervention that the SWD was operating at this time was set too high. The review team considers that poor co-ordination of information at this early stage also contributed to the lack of awareness of learning difficulties which was so evident subsequently. This was a crucial early omission by the SWD which influenced the later planning and availability of services to Luke.

The review team further finds the absence of records for this period in the HSE (apart from public health nurse notes) to be a serious breach of best practice, which has hampered the work of this review.

Foster placement

When Luke's father died, the SWD was notified by Gardai but there is no evidence that the SWD was actively involved in Luke's placement with the foster family. The review team could find no evidence of any SWD response to requests from the PHN and the learning disability service for a case conference to be convened to assess the needs of Luke and his brother and to co-ordinate planning. All of the information available to the review team points to the conclusion that it was Luke's relatives who initially took on both children and who then considered the options for their longer term care. Whilst Carol was able to commit her life to rearing Sean, the family did what they thought

was best by facilitating Luke's placement with friends who they felt had the commitment and the capacity to look after him. This is the context in which Mr. and Mrs. Jones were identified and selected as Luke's foster parents. However, it is the opinion of the review team that Luke was a more complex child than it may have appeared at this time, either to his family or to his foster parents.

The relevant legislation and procedure governing social work practice in fostering, care planning and child protection during this period was the Child Care (Placement of Children in Foster Care) Regulations 1995; the National Standards for Foster Care; and Children First. There is evidence that for at least part of the period Luke was not assigned a social worker, contrary to the Child Care Regulations and the National Standards for Foster Care. The foster carers, Mr. and Mrs. Jones had no previous experience of child care and had not previously been approved as foster carers. The SWD was unable to provide evidence of compliance with any of the statutory requirements regarding foster family assessment and approval at the time the placement started. Four years later the placement was considered by the Placement Committee but could not be approved as medical and background information on Luke was still outstanding.

The main input to the foster home from the SWD was, according to the information made available to the review, regular home visits by a social worker from the Fostering Team (whose role was to provide direct support to foster parents, but not to carry out planning or direct work with the child). The SWD was also unable to provide evidence of compliance with any of the requirements under the Child Care Regulations 1995 regarding assessment or care planning for Luke. The review team would have expected that a comprehensive multi-agency assessment would have been available to statutory Child in Care reviews in order to provide the basis for a considered plan of action to be drawn up, together with identification of necessary additional supports for the foster placement. Such a plan should have been regularly reviewed, according to the regulations, enabling other agencies and services to have input as required, in order to meet Luke's needs. The chronology compiled as part of this review draws attention to psychological reports indicating, from an early age that, inter alia, Luke had low IQ, severe emotional and behavioural problems and general learning difficulties. There is no evidence of any activity by the SWD to integrate the disparate elements of this case or to plan for the medium/long term. The only visible attempt to co-ordinate information on Luke was instigated by the community education project.

Tension between family members and the foster carers, which took the form of ongoing allegations by family members about the suitability of the foster carers, quickly became a feature of the placement. The review team cannot comment on the detail of this conflict. The allegations were assessed as unfounded by the SWD, which, over years, was unable to resolve or diffuse the intensity of the criticism by the family. Social Worker 6 later referred to the context of what she described as 'disordered attachment' in which Luke operated. His loyalties appear to have been split. The review team was told by the GAL that Luke desperately wanted his family in his life, but also wanted to be loyal to his foster carers. She commented that 'no matter what he did, it was a tough road'. The review team believes that this tension between foster carers and relatives impacted on Luke, who subsequently appeared to vacillate in his allegiances to one side or the other. Luke needed both his family and his foster carers and was unable to resolve the conflict between them. The manner in which family members dealt with their concerns about the foster placement, in the assessment of the review team, was a contributory factor.

Later in the placement, analysis of the significance of issues such as contact, transition to secondary school, additional educational needs, references to sexual abuse in early childhood, and frequency of absconding, concern about drugs, required regular multi-disciplinary review and action planning (the frequency of Luke's absconding, as alleged by his relatives, is not documented). The absence of statutory Child in Care reviews, and the limited records for this period, made it impossible for the review team to assess how the SWD understood or responded to these concerns. Apart from a brief reference by the social worker when Luke was 15 years of age, there is little indication that learning disability was considered as a factor, despite the fact that it had been flagged up in earlier psychological reports. Proper consideration of this aspect of Luke's life by the SWD should have materially altered the management of his case.

There are at least two episodes towards the end of the foster placement which, in the assessment of the review team, should have resulted in the application of Children First child protection procedures. The emerging pattern in his 16th year of absconding, withdrawal from school, involvement in drugs and other street related activity gave Luke a child protection profile which required a multi-agency response in order to seek to reduce risk. Some two months later the foster placement ended following an allegation by Luke that he had been physically assaulted by his foster mother. Although this incident was referred to the Gardai, there is no record of a child protection case conference to assess its significance. Nor is there any indication of how or whether the SWD responded to Luke's allegation, when he was 15 years old, of sexual abuse by his father.

The SWD did not comply with the statutory regulations regarding retention of records. It was able to provide almost none of the records required by statute to be on the child's file in perpetuity, e.g. Luke's medical and social reports or school progress reports. There were significant gaps in files and records were missing from an early date. Individual social workers referred in passing to the absence of information. There is little evidence of case summaries or case analysis on Luke and transfer documentation (from one social worker passing the case to another) is poor. The SWD was not able to provide evidence to enable the review team to assess either the existence or adequacy of professional supervision or the quality of practice during this period.

First breakdown of foster placement

In the opinion of the review team, the SWD's failure to implement the statutory care planning process and have a comprehensive assessment of need in place seriously jeopardized efforts to respond to the termination of the placement when Luke was nearly 16 years old. It is not clear how, or whether, Luke's needs were matched to the statement of purpose and function of the residential unit to which he was initially admitted. It was confirmed in interview to the review team that this was a short term residential unit attached to the social work OOH service. There is no evidence of any emergency statutory Child in Care review to assess the situation and co-ordinate a response to the placement breakdown, or to involve unit staff and other relevant professionals, in planning for him.

There was, in the assessment of the review team, a further compelling case for an emergency statutory Child in Care review at the point of Luke's entry to the social work OOH service and his placement in an emergency hostel where, according to the record, he was based for the next two months. This was because of his level of vulnerability, the very limited care provision in the emergency hostel and the high probability of further escalation of risk to his safety in the volatile and hazardous city centre environment. The emergency hostel used frequently by Luke was specific in its function to provide accommodation at night, which it did in a well organised manner. It frequently and appropriately drew the attention of the SWD to Luke's escalating risk profile, and to its own limitations in meeting his needs. It was not designed to cater for children with complex needs. Care Worker 1 who provided a support service to Luke spoke to the review team and described a number of serious difficulties in the social work OOH system, including the lack of proper

placement facilities, and lack of regulation. She also referred to the 'alarming' rate of decline in the presentation of children/young people placed in the OOH system and to staff constantly watching children 'disintegrating' on the streets. A Senior Professional manager commented that "we always despaired a bit when we knew that he (Luke) was in [the emergency hostel]". There was no evidence that the repeated use of this type of limited accommodation by vulnerable children/ young people was monitored by the SWD at managerial level. The use of the emergency accommodation is a recurrent theme in this report, and there is a strong case for senior managers in the HSE, from the perspectives of parental responsibility and corporate risk assessment, to have processes in place to track vulnerable children in care who are referred into it and to ensure that its use is kept to a minimum and that levels of risk in individual cases are closely monitored. All the evidence in this case points to the inherent limitations of this service for children in care or children with complex needs.

The review team could find no evidence of any child protection investigation into the allegations of sexual activity involving Luke and another young person in the residential unit and possible sexual exploitation of another young person. This represents a breach of compliance with Children First.

The review team notes that a family welfare conference was convened the month after Luke's placement in the residential unit broke down, which considered an alternative placement in a residential unit in a rural area. This is the first evidence on file of a formal meeting to co-ordinate planning. It is the opinion of the review team, however, that whilst family welfare conferencing has an important role in facilitating family engagement and family contribution, it is not a substitute for statutory care planning, which is the responsibility of the SWD, not the family. A critical, recurrent theme in this case, has been the absence of SWD leadership in care planning for this child.

The review team notes that the case was unallocated for some two months in the spring after Luke's 16th birthday. The team was unable to ascertain the workload demands on the Looked After Children (LAC) team in the SWD at this time, to establish whether any caseload weighting system was in place for the allocation of work, or to determine the criteria for prioritising cases. It is the opinion of the review team that Luke was a child in care, who was very vulnerable and was on an upward trajectory in terms of personal risk. The risks were augmented by a failure to allocate the case.

As noted above, the review team has been unable to confirm the exact length of Luke's placement with Annie, and there are widely conflicting accounts between the file record, including material contained in reports to the Court, and the testimony of Annie and one care worker. This discrepancy is indicative of the minimal evidence on file of preparation, assessment and review of the placement. This was a relative foster placement under articles 6 and 7 of Part 3 of the Child Care (Placement of Children with Relatives) Regulations 1995. There is no reference on file to the requirements for assessment of the placement. The review team was unable to access verbal evidence about decision making for this placement from any social worker or team leader. It is the opinion of the review team that, given the knowledge available of Luke's multiple and complex needs, this placement required an intensive 'wrap around' support plan as well as a child protection assessment in relation to the young children in the home. The evidence from Annie to the review team was that Luke was very difficult to manage; that she had to consider consequences for her own children; that, in her view, 'nothing was delivered'. The family came to the conclusion at this time that the social work service was not alert to his needs, and that they needed to instigate court action, including the appointment of a GAL, in order to draw attention to the case. Factors which are all likely to have undermined confidence within the family that they could have worked with the SWD in the future include their perception of lack of effective support at this time, the scale of the challenge presented by Luke, and the adversarial context created by the legal action.

When Luke accessed the social work OOH service for the second time he was placed in emergency accommodation once more and remained there for another six weeks, according to the file record. This review has already commented on the limitations and risks inherent in this setting. The evidence of Luke's extreme vulnerability is available on the file record: his low IQ, bordering on mild learning disability, but probably masked by competent social presentation; poor levels of concentration and retention; impulsivity and lack of boundaries; tendency towards aggression; and a history of drug and alcohol abuse. Again, there is no evidence of any statutory Child in Care planning activity to address what was becoming an increasingly unstable pattern, or of any senior management overview. The review team notes the absence of any evidence of an internal accountability process for delivery of statutory Child in Care planning requirements, or for the management of the risk in this case. There is evidence on file that Luke remained at enhanced risk for several months, also confirmed in correspondence from the legal representatives of Annie and Carol to the SWD. There is no evidence that the proposal for a shared placement between a rural residential unit and his relative, Annie, was matched to his needs. Nor was there any indication of how the placement with Annie, which had previously broken down, would be sustained. There is no

evidence of a statutory Child in Care review, which would have been essential to establish the necessary supports and arrangements for the shared placement. The review team is of the opinion that good practice required more frequent statutory Child in Care reviews in this case than the minimum level required by the regulations.

It is noted that the arrangement with Annie was terminated due to Luke's behaviour and the residential unit in which he was then placed later concluded that Luke's placement with them was unsuitable. The description of Luke's situation, as recorded by Social Worker 4 as 'medium risk' is at odds with other evidence on the file which led to a special care application, raising the question of how consistently the risk was assessed and understood.

The fact that Luke then returned to the social work OOH service for the third time in six months confirms a serious gap in provision by the State for a vulnerable young person in its care. There is evidence that senior managers were aware of the circumstances and risk level by this stage, but no indication of increased attention to his safety, despite exhortations from the GAL and family legal representatives to this effect. There are some contradictions between court reports and social work records in respect of the application for a special care place; later file evidence indicates a lack of shared understanding between frontline social work and social work management about what actions would most appropriately and realistically meet Luke's needs at this stage, which indicates questionable standards in supervision, decision making and governance.

In the opinion of the review team, the special care application was not completed with the urgency and attention to detail that was warranted. It appears to have been initially delayed and then sent hastily and in an incomplete state that was not acceptable to the admissions panel, which set back decision even further. Ultimately, the application was refused on the grounds that Luke did not meet the criteria and was close to the upper age limit. The review team were unable to interview the staff involved in making the application, but find the process to have been questionable at two levels; firstly the lack of urgency and oversight applied to the application process by the SWD and secondly, the decision to reject the application. The criteria for access to special care which were operational at this time are contained in the Special Residential Services Board document 'Review of Admission Criteria and Processes for Special Care' Sept 2005 (Appendix 1). In relation to the criteria related to the needs of the child, Luke was within the age range of 11-17 and had exhibited behaviour that posed a real and substantial risk to his health, safety and development. He had documented involvement in drugs, alcohol, violence on the streets, sleeping rough, impaired

socialisation and impaired impulse control and an established history of absconding. He was likely to cause self-injury or injury to other persons if placed in any other form of care as illustrated in reported episodes from his first residential placement, and the social work OOH service. He did not have other non-special care options; he needed a more structured environment to meet his needs (including his primary need for safety). The review team is of the opinion that these criteria, based on needs and risk, were met at this time. The criteria for admission to special care at this time also required the SWD to complete a number of tasks – these included a comprehensive needs assessment, a statutory care plan, a discharge plan, the provision of an up to date psychological report and a recommendation from a consultant psychiatrist in relation to mental health. The review team has already drawn attention to the absence of a comprehensive assessment. Luke had refused to engage at this point with psychiatric services, and there had been no care planning process to seek to identify any possible discharge plan. Good practice and adherence to regulations would have ensured that most of these requirements were in place.

There were two changes of social worker during the 11 months after the first foster placement breakdown, with a period of two months when the case was not allocated at all. The continuity of social work service was very disrupted. The record shows that the allocated social workers were actively involved in managing the case as best they could. However Luke was an extremely difficult young person to engage, and could be very volatile to work with. The evidence on file suggests that he was distrustful if not dismissive. This was almost certainly compounded by his drug use and low cognitive ability. One consequence was that the time and energy of front-line staff appeared to be almost entirely taken up in trying to respond to the series of crises that he presented. The review team saw little evidence of management oversight of social work practice, which was particularly important, given the complexity of the case and the changes and gaps in the social work service.

In summary, the period after the first foster care breakdown saw two residential placements which were poorly planned, a relative foster placement which was neither properly assessed or supported (or even properly documented), and three hazardous placements in the social work OOH service, two of which were of lengthy duration, significantly increasing the risk to the safety of the young person. The special care application appears to have been very poorly processed by the SWD. There was no evidence of considered assessment of needs matched to suitable and properly supported placements. There was no consistent review and decision making process as required by regulations. The team has concluded that social workers and managers underestimated the levels of risk, and that the issue of Luke's basic safety did not get the recognition that was needed. There is little

evidence of co-ordination of planning by the SWD with other key agencies even though law enforcement and education were major issues which needed to be addressed in an integrated plan.

Second foster placement

At the end of summer Mr. and Mrs. Jones provided bail for Luke when he was arrested. Luke then returned, at his own initiative, to their care. The renewed placement was accepted in the short term by the social worker. There was then a gap of some four weeks before the decision was taken by the SWD to ratify it. This decision represented the reversal of a plan, which was formally reported to the District Court, for special care, in favour of a direction instigated by Luke himself. The reversal was completed without social work assessment or extended family agreement, and took him back to a foster placement which had broken down in some disarray 12 months previously. The review team was not able to establish if the fundamental change in direction was ever queried or endorsed at senior management level in the SWD, where the initial special care option had been mandated.

Although the front line manager made a personal file note of his concern about the stability of the foster placement, he did not give any reasons or alternatives. The decisions made at a statutory Child in Care review the following month depended for their effectiveness, in the assessment of the review team, on the continuing stability of the foster placement. It is not clear from the record whether the existing care plan was reviewed. There was no record of any consideration of the circumstances of the previous breakdown of this placement and of the unresolved issues arising from this; of the more recent high risk factors leading to the special care application; the safety issues; the learning disability issues; the additional support needs of the foster parents, or of inter-agency strategies to respond to future instability. There is no indication of contingency planning, despite the fact that Luke was in a much more vulnerable and risky situation than he had been before the placement broke down on the first occasion. There is no evidence as to how the renewed use of this foster placement for Luke was approved or sanctioned by the fostering team or of whether any assessment had been carried out with regard to its viability. Good practice would have required the needs of the young person to be formally assessed and the foster carers to be formally approved as capable of meeting any identified specific needs. The review team questions whether any consideration was given to how to address the shortfall between any limitations of the foster carers and Luke's current needs. The review team notes that agencies with a direct input into Luke's management and care at this time which included Gardai, the emergency hostel, Probation & Welfare, education and health professionals did not contribute to this care plan.

The fact that Luke appeared to be settled for a period meant that there was a short term window of opportunity to stabilise the placement for him, and to put in place an urgent comprehensive assessment to take stock of his needs and to design an intensive 'wrap around' care plan. The child care decision-making process, in the view of the review team, remained very weak. This opportunity, possibly the last opportunity for effective intervention, was not taken.

Within a month of the renewed placement Luke was reported as overdosing on anti-depressants and being in negative company. Six weeks into the placement the social worker reported that Luke was doing well. It was noted that there was no psychiatric service for young people aged 16 – 17 years. The GAL referred to the foster carers' sense of 'over responsibility' and to Luke's limited understanding of the impact of his previous allegations against them. The review team has noted a further care plan on file at this time. This document envisages that Luke should remain in care, in a residential high support unit, with a review date some 10 months later just before his 18th birthday. In fact, the next care plan review, according to the statutory requirement, should have been scheduled within six months. The review team is puzzled by the content of this plan, which does not sufficiently reflect the issues that were current at the time. There is no evidence on file of a care plan review meeting to support the drafting of this document. The file records that the Court had misgivings about it. A further care plan is on file dated a month later, which recommends that Luke remain in care, but in short/long term foster care. It also notes referral to a semi-residential unit and to financial support for private rented accommodation. There is no evidence that a care plan review meeting was convened to agree this plan, nor is its relationship with the previous care plan clear.

Evidence on file in respect of this time is slightly contradictory, with reports of Luke's risky behaviour, his foster carers feeling pressurised by him, and a social work report that he was 'doing well'. Two of the care plans referred to above, dated within weeks of each other, contain differing proposals and the second one makes no reference to the first. Neither appears to have been drawn up at a Child in Care review. There were numerous reasons to regard this placement as inherently unstable from the beginning, which underlined the need for close monitoring of the care plan through frequent statutory Child in Care reviews. On the contrary, the available evidence reveals an inconsistent and partial approach to care planning. These plans lack rigour in their assessments of attachment, safety and placement stability. The review team notes that HIQA standards in foster care were in place from 2004. Despite this, no arrangements were in place to quality assure child care decision making and implementation of regulations, and to ensure that a child with such a high risk profile could be managed appropriately.

It is noted that social workers had tried hard to source an appropriate psychiatric assessment for Luke, but the absence of mental health services for 16/17 year olds meant that the assessment of Luke which was undertaken by a psychiatrist from adult mental health services was limited in its scope. The assessment makes no reference, for example, to the family history of learning and intellectual disability. This gap led to referral to a consultant psychiatrist who specialised in learning difficulties. The review team notes that this is the first attempt on record to pursue the issue of learning disability. Luke subsequently declined an assessment, stating he did not consider he had a learning disability. This case highlighted a critical gap in psychiatric service provision for 16/17 year olds at this time, and the consequences of reliance on adult service for complex adolescents. It is now understood that many CAMHS services will work with young people up to the age of 18 years. . However, services for this age range are still far from comprehensive, particularly when hospitalisation may be necessary.

As detailed in the chronology, there is further contradictory material on the file about Luke's progress in the foster placement in the following months. At the turn of the year the social workers involved were positive about the durability of the placement but the records show that their opinions fluctuated. Social Worker 4 reported that he was settled in the placement. Social Worker 5, reported to court a couple of weeks later that he was doing well and stated that an aftercare plan was not in place as Luke intended to stay in his foster placement. Only a week later the file records Social Worker 5's warning to Luke that his behaviour was jeopardising his placement. Shortly afterwards, the file records increasing concern about the viability of the placement because of drugs and criminality. Nevertheless, in a report to court six weeks later, Social Worker 5 repeated her view that Luke did not have any plans to move out from his foster home and for that reason, no aftercare plan was in place. She undertook to put one in place. A month later, Social Worker 5 advised the Court that the placement had been jeopardised, but was still tenable with social work support. The review team notes the inconsistency of this assessment of the placement. It notes that no statutory Child in Care reviews were convened even after it had become clear that the placement was under strain for the second time. Good practice would have required a considered view of the young person's needs, his progress in the placement and of the options, and the contingency planning, to be in place. A 'professionals' meeting was held, but does not appear to have addressed some of the serious concerns that were current at the time. The review team is concerned that the 'professionals' meeting appears to have had an *ad hoc* co-coordinating function which is not defined in any legislative or procedural form. This meeting, according to the available record, focused on the aftercare plan, but did not address the current problems and pressures in the placement. There is no

rationale for a professionals meeting, as against a statutory care plan review, on file. Furthermore, the review team is concerned that much of the content is almost a verbatim account of the minute of the care plan review more than eight months earlier.

The review team believes that the GAL was correct in her assertion at this time that an urgent statutory Child in Care review was required. Given Luke's history and risk profile, and the imminent breakdown of the foster placement, the review team would have expected the chairing of such a review to be undertaken at principal social worker level. The review team has concluded that this episode represents a further serious failure on the part of the HSE to assess the urgent needs of a child in its care through failure to implement regulations.

Planning for leaving care and aftercare

After Luke's second placement with the Joneses broke down, the SWD proposed a plan to move him from the OOH service to another mainstream residential unit; this was in contradiction to the recommendations of his GAL which included special care. It is not clear to the review team how the SWD plan at this time was formulated, as there is no record of statutory Child in Care review to address the implications of a change in placement at a very critical time. The SWD did not appear, in the review team's assessment, to have understood the upward trajectory in terms of risk and the precariousness of Luke's situation. The review team notes the descriptive rather than analytical nature of the social work report on file. This coincided with the transfer of the case from Social Worker 5 to Social Worker 6. Evidence of social work supervision is weak. This was a further point where, in the opinion of the review team, an emergency statutory Child in Care review should have been convened, chaired at principal social worker level in order to reflect the high risk prognosis, to ensure that all available resources could be mobilised and to quality assure planning. An aftercare plan, recorded three weeks *after* the foster placement breakdown contains a seriously inaccurate assessment of Luke's situation at the time, referring to him as being in good health and happy living in his foster placement for the time being. This is substantially a repeat of the aftercare plan drawn up the month before, which, as noted above, was itself a repeat of a previous care plan. There was a failure to analyse and record the changes that were taking place between the drafting of these documents, indicating poor child care practice.

The fact that no appropriate placement could be sourced for Luke over the next few months, despite the persistent efforts of the social worker, reflects the serious lack of placement options available to

the SWD Admissions and Discharge Committee, which was ineffective when faced with the reality of a complex, unstable and very risky 17 year old. At interview with the review team, a previous chair of that Committee confirmed that it had no planning role, nor was aggregated needs profiling available of children requiring residential placements; it merely assessed applications to ensure their suitability and consider necessary supports. The report has drawn attention to the absence at the time of a coherent needs-based system for forward planning for residential provision.

The review team has been unable to establish whether any attempts were made at a corporate level to recognise the risks to this young person. There is no file record of any response at senior management level. The minimum statutory requirement was that Child in Care reviews should be convened at six monthly intervals; this clearly had not been met in this case. In the opinion of the review team, there were compelling arguments for additional urgent reviews. The Child in Care review that was held some ten weeks after Luke's second foster placement had broken down when he was living in very risky circumstances, made comprehensive recommendations but the review team is surprised that this plan appeared to lack any real sense of urgency. This was the fourth episode of homelessness over a 20 month period for a young person in the care of the State. All indicators are that he was very disengaged from professionals; that he was spending significant amounts of time on the streets; that drug and alcohol abuse was an on-going issue; that his criminality was increasing and that he was living at a heightened degree of risk. There was no provision for occupying Luke during the day, no mentoring and no provision for his vulnerability as a young person with additional needs. There were suspicions that Luke may have been sexually exploited. It is the opinion of the review team that there was a lack of focus and of urgency about his immediate and presenting need for safety and Children First child protection procedures should have been applied at this time. There is no evidence of any serious attempt by the SWD or any other agency to arrest the deterioration in Luke's circumstances. On the contrary there is evidence of toleration of unacceptable levels of risk to a young person in care. In the classical formulation of need by Maslow (1954),⁶ the primary tier is for the very basics of food, shelter, warmth; safety is the second tier and self-actualisation (or the capacity to engage with support) is the third. All the evidence available to the review team suggests that Luke, a young person in the care of the State, was barely surviving at the primary tier of need as he approached his 18th birthday. Many of the services sourced by the SWD are predicated on the assumption of stability at the third tier (e.g.

⁶ MASLOW A.H. 'Motivation and Personality'. New York; Harper and Row (1954)

ability to access to psychiatric or psychological services.). There is very little evidence that the State addressed his safety at tier two. The gaps between the services offered by the State and the needs of this young person in care were considerable.

The GAL is recorded on file at the time of his 18th birthday as noting that Luke was in a 'chicken and egg' situation – he could not access services until he stabilised, but could not stabilise without services. The review team was informed at interview that there were other young people in similar circumstances, and that, in reality, Luke was not exceptional. There is some evidence of planning activity during this period, which features a combination of professionals' meetings, a single care plan review and aftercare planning. The report has also drawn attention to the failure to implement child protection procedures. Assessment of Luke's situation continued to be carried out in a reactive and *ad-hoc* basis: the first ever risk assessment on file was in fact completed by the emergency hostel rather than the SWD.

The SWD introduced a Leaving and Aftercare policy in November 2006 (entitled Model for the Delivery of Leaving Care and Aftercare Services in HSE North-West Dublin, North Central Dublin and North Dublin), which stated that preparation for young people leaving care between 16 -18 would be undertaken by the HSE, with post 18 services to be undertaken by the voluntary sector in partnership with the HSE. This model provided for needs assessment, a continuum of through care services, collaborative working and contingency planning. The review team heard evidence that Luke was one of the first young people to be taken on by a voluntary organisation under contract to the HSE. Whilst the review team acknowledges that the contract with the after-care agency was comprehensive, it was dependent on co-operation from Luke. The note of the aftercare review shortly after his 18th birthday confirms that Luke was not consistently engaging with anyone and was unable to avail of any accommodation without causing difficulty. It was agreed that the SWD would now withdraw and the case would be fully managed by the aftercare agency. The record shows that the aftercare agency continued to offer support and to seek to engage Luke up until the time of his tragic death, but that he was heavily compromised by his life style on the streets, use of drugs, criminality, and involvement with the criminal justice system.

The review team is of the opinion that planning for leaving and after-care is a phase of care planning which is specifically focused on the transition from adolescence to early adulthood, and from the care environment to gradual independence. Its impact relies heavily on the quality of engagement with the young person. In the case of Luke, this report is critical of the failure of the child care system to engage with Luke throughout his life at a series of levels: to assess his needs, to intervene

appropriately, to carry out even basic care planning, to listen to him, to ensure his safety. Luke had effectively disengaged from the child care system some time before leaving and after care services tried to work with him. There is an important foundation for successful aftercare planning, which is the young person's lived experience of the care system in the preceding years. In this case, in the assessment of the review team, such a foundation had not been built.

The review team could find no evidence of any SWD critical incident review or review of service provided to Luke after his death.

3.4: Practice Context

Luke lived in inner city areas and in a large social housing area – both were characterised by levels of socio-economic deprivation which were amongst the highest in the state. In relation to child care practice, the SWD responsible for his care had a very high ratio of children in care per 1000 population, high numbers of child care cases, as well as low levels of staff experience, compared nationally.

The review team sought to speak to a number of SWD staff who had worked with Luke from his entry into care, in order to discuss the operational context for social work practice in this case. A number of the staff who worked with Luke were either unavailable, or declined, to speak to the review team. It is noted that the review team, operating under the auspices of the NRP, had no power to compel any person to give evidence, and relied upon co-operation and voluntary participation from all those who were in a position to assist. Where this was not forthcoming, the overall quality of the review process was adversely affected. It was disappointing to the review team that several key informants choose not to assist its work.

As far as the review team could ascertain, at least seven social workers had input into this case from 1999 onwards, six HSE frontline social workers to whom the case was formally allocated, and one aftercare social worker from a voluntary agency. There was also social work input into the foster home from the SWD foster care team. In addition two social care workers provided back up to the allocated social workers during Luke's episodes in the social work OOH service. The review team was able to interview three of the frontline social workers, including one from the voluntary aftercare agency, as well as several managerial staff, and the care workers. Of the five social workers to whom the case was formally allocated, only two were available for interview. The narrative in respect of the work context is therefore based on evidence from a total of ten current or former HSE members of staff consisting of two social workers, two care workers and five professional managers who had direct involvement with the case, and a senior manager who had no direct involvement with Luke.

This was supplemented by information provided at interview by one of two Guardians ad Litem who had involvement with the case.

The review team developed a framework for the analysis of the organisational context of social work practice. Its scope included arrangements for a number of measures regarded by the review team as core managerial requirements, which are listed below (See also Appendix 2). The evidence has been gathered from social workers, managers and from other reviews.

Direct line of Professional Accountability

The line of professional accountability for child care social work in the HSE at the time when it was managing Luke went from social worker (front line worker) to team leader (front line team manager) to principal social worker (manager for an administrative area with typically several social work teams and services). Principal social workers carried the responsibility for the quality of professional practice, but were accountable in all other managerial aspects to a line of general management within the HSE. This structure changed in 2012, with the introduction of a direct line of professional accountability from social worker to HSE National Director for Children and Families.

Supervision

The review team was told by a senior professional manager that there was a supervision policy in the administrative area which required monthly supervision of social workers by team leaders who were trained in a particular model. The review was informed that team leaders had monthly supervision by the principal social worker. Monitoring of the delivery of supervision to social workers was carried out by the principal social worker in her meetings with the team leaders. A team leader, whose involvement was at the latter stages of Luke's career in the care system, told the review team that supervision was carried out regularly, although she acknowledged that this was not fully evidenced on the file. Social Worker 3 commented that she received regular supervision. Social Worker 5 told the review that she was inexperienced and did not receive formal supervision when she managed this case. Social Worker 6 told the review team that her workload was challenging but manageable. She received regular supervision and support from colleagues. Care Worker 2 who also provided a support service to Luke, referred to lack of support from management with no professional supervision and described the workload as 'manic'.

In reviewing the available SWD case files, the review team could find only sporadic written evidence of supervision. The files were not maintained to a sufficient standard to enable the review team to conclude that that professional supervision was carried out regularly as required by good practice.

Guidance on assessment of need at operational level

In relation to guidelines for assessment of need at operational level, the review team was informed that there was no standardised policy for assessment of need, but that team leaders in the area developed their own assessment protocols around 2005. The review team has concluded that there were no organisational guidelines in place at this time to assist front staff to prioritise need at operational level.

Operational Guidance on prioritisation

The review team was told that team leaders prioritised responses according to external factors (e.g. Court). There were waiting lists for the allocation of cases of children in residential care and in foster care. Factors considered in prioritising cases included age of child, child protection concerns, parent and foster parent relationships. The review team understands that a new policy is shortly to be disseminated to guide staff on the establishment of thresholds.

Monitoring of Child Care Work Flows

The review team was informed that information on workflow was available from the SWIS system, from 2003 onwards. It was intended, according to a Senior Professional Manager, that the child care management team would review this data regularly, but it was not high on the agenda and was eclipsed by the need to address urgent operational matters. This, however, appears to have been a local area initiative, and was not part of a corporate child care data collection system.

Caseload Weighting

The review team noted evidence of some experimentation in this area with caseload weighting models, but that no standardised format had been mandated by the organisation at the time. The review team understands that this is under consideration.

Profiling the Needs of the Population of Children in Care

The review team was informed by the Children and Families National Office that profiling the needs of children in care has only developed recently. The review team was informed that this process has become more robust in recent times. A manager reflected on the unavailability of care places for 17 year olds at the time, commenting that 'with kids like [Luke], we are stuck'.

Corporate Risk Assessment in relation to Child Care

There was no evidence of any formal system for corporate risk assessment in relation to statutory child care duties. The review team was told that meetings took place with the principal social worker and team leaders to identify high risk cases in the area, with a view to alerting the general manager as appropriate. It was stated that risk registers have only been developed corporately over the past couple of years and that, prior to this, there was no uniform approach to assessing risk. One senior manager told the review team that “one would expect that they (principal social workers) would manage a certain amount of risk at that level and that they would escalate it if they needed to..... There isn’t lengthy history anywhere in community services of comprehensive risk management”. A senior professional manager told the review team that resource availability did not hinder the response to Luke and that the corporate system was alerted to him as a child at significant risk. The review team did not however see any evidence of the necessary response.

Corporate assessment of need and arrangements for planning and review of services

In response to questions about corporate arrangements for assessment of need in child care and arrangements for planning and review, the review team was told that resource management is a major issue for child care – which could “eat all the available resources if we let it”. The predominant organisational attitude to need in the child care system was characterised by one member of staff as follows: “children in care weren’t the priority... the priority was cases coming in the door...and the at risk children in the community... There was a sense corporately that children in care are safe enough... so we will focus on the other stuff until we get more resources”. It was also accepted by senior managers that there were gaps in planning for provision of care. It was confirmed to the review team by one manager that it was *not* the role of the Admissions and Discharge Committee to carry out planning for residential places, and that needs profiling of the population of children in care was not carried out at this time.

Corporate arrangements for Review of Statutory Functions

The review team saw very little evidence of arrangements to monitor the implementation of statutory functions, such as the 1995 Child Care Regulations at the time of this case. More recently HIQA reports and the HSE’s own Review of Adequacy Reports have focused attention on this key area.

Inter-agency Co-ordination

The review team was told that strategies to promote inter-agency co-ordination at a formal level did not exist until recently and that Children's Services Committees are currently undertaking this role.

Quality of practice

Effective social work practice in child care needs to be situated within a range of quality support systems, some of which are administrative and routine in nature, some of which need to be knowledge based and reflective. The terms of reference of this review did not require the review team to carry out a systemic analysis of the organisational or managerial environment in which social work practice in this case took place. The bulk of the evidence underpinning this report has been drawn from social work files relating to the experience of one young person and the foregoing section entitled Managing the Case in particular draws out a number of organisational characteristics which impacted on the practice. This has been supplemented by interviews conducted by the review team with people employed by the HSE SWD whose work was of direct relevance to the management of the case, as well as a number of others whose work interfaced with that of HSE SWD staff. Those people who agreed to participate in the process have given the review team accounts of their professional roles and responsibilities and the review team have given careful consideration to all of the evidence presented, both in interviews and in written submissions. A number of the conclusions reached by the review team in relation to gaps in the management and practice of child care in this specific case, have also been supported by the analysis in recent national reports (including the HSE Review of Adequacy Reports from 2007 – 2010, the HSE Social Work and Family Support Survey 2008, the Ryan Report 2009, the HSE Strategy Review 2009, the Roscommon Report 2010, and HIQA Inspections of HSE Foster Care 2010).

The review team is aware that a number of reforms have been instituted and more are planned in line with the transfer of HSE Children and Family Services to the Child and Family Agency. These include the development of standardised business processes, a standardised approach to caseload management, an equitable resource allocation model, better systems for planning residential care provision, quality assurance in child protection and monitoring of adherence to care planning.

The events in this case unfolded prior to these reforms. The review team has concluded that the managerial context of practice in this case was characterised by significant weaknesses in a number of essential routine aspects of the work, for example, basic workflow information, needs profiling of children in care, monitoring of the discharge of statutory functions. This was compounded by a lack of commitment, very visible in this case, to ensuring that core duties such as care planning and

review took place. Corporate governance arrangements for assessing risk in relation to statutory child care were not evident. Consequences of a weak managerial infra-structure evident in this specific case were poor planning processes and inadequate professional governance at the front line. In the assessment of the review team the earlier introduction of the measures referred to above for assessment of need, quality assurance in child protection and care planning, and better systems for planning residential care would have made a difference to the organisational environment in which case work with Luke was conducted, by ensuring that core processes for case planning were in place. A framework for corporate risk assessment in the Child and Family Agency for its statutory child care functions still needs to be developed.

In relation to front-line practice, the deliberations of the review team have been hampered by poor record keeping and by the unavailability of several members of staff for interview. However, some of the basic requirements for assessing good practice were poorly evidenced. These included record keeping, supervision, assessment of need, implementation of statutory and procedural requirements. The review team has concluded that child care practice in this case took place in a largely unregulated environment. Key dimensions of need, in particular the issues of safety and possible learning disability, were not addressed. The complexity of the foster placement was not addressed. There are examples of decision making that appears to have been inconsistent, for example, the switch from consideration of the need for special care to a passive plan to support Luke's decision to return to his foster placement. There are further examples of decision making that appears to have been over optimistic in the months prior to the termination of the second foster placement. In instances where statutory functions such as care planning are evidenced, there was a lack of urgency in relation to safety.

In order to work effectively with children whose needs as complex as Luke's, child care staff require healthy and functioning support systems. The review team recognises that there were individual social workers who took on the task of building a relationship with Luke to the best of their ability, who tried to alert the system to the safety concerns, and who tried to search for better placement options for him. However too much of the effort was crisis driven. The short and transitory nature of much of the social work input, allied to poor governance and managerial systems, has led the review team to conclude that most of the social work practice was weak and inadequate for lengthy periods throughout the duration of this case.

3.5 Policy

The sections above have highlighted of key themes from the perspectives of the child, family and the management of the case. A number of these reveal gaps in provision of services and in child care governance, and to other managerial shortcomings, by agencies in involved with Luke and his family. Two critical areas relate to the policy level, which, in the opinion of the review team, need to be addressed nationally.

Accountability of the HSE/CFA for its performance in the discharge of statutory child care functions.

The report has drawn attention to two specific areas where, in the view of the review team, the HSE has been weak in its implementation of statutory or procedural duties: in care planning and in child protection procedure. These have been linked to weak professional governance and poor management practice. The review team notes the reforms which have been introduced subsequently (in particular the establishment of the Child and Family Agency), and the role of HIQA in driving the quality agenda. The proposed performance framework by the Department of Children and Youth Affairs for the HSE/Child and Family Agency is an important development for strengthening accountability in child care services. The review team considers that there is an overriding need to ensure, through regular monitoring of standards, management performance and crucially, outcomes for children in care that these structural changes are reflected in better operational practice. It also believes that the frontline services are supported managerially and professionally, and are resourced to recognise and respond to young people with similar complex needs profiles to Luke.

Learning Disability

It is a conclusion of the review team that a recurrent aspect of Luke's story was the failure by professionals and agencies to properly connect with and act on information relating to his learning disability. Developmental delay was, in the review team's assessment, likely to have been a major factor in understanding Luke's vulnerability and difficulties in engagement, comprehension and social interaction. It should have provided a context for responding to his more extreme and reckless behaviours, and for raising his child protection profile at a much earlier stage. It should also have provided the context for a much more sustained effort to support his foster parents. The review team suggests that the National Child Care Information System which is due to come on stream in the near future should collect data on the prevalence of learning disability in the population of

children in care and its correlation with other vulnerable populations of children (such as children at risk of offending). Its implications for care planning should then be addressed. The interface between learning disability services, youth services, mental health services and aftercare services needs to be managed, particularly as there is a risk of the Child and Family Agency becoming isolated from these services.

Section 4: Conclusions

Luke's needs

- Luke was a young person with a range of basic and additional needs which were not met through contact with HSE child care services.
- There was considerable knowledge in the multi-agency system about the extent of Luke's developmental delay as a child, including knowledge of the family history of learning disability and a number of psychological reports on him dating from the time he was four years old. There was evidence of neglect and suspicion of sexual abuse. His difficulties were very apparent at primary school. There is no evidence that the SWD child care service, responding to its remit to assess the needs of children who were not receiving adequate care and attention, took any steps to co-ordinate the information which was available and to assess the need for child care intervention with the family. The SWD had no involvement in selecting the foster placement or in subsequently matching Luke's range of needs to the ability of his foster parents to meet them.
- There is no evidence in the file record that Luke's needs were reviewed by the SWD during the first foster placement, or that appropriate plans were put in place to support his foster carers. There is no written evidence of whether, or how, the difficulties which emerged in his early adolescence were responded to.
- The termination of the first foster placement was not managed appropriately by the SWD and Luke's needs, including an escalating need for safety, were not assessed in the subsequent months. Luke's actions put him at great risk, but his needs in respect of his learning disability made him particularly vulnerable at this time. There is no evidence that this was taken into account.
- There is no evidence that the SWD undertook adequate assessment, planning for or monitoring of Luke's placements with his relative Annie and in residential care, after the breakdown of the first foster placement. Annie did not get the close level of support that she needed, nor were the residential placements matched to Luke's needs and abilities.

- There is no evidence that the HSE corporately undertook any risk assessment in relation to the number, duration and consequences of Luke’s placements in an unstructured emergency hostel after the breakdown of his first foster placement. As noted, it was Luke’s actions which put him at risk, but his learning difficulties and their impact made him particularly vulnerable in this environment.
- The SWD response to Luke’s decision to live with his first foster carers for a second time lacked urgency and consistency and there was a missed opportunity to carry out a comprehensive review of his needs to design a thorough care plan. Following the second breakdown of the foster placement neither the SWD nor the HSE, as the corporate body, responded appropriately to Luke’s escalating need for safety and to his range of other needs. There was an unacceptably high tolerance of risk for a young person for whom the HSE had corporate parental responsibility, especially given his developmental difficulties.
- Whilst there is evidence of planning for leaving care in the months prior to Luke’s 18th birthday, his capacity to engage with services offered at this time appears had been undermined by a combination of previous omissions on the part of the SWD and by his own actions.

Support provided to Luke’s family and foster carers

- Too much responsibility for Luke’s care was left with his family and foster carers. The burden was all the heavier in the light of the conflicts at different times between them. It was unfair to expect that they would be in a position to provide for Luke’s needs without significant supports.
- Luke was a child with complex developmental needs which were exacerbated by severe neglect and by possible sexual abuse. It is unlikely that the extent of his needs were fully understood either by his relatives or by his foster parents.
- In the absence of any SWD input, all of the information available to the review points to the conclusion that it was Luke’s relatives who chose his foster placement. The review team could not establish whether or not there had been a full assessment or approval of the foster parents by the SWD as required by the Child Care Regulations 1995. There was no formal process for matching of the needs of the child to the abilities of the foster carers.

- There was no record of assessment of the relationship between the foster carers and Luke's relatives at the time of the placement. The impact of the emerging tension between his foster carers and his relatives on Luke was not assessed.
- There is no evidence that the first foster placement was supported by the SWD by a comprehensive assessment of Luke's needs or by regular Statutory Child in Care planning. This process should have addressed Luke's attachment and contact needs at an early stage, any difficulties such as frequent absconding, as well as the management of any divisions or tensions between family and foster parents.
- The SWD was not responsive to the concerns about escalating risk and lack of assessment of his needs expressed by Luke's relatives following the first fostering breakdown.
- The SWD did not provide adequate preparation or support to Annie during Luke's first placement with her. The subsequent rural residential placement, which involved week-end care by Annie, was poorly planned by the SWD.
- The response of the SWD to Luke's choice to return to his foster placement for a second time was based on an over-optimistic assessment of its viability. The opportunity to take stock of his needs as the basis for a comprehensive 'wrap around' support plan was not taken. The second phase of this foster placement was not formally assessed or approved by the SWD. Luke's foster parents did not get the levels of support that they needed.
- Luke's actions, following the breakdown of the second foster placement, meant that he had distanced him from both his family and his foster carers.

Case management

- The case was poorly managed by the HSE.
- Record keeping by the SWD has been very poor and the absence of records has seriously impeded this review.

- There is no evidence that any initiative was undertaken by SWD services to assess the needs of Luke and his brother when they were young children, despite considerable available evidence of neglect
- There is no record of the SWD response to child protection concerns referred by Luke's primary school when he was 7 years of age.
- The SWD response to its duty to assess and approve Luke's placement with family/ friends, according to the available evidence, was incomplete and took too long. There is no substantive evidence of assessment of the foster parents, or assessment of the needs of the child as the basis for case planning.
- The SWD did not carry out Child in Care reviews as required by the Child Care Regulations
- The SWD did not carry out comprehensive assessments of Luke's needs at any of the critical points in his childhood or early adolescence.
- The SWD response during the 11 months following the breakdown of the first foster placement was very fragmented. There was no assessment, poor matching of needs to services, casework was crisis driven, the safety issues were not addressed, and the use of the homeless service exacerbated the risk.
- The SWD responded with a lack of urgency to Luke's decision to re-join his foster parents. The decision making leading to ratification of the placement was inconsistent, was not compliant with regulations and good practice, and was based on over optimistic assessment of Luke's needs and the capacity of his foster parents to meet them.
- When the second foster placement broke down, the SWD response to Luke's need for safety was inadequate. Children First procedures were not implemented.
- The further use of the social work OOH service intensified the risks. There was a lack of available placement options.
- Whilst there was some evidence at this time of care planning activity, it lacked urgency and focus, and communication and co-ordination of case planning and information with other agencies was limited.

Management and accountability

- There were serious weaknesses in management and accountability within the HSE.
- Whilst there is some contradiction between written and verbal evidence of formal supervision, there is considerable evidence of lack of analysis, poor case planning and inconsistent decision making.
- There was evidence that management and professional governance systems in the SWD were not developed; basic information systems were poor, information management was poor, and quality assurance was not in evidence at any level in this case.
- The short periods of engagement of allocated social workers in most cases, and the gaps in allocation of a social worker, created a high level of disruption in the service to Luke
- There was a lack of management oversight in respect of this young person, the population of children in care generally, and of corporate parenting responsibilities and risks.
- Systems for accountability for the discharge of statutory child care functions, between the HSE and the Department of Children and Youth, and between the HSE and the SWD, were not evidenced. This case has highlighted significant shortcomings in implementation, for example, of statutory Child in Care planning

Section 5: Key Learning

The practice of child protection, either by professionals in the front line, or by those with management responsibilities in this area, is not a routine process. It involves complex interactions related to the circumstances of children and families, the quality of relationships, professional judgments, agency mandates, work context and other variables which cannot be pre-scribed. The review team has identified a number of basic and serious practice implications, arising from this report on Luke, both at front-line and management levels. The points outlined below identify a number of the lessons which need to be addressed, disseminated and embedded within the processes that shape the culture of child protection and welfare practice and governance: training, practice teaching, professional supervision, reflective practice, team development and peer review. They should be widely disseminated and their importance should be emphasised. Their application should be subject to ongoing monitoring and review within a framework for professional governance and quality assurance.

This report has tried to convey some of the complexities of this young person, and to reflect the difficulties and dilemmas experienced by those staff who tried to work with Luke. The review team has seen and heard of efforts by staff in different disciplines and agencies to engage with him, to address his needs, and to raise concern about his safety and wellbeing. This is evident in the work of primary and secondary school teachers, psychologists and other child guidance professionals, the staff in the community education project, individual social workers including staff from the fostering service, the staff in the homeless hostel and in the Crisis Intervention service, the input from the aftercare service, and others. However Luke's needs were too great to be met in any one setting, and he required, from an early age, a high degree of shared assessment, planning and co-ordination. In the absence of any care planning structure to deliver this, the work with him became increasingly reactive and driven by crisis management.

Recognition of child neglect

This report has documented material available on file (albeit incomplete) which points to an unacceptably high threshold for tolerance by the HSE of information concerning child neglect for the first nine years of Luke's life. The case records make reference to a number of factors which, in the opinion of the review team, should have brought this case within the threshold for intervention by the HSE mandated by Section 3 (2) of the Child Care Act 1991 to assess the needs of children who were not receiving adequate care and attention. The review team has concluded that no such

intervention is evidenced. The consequence of lack of intervention meant that Luke remained in a family situation that could not meet his needs and where he suffered neglect and possibly sexual abuse. Opportunities were missed to co-ordinate all of the available information. The long term implications of neglect and emotional abuse, and of the associated concept of compromised parenting, are well documented, as are the findings from neuroscience about the critical importance of early intervention in order to redress the impacts of deprivation. Practitioners need to be competent in understanding child development and in recognizing developmental delay, as well as concepts such as attachment and complex trauma. There is a crucial interface in operational assessment and decision making between strengths based practice with children in their families and recognition of the long term consequences of exposure to neglect.

Comprehensive assessment of the needs of the child.

It is a basic precept of good child care practice that actions and interventions must be based on careful consideration of all of the information that is available, across agencies, about the needs of the child. The absence of a baseline comprehensive assessment of Luke's needs is a consistent thread running throughout his life. With the exception of the community education project, there is very little evidence available to the review team of any coherent attempt to carry out a comprehensive assessment of Luke until he was in his mid-teens. The review team has seen evidence that Luke's many developmental needs as a young child were exacerbated by compromised parenting and neglect. Complex⁷ trauma is strongly indicated in the suspicion of sexual abuse, in impaired attachment, in separation after the death of his father, in the loss of contact with his mother and in the sudden circumstances of his placement with foster carers. The profile of learning/intellectual disability in Luke's family was high, and early psychological assessments indicated that Luke was functioning near the level for mild learning disability. This had major implications for his care and management. There is evidence that he did not cope well with the change to secondary school, and that patterns of absconding and involvement in the streets

⁷ The term complex trauma describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. Since they often occur in the context of the child's relationship with a caregiver, they interfere with the child's ability to form a secure attachment bond. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders.

(including access to drugs) were established in early adolescence. He experienced intense conflict between his foster family and members of his extended family. There is very little reference on the record as to how attachment issues were understood or managed in early adolescence. It is possible that Luke's outward presentation of competence could have masked a range of difficulties with comprehension, communication, and emotional integration which rendered him particularly vulnerable when his foster placement ended. It is the assessment of the review team that the extent of Luke's underlying difficulties and vulnerability became very visible following the first breakdown of the foster placement, when (aged 16) he was manifestly unable to cope and was at heightened risk, to himself and to others, within a very short period of time. The reasons for the elective return of Luke to his foster carers are not well analysed. Following the second breakdown in the foster placement there is ample evidence that the self-destructive pattern had re-asserted itself and become more intensive in the period leading up to his 18th birthday with heightened evidence of addiction, criminality, aggression, physical risk and acute emotional and psychological disorientation. From this point onwards he was functioning in an increasingly reckless manner, subject to enhanced visibility within the criminal justice system and unable, despite efforts to support him, to extract himself from a tragic downward spiral.

Recording.

The review team has repeatedly drawn attention to unacceptable gaps in the availability of written information in relation to the conduct of this case over a number of years. This is a very basic requirement of practice and management. The poor quality, significant gaps and inconsistencies in recording in social work files represents, in the view of the review team, a failure of effective professional governance – which is apparent throughout the reviewed history of Health board/HSE involvement in this case. The function of recording goes beyond the documenting of facts, to provide an opportunity for practitioners to reflect on the circumstances of the case and their own interventions. It also facilitates consideration of optional ways of making their practice more effective.

Care Planning.

The need for regular comprehensive assessments of need has been highlighted above as a central aspect of good practice. However, the sharing of information *per se* is not a prescription for better practice. Rather it is the critical interrogation of all available information by professionals within a coordinated and practice based culture that is more likely to make a difference. Care planning is not just a statutory requirement, but is a key forum for coordinating professional assessments, the child's view, and the family input into planning; for routinely reviewing and tracking the progress of

the care plan; for agreeing long term case strategy; and for taking changes into account. Care plans and statutory reviews should also be a primary source in tracking the decision process for children in the care of the state. This case illustrates vividly the consequences of 'drift' in the care system. The level of adherence to the requirements for statutory Child in Care planning in this case is poor, according to the file evidence available to the review team. The absence of a coherent planning process, capable of integrating all available information to inform operational and strategic planning for this case, had major implications for Luke at every stage of his life in care. It meant that planning was often short term and lacked urgency, and that the overall process, or lack of it, did not have accountability. The HSE/CFA has the lead role; this is a role that requires it to be pro-active not just in convening the reviews but in facilitating and seeking the input of other agencies. Given that the legislative underpinning has been in place since 1995, that quality standards were in place since 2003 and that there was a system for regulation, the review team was very surprised at the very poor quality of implementation.

Listening to a child/young person.

It is acknowledged by the review team that Luke, from mid early adolescence onwards, could be a challenging young person to engage with, who refused many of the services offered to him. The team has been unable to interview a number of the social workers who worked with him, and it has been difficult from file records to make judgments about the kind of relationships that he formed with all of them. The review team has already noted the extent to which his social presentation may have masked difficulties in learning and comprehension. There is also evidence that he was capable of being reflective and observant. It is evident to the review team that some of the social workers and care workers had taken the time and made the commitment to get to know him. Overall, however, it is very difficult to see Luke's views and perspectives throughout the available record of this case. This is a significant omission. The right of the child to participation is a basic principle of good child care practice.

Supervision.

This report has already noted that good quality practice in social work involves the reflective assimilation and assessment of complex information. The facilitation of good practice depends on critical feedback and review of the management of each case, and the role of regular one to one supervision by the line manager is a vital component of this. Investment in quality of practice at the front-line requires investment in and monitoring of effective supervision. There were too many instances in this case where social workers appeared to be operating without supervisory guidance, and where decision making was fragmented or in some instances contradictory.

Management and governance.

There is a recurrent lack of evidence in the case files of appropriate social work management, supervision and governance arrangements. The absence of managerial overview, in the assessment of the team, was the context for gaps in the social work service to Luke at critical times, particularly in relation to assessment of needs and risks. The poor governance and management framework was compounded by the absence of a corporate risk assessment framework for the population of children in care. A consequence was the lack of response by any senior manager to take steps to mitigate unacceptable risk to a child/ young person in care. Effective management of child care services requires to be defined by a culture which achieves a balance between effective quantitative regulatory systems (such as information flows, monitoring of statutory functions and procedures), and the promotion of quality front line professional practice (through training, supervision, peer review, reflective practice, and needs led assessment/analysis).

Fostering by friends/relatives.

Fostering is a complex task, and needs to be closely supported by the effective functioning of the systems outlined above, such as care planning, comprehensive assessment of need, listening to what a child or young person wants. The fact that friends/relatives may be the most desirable option for children in care should not mask the challenges that such placements can present, and the need for vigilant assessment of child, carers and relatives. The review team could find only limited evidence on file that the SWD complied with the fostering regulations, in relation to assessment, monitoring and support. The matching of a child to a fostering environment appropriate to his needs is a dimension in this case which did not appear to have been given consideration. While the fostering social worker gave continuing support to Mr. and Mrs. Jones there is little evidence of any analytic review of the suitability of the foster placement either initially or on its renewal. Although there was support to the foster parents, there is no evidence that the placement was adequately planned or supported. It has to be understood that family sponsored placements may be extremely complex, are difficult to alter once they have been instigated and, once relationships have been formed with children, need to be very carefully assessed and negotiated. This case is an example, unfortunately, of circumstances where a hostile relationship between relatives and foster parents became a barrier. This case reinforces the importance of matching the needs of children in foster care with the capabilities and skills of their carers.

Child protection for children in care.

The review team has concluded that Luke was a child at risk of significant harm whilst in the care of the state. This refers in particular to the periods when he was spending unacceptable periods of time

on the streets or in the OOH service. There was minimal implementation of child protection procedure during these periods, either to formally consider a child protection plan, or to increase his risk profile. The fact that a child may be in care is not an acceptable rationale for failure to address his/her need for safety. There were, in the view of the review team, two periods, during his time outside the foster placement, when Luke, although a child in care, was at heightened risk of significant harm. The review team could not find evidence of any recognition by the SWD, or by the HSE corporately, of the risk profile, or any attempt to take action to mitigate it, or of any consideration of 'Children First' procedures for child protection.

Working with relatives.

Good practice requires that every effort should be made to involve relatives in care planning, centered on the needs of the child. The use of Family Group Conferencing is entirely appropriate for the engagement of family and relatives, but needs to be connected to formal care planning. It is not a substitute process for care planning, which is the means by which the HSE, as corporate parent, leads on its statutory role. The review team has concluded that the concerns of Luke's relatives about lack of planning by the SWD to meet his needs and about his safety when he was homeless, were real and justified. It is regrettable that they felt that the only option available to them to draw attention to their concerns was by means of exercising their right to court action. In the absence of a care planning process (above), this meant that assessment and decision making was effectively displaced into a contested legal environment which ultimately created delay and did not result in a better outcome for Luke.

Inter-agency working.

Although individual social workers have told the review team that relationships with other agencies on the ground were good enough, the review team could find very little evidence of effective inter-agency planning (and this was confirmed in interviews with senior managers). This is a consequence of the lack of Child in Care planning, but also requires to be driven at a strategic level by agencies and Departments of Government. This report has also drawn attention to interface issues between child care and CAMHS and learning disability services. Outside the HSE, issues related to education, anti-social behavior and law enforcement were key areas. Luke was a young person whose care and safety required a sustained multi-agency effort.

Section 6: Recommendations

The recommendations of this report are intended to promote action and improvement in relation to five key strategic themes – children in care, learning disability, accountability for statutory functions, care planning guidance and support for relatives/friends fostering. Collectively, they form the basis on which the changes necessary to prevent recurrences of histories, such as the one described in this report, need to be built. Work is already under way in some of these areas, but its impact at the level of practice needs to be evidenced. In line with the guidance set out by HIQA for the conduct of reviews this report needs to be followed by an action plan to address these recommendations, with details of actions, time frames, accountability arrangements, and protocols for monitoring and review.

Recommendation 1: Children in care

The Child and Family Agency should lead on the development of proposals to ensure that the system for working with children in care is strong in relation to the following baseline requirements:

Assessment of Need and Care Planning;

The existing standards for children in care which are utilised by HIQA (National Standards for Foster Care, Sect 6 and 7, and National Standards for Children’s Residential Care, Sect 5) establish that every child/ young person in the care system of the State must be subject of a comprehensive assessment of need, which is regularly reviewed and updated, and which is the basis for both long term and day to day planning. Care planning is the formal vehicle through which assessment of need can be convened, and through which planning can be reviewed with partner agencies. This needs to be understood as an open, on-going, creative and accountable process. The CFA has a statutory duty to lead on care planning and to ensure that care planning is implemented. These are fundamental requirements of good practice, and of the State’s obligations to implement the rights of the child. The CFA needs to demonstrate that it has effective management and accountability frameworks in place to ensure that these measures are implemented for every child, and to guarantee the quality of practice.

Child Protection:

This case demonstrates the folly of assuming that children are safe merely because they are formally in the care system. Policy for all children, including those in care, should include a standardised response to manage issues of safety and protection. The CFA needs to ensure that the interfaces between Children First procedures and the requirements of the Children in Care Regulations 1995

are kept under review and managed appropriately, in order to fully to address the need for protection of the children in the care system who have a heightened risk profile.

Multi-agency working:

The needs of children who require the intervention of the state in their family life are typically multiple, and span services provided by all of the Departments of Government and sectors. The interfaces within and between child care, CAMHS, education, youth justice and an Garda Síochána , are clearly demonstrated in this history. There is a need to develop cross departmental and cross sectoral protocols to develop joint working in individual cases and to recognise the population of children in care as a priority group at the level of planning and policy. The review team welcomes the proposed Joint Protocol for Interagency Working being developed by the HSE and the Child and Family Agency.

Profiling Information:

The development and planning of appropriate services for children in care requires to be based on a comprehensive data base about the needs profile of the children in care population. The CFA must ensure that a detailed data base of aggregated information on the needs and characteristics of the care population is developed and is central to its outcomes monitoring processes and to planning and procuring the range and mix of placements options that social workers need to be available to them.

Use of OOH service:

This history has clearly demonstrated the limitations of current Out of Hours provision for children. The review team has noted that some aspects of this service have recently been improved. The CFA must take steps to review and redesign the system for supporting vulnerable young people who are homeless, especially in inner city areas. This will require a flexible, multi-agency model of care, which is comprehensive and wider than provision of physical accommodation.

Recommendation 2: Learning/Intellectual disability

A central theme underpinning this entire report has been the very low profile given to the significance of learning disability in planning for this young person. There was a clear history of intergenerational moderate to profound intellectual disability within Luke's immediate family. The history points to early evidence of developmental problems that was never properly factored into his care planning until Luke was in his mid-teenage years. Evidence in other jurisdictions suggests that the incidence of learning disability for children in care or in conflict with the law is significantly higher than in the general population. The Ombudsman's Report August 2011 recommended that

children with special needs in foster care be prioritised over other children in care. Further clarification has confirmed that this recommendation relates to children with moderate to profound special needs in foster care. Such was the complexity of Luke's needs, especially in relation to his early development, that it is arguable that he was in need of specialist disability services. In present day terminology it is doubtful if the CFA or local Primary Care Team could have met these needs. There is a strong case that the lead agency should have been the learning disability service.

This report recommends that the proposed Joint Protocol for Interagency Working being developed by the Child and Family Agency be speedily implemented to allow for referral pathways to be put in place that will ensure appropriate local interagency assessment and service provision. This will assist the most appropriate lead professional/key worker to be identified for each child and family. Such a system will entail a flagging system that will allow professionals to flag cases of concern to other relevant care groups, where there is a reasonable expectation that cases will require cross-care group/service input. For example, in Luke's case this may have meant that intellectual disability services, CAMHS and addiction services would have had a much larger input into a coordinated care plan at different stages in his life.

Recommendation 3: Accountability for statutory functions

A recurrent theme of this report has been the failure of the HSE to implement duties in respect of care planning (required by regulation), or in respect of child protection (required by policy). The review team understands, as already noted, that arrangements are under way in the Department of Children and Youth Affairs to develop a performance framework for children's services for the CFA, and notes also that the CFA have committed to improving their internal arrangements for quality and risk management (in the wake of HIQA assessments). It is recommended that the CFA implements sufficient audit and monitoring processes to demonstrate that the necessary improvements in practice have taken place at operational level.

Recommendation 4: National care planning guidance

The review has demonstrated that there were deficits in this case in the practice of care planning which need to be addressed through more detailed operational guidance. The review team notes that the CFA has taken steps to produce national guidance in relation to the implementation of care planning – particularly in relation to the basic steps such as protocols for chairing, review processes,

agendas, invitation protocols, frequency, attendance and administration arrangements. Practice in care planning should now be benchmarked against this guidance and monitored.

Recommendation 5: Friends and relatives providing foster care:

This review has highlighted the potential complexity of placing children and young people in foster care with friends /relatives. The review team acknowledges that a national action plan is being implemented in the wake of HIQA inspections, including practice guidance in relation to the assessment and management of relative foster carers. The CFA must commit to keeping this area of work under close review, including comparative tracking of the outcomes for this cohort of children and young people.

Dr Helen Buckley

Dr Bill Lockhart

Chair National Review Panel

Chair of the Review Team

March 14th 2014

APPENDIX 1

Criteria for Special Care

The criteria for admission to special care that were operational in 2007 (SRSB/HSE 2006)

Were as follows:

1. The young person is 11 – 17 at admission. (It is the view of the Health Service Executive and the Special Residential Services Board that given the intense nature of special care placement, it is generally preferred that the lower age limit be 12 years of age, but there may be exceptional circumstances where a younger child might be considered for a Special Care intervention)
2. The behaviour of the young person is such that it poses a real and substantial risk to his /her health, safety, development or welfare unless placed in a special care unit, and/or on 'an objective basis' is likely to endanger the safety of others.
3. The young person will present with a history of impaired socialisation and impaired impulse control, and may also have an established history of absconding which places them at serious risk.
4. If placed in any other form of care, the young person is likely to cause self injury or injury to other persons.
5. Consideration has been given to placement history and the elimination of **all other** non special care options, **based on the child's needs**.
6. It is clear that a less secure structured environment would not meet the young person's needs at this particular time.
 - a. As a general rule, the criteria must be met in determining the appropriateness of placement in a special care unit.
 - b. Any exceptions must meet the overriding majority of criteria.
 - c. All applications will be reviewed by an Admissions and Discharge Committee of the HSE.
7. Applications for placement in special care units should be based on a comprehensive needs assessment including the following:
 - a. A comprehensive and up to date social history.
 - b. A detailed care placement history outlining all social services and other interventions.
 - c. A care plan that supports the aims and objectives of this placement based on the identified ongoing needs of the young person.
 - d. A discharge plan, identifying the subsequent less secure placement or alternative, and identifying agency personnel with responsibility for actioning the plan.
 - e. Up-to-date psychological and educational reports which comment upon the grounds for seeking admission to a special care unit.

f. Where there are concerns regarding a young person's mental health, a psychiatric report may be appropriate. Should a young person decline to participate in such a referral, the psychiatrist may report, having reviewed the young person's file.

8. The HSE should co-ordinate the sharing of these intensive facilities within and across regional areas. While it is preferable that the young person resides in a specific regional area to facilitate family and community contact and reintegration, given the secure nature of these units and the care obligation, the number of units should be strictly limited. Where it is not possible to place a young person in a regional area more local to the family, the care plan must specify arrangements for family and community contact and integration.

Situations where a placement was not appropriate were where the primary reason for seeking placement was:

- 1.** The young person has a moderate, severe or profound general learning disability.
- 2.** The young person requires medically supervised detoxification for drug misuse.
- 3.** The young person has an acute psychiatric or medical illness requiring intensive medical intervention.

SOURCE: *Children Acts Advisory Board: Tracing and Tracking of Children Subject to a Special Care Application* – CAAB Research Report No 8, Mark Brierly, Social Information Systems (June 2010), P.6

APPENDIX 2

Management baselines: Child care social work

What organisational arrangements existed to quality assure social work governance?

- Was there a direct line of professional accountability from operational to senior management level in the organisation?
- What were the formal requirements for supervision? Was there a supervision policy, setting out objectives, expectations, frequency?
- Were arrangements in place to monitor the implementation of a supervision policy?
- Were arrangements in place along the professional management line for risk assessment? What were they?
- What guidance was in place for implementation of key legislative and procedural responsibilities - Children First, Child Care Act, 1995 Child Care Regulations, 1987 Child Abuse Guidelines?
- What guidance was in place at operational level for assessing need?
- What guidance was in place at operational level for prioritizing service responses?
- What organisational arrangements were in place to monitor and ensure compliance with key legislative and procedural responsibilities?
- What were the arrangements for strategic planning of Social Work Child Care services?
- What arrangements were in place to monitor work flows (new referrals, rates of disposal, throughput of work, individual and team caseloads, thresholds – at the front door and in the interfaces between teams and localities)?
- What arrangements were in place organizationally to monitor adverse/ untoward incidents, for example, absconding from residential care rates?
- Were arrangements in place to profile and monitor the needs of children and young people in the care system (e.g. school attendance, educational attainment, disability, health, mental health, training etc)
- Was there a caseload weighting system?
- Was there a recording policy?
- What arrangements were in place to review provision of services, identify gaps, and manage the prioritization and allocation of available resources, including specialist services, according to need?
- What were the arrangements for training and workforce development?

Corporate

What corporate arrangements were in place to quality assure the delivery of child care social work services?

- What were the corporate reporting arrangements for the operation of the child care social work service?
- What were the corporate risk assessment arrangements for the child care social work service?
- How did corporate strategic planning arrangements incorporate the child care social work agenda?
- What arrangements were in place to review and monitor the resource allocation to child care social work services against assessed need?
- How was workforce planning undertaken?

Inter agency collaboration

What arrangements were in place at interagency level to;

- Promote the best interests of the child as the primary consideration
- Promote joint assessment of need in child care
- Monitor and review implementation of legislation, policy and procedures from a multi-agency perspective
- Monitor and review trends from a multi-agency perspective
- Identify gaps in service provision from a multi-agency perspective
- Promote and facilitate joint working (e.g. training)
- Resolve difficulties in joint working arrangements
- Promote better strategic co-ordination between agencies and sectors