Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review undertaken on the death of a young person who was in the care of Tusla: Mary

Executive Summary

February 2021

1. Introduction

This report concerns a teenager, here called Mary, who died from suicide at 16 years of age. She was in the care of Tusla at the time of her death. Mary was described by those who knew her as a lovely, bright, articulate and assertive girl who was very creative. She was also described as a troubled young person who had difficulty regulating her emotions which let her to behave very aggressively at times. Her family had been known to social work services briefly when she was younger but most of their contact with social work and family support services began when Mary was 11 years old. Her parents did not live together and she had contact with her father. Mary's mother had experienced a difficult childhood and a negative experience of care herself which led her to mistrust social work services. Over the period under review, Mary had four social workers and apart from a brief period, the case was always allocated.

2. Background and chronology of service delivery

When Mary's family came into contact with family support services, it was noted that her mother provided good basic care for them but there were concerns about her ability to manage the children's emotional and psychological needs. After a period, the family support service referred the family to the social work department (SWD) for extra support. They were concerned about Mary's aggressive behaviour and her mother's mental health and stress levels and the level of negative interaction in the family home. Mary's mother was not happy to have social work services involved with her family, however the family support service continued to make referrals because they felt that she was well motivated but unable to make sufficient changes to ensure the children's welfare. Although the children's father was in regular contact with them at this time, they had been told by their mother not to reveal this to the SWD. Her social worker made a lot of efforts to find contact details for him but was unsuccessful and the SWD did not manage to meet with him until much later.

The SWD became increasingly concerned about the safety of the children over the following months and was granted supervision orders. A child protection conference that took place around six months later concluded that the children should be listed on the Child Protection Notification System (CPNS). A child protection plan was developed. Mary's mother behaved very threateningly towards the social worker after a court hearing and had to be restrained. The children had respite care in a foster home but this did not work out well and was discontinued. The family support service continued to make referrals. At this time, Mary was 13. She rarely attended school. She was referred to CAMHS for emotional and behavioural problems but her behaviour was considered to be so unmanageable and

risky at this point that wraparound residential care was being considered, with a view to possible foster care. Mary was agreeable to entering care. It was difficult to find a suitable placement and after a delay of several months she moved into a residential unit near to her home under a care order. Her mother was very hurt at her entry into care.

Mary settled reasonably well into her first placement and her social worker negotiated a place for her in a special educational facility which prevented her likely expulsion from school. She absconded from the unit twice and had some episodes of self-harm but also participated in activities and became more settled. She had some contact with her family and was seen by CAMHS and a psychologist attached to her unit. Her social worker felt that she had opened up a lot during her period in care. When she had been in care for a number of months, Mary expressed a strong wish to move to foster care and arrangements commenced. At this point her social worker left and the new social worker found it very difficult to gain Mary's trust. After a lot of preparation, she moved to the foster home, just over sixteen months after her admission to care. However, the placement lasted just a few days because of episodes of aggressive behaviour on her part.

It became difficult to find an onward placement for Mary as her former residential place was no longer available despite the efforts of the SWD to place her back there. She stayed for a few weeks with a relative in an unapproved placement and was then moved to her second residential placement in another county which was the only available option. Mary found it very difficult to be far away from her family. She absconded and self-harmed quite seriously and was admitted to hospital for treatment of her injuries. Ultimately, her mental health deteriorated to the point where admission to an inpatient psychiatric unit was considered necessary. A short term detention order was granted under the Mental Health Act and a guardian ad litem (GAL) was appointed by the court.

Mary was 15 years at this point. Although the inpatient unit was open, she never tried to abscond when her detention order was discharged. However, she did not form any therapeutic alliances that would allow her to benefit from her admission and spent a lot of time sitting on her own. She refused medication. She was visited regularly by her social worker and her GAL but often refused to engage with them. She also refused to attend school. After five months, it was acknowledged that she was not gaining from her stay there and was unlikely to benefit from an extension. The reviewers were told that the type of specialist attachment centre that Mary needed was not available in the jurisdiction and that placement elsewhere was not suitable given her need to be close to her family. The SWD started to search for a suitable onward placement.

Mary was discharged from the psychiatric unit and moved to a private residential unit which was nearer to her home. Her relationships with her social worker and her GAL were ambivalent and she often refused contact. She had been referred to the local CAMHS service but refused to attend. She tried to self-harm on a number of occasions in her first few days in her new placement and objected to the protective measures that were being taken but this abated after a few weeks and she settled somewhat. She continued to refuse to see CAMHS, or attend meetings and would not meet her social worker or her GAL. Her father and a relative visited her regularly.

Sadly, two months after she was admitted to the unit, Mary died from suicide. In the final progress report completed by the residential unit four days before her death, she was described as having had a positive week although she was low at times and had self-harmed. She left letters which in which she very clearly articulated her intention to take her own life.

3. Review Findings

The review has found that the level of services offered to Mary and her family over the years was of a good standard. The family support service made numerous reports about the family to the SWD. These were responded to, and although Mary's mother objected to the involvement of the SWD, there is evidence that efforts were made by each of the allocated social workers to work with her as openly and fairly as possible. Family support interventions were positive.

The SWD was primarily concerned about the children and used child protection conferences, interagency safety plans and legal means to try and secure their physical and emotional safety. Assessments were carried out by the different services but the ability of the SWD to act on recommendations for Mary's care was hampered by the lack of appropriate placements. The lack of a backup plan following the breakdown of her foster placement was short sighted and Mary's next placement in residential care was difficult for her as she was at a distance from her family. This period coincided with deterioration in her mental health and while admission to an inpatient unit was considered necessary, she did not engage with therapeutic services. The plan to move her to an open unit and a more normal type of living environment, together with the decision to cease night cover after a few weeks was taken after a lot of consideration and debate. It was acknowledged by the staff that participated in the review that this plan was made in a context of limited options as the type of placement i.e. a therapeutic community that was proposed by her mental health team and her GAL, was not available in this jurisdiction.

The review noted evidence of active management of the case for much to the time, with line managers involved in regular meetings both within the SWD and at a wider level where decisions were made. Senior management in the local area was made aware of the challenges presented by Mary's need for a suitable placement. There was evidence of consistent communication and collaboration between the SWD and other agencies. A significant number of meetings were convened to share information and formulate strategies to encourage Mary to take up services and these were attended by relevant professionals from different agencies and services involved.

4. Conclusions

The reviewers are cognisant of the tragic loss experienced by Mary's parents, her siblings and her extended family as well as the many professionals that worked with her.

The following conclusions have been reached:

- Although Mary's death was shocking and distressing to those who knew her it was not unexpected. In the two years prior to her death Mary had made a number of serious suicide attempts that were escalating in frequency and potential lethality. Her writings and her drawings reflected a young person who had feelings of hopelessness, worthlessness and who was quietly and persistently determined to end her life.

- The review has concluded that all the services involved with Mary did their best to keep her safe and promote her welfare. Interventions had been made with Mary by staff from social work, mental health and the residential care staff and safety measures had been put in place and monitored. Many of the services offered had been declined by Mary, who found it difficult to engage directly with professionals. The goal of the services was to enable her to continue her young life in as normal and as safe an environment as possible. In the management of her placement, risks had been considered and difficult balancing decisions about her care had been agreed at the time that she died. While some individual professionals expressed misgivings about specific decisions that were made, the record indicates that judgements had been reached in collaboration and with Mary's best interests to the fore.

- The review has noted certain shortcomings in the planning and provision of care for Mary which were related to the availability of placements for young people at risk of self-harm and suicide.

- The review has also concurred with the view of the mental health services and Mary's Guardian ad Litem that there are deficits in the provision of mental health care for young people with serious attachment difficulties and suicidal ideation. It also concurs with their view that Mary required a type of intensive therapeutic environment that is not available in Ireland.

5. Learning points

The following learning points have been identified by the reviewers and have been informed by discussions with the participants in the review who made a number of suggestions:

- **Engaging young people in therapeutic services:**

Young people can be resistant to therapeutic services which may result in their increased vulnerability. Research has shown that the interface between normal developmental changes and psychopathology can present particular challenges when attempting to assess and treat young people. In addition, factors such as stigma, avoidance and denial, ambivalence and hopelessness may be at play[1]. The importance of workers taking the time to build trust and facilitate young people to be actively involved in making decisions about their own lives as far as possible is important. However, research demonstrates that there is a danger that the current child protection system may impede the growth of such positive relationships with children and families[2][3].

- **Matching needs and placements**

Children in care need to be matched with a placement that meets their identified needs rather than just 'slotting children into services with a vacancy' (Mason and Gibson, 2004)[4]. This point was also identified by a Tusla line manager during interview. Placements need to provide children with a sense of a safe space (both emotionally and physically). Continuity in terms of place, relationships, and support networks are also crucial. The relationship between stability and long-term outcomes for

[1] McCutcheon LK, Chanen AM, Fraser RJ, Drew L. & Warrick Brewer (2007)Tips and techniques for engaging and managing the reluctant, resistant or hostile young person.

[2] Robb. L. (2014) Resistance, a complex challenge for practice, WithScotland.org http://www.inverclydechildprotection.org/GetAsset.aspx?id=fAAzADcANwAzADkAfAB8AEYAYQBsAHMAZQB8AHwANgB8AA2

[3] The Munro Review of Child Protection: Final Report A child-centred system (2011) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

[4] Mason, J. and Gibson, C. (2004) *Developing a model of out-of-home care to meet the needs of individual children, through participatory research which includes children and young people.* Sydney: University of Western Sydney and Uniting Care Burnside.

young people in care is clearly supported by international research[5]. Children should generally be placed within their own communities except in circumstances where their safety might be compromised[6]. Times of transition and disruptions can be very challenging for them. There is a need for greater recognition of the impact of moving on young people and the provision of support that is practical, emotional and social. Given the high risk of placement breakdown a contingency plan should be agreed and recorded in the child's file, a point also identified in interviews by Tusla staff.

- **Understanding self-harm.**

Self-harm involves a variety of behaviours that are used by some people to help them cope with distressing feelings. This act is often carried out without suicidal, sexual or decorative intent (Sutton 2005)[7] but at times, such behaviours can present as a risk to safety. Causes can be complex although Selekman (2006)[8] has identified the following: the quality of attachments between parents and their children; difficulty in self-regulating during times of emotional distress; failure of young person to 'fit in' with peers; association with negative peer groups. Byrne and McHugh (2005) highlighted that these issues are common in the lives of young people living in residential centres due to the childhood adversity that they have faced[9]. All staff working in both the community and in open residential units with high risk young people with self- harming or suicidal behaviours need a very high level of training, support and supervision.

- **The importance of education**

Education is a fundamental right of every child. Besides offering a daily routine and structure, education affects all aspects of the development of a young person. Research carried out by Dermody (2013) has shown that children in care can face major difficulties in education, including attitudinal barriers, placement disruptions, poor care planning and review and delays and deficits in assessment. These issues result in children in care being at higher risk of suspension, exclusion, absenteeism and early school leaving. The negative consequences for children can be both immediate and long term.[10]

- **Engaging fathers**

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[5] *Someone to care: The mental health needs of children and young people with experience of the care and youth justice systems*

[6] Placing children in out-of-home care – principles and guidelines for improving outcomes https://www.communities.qld.gov.au/resources/childsafety/practice-manual/ppplacinghomeprin.pdf

[7] Sutton, J. (2005) *Healing the hurt within: Understand self-injury and self-harm, and heal the emotional wounds.* Oxford: How to Books

[8] Selekman, M.D. (2006) *Working with self harming adolescents: A collaborative strengths based therapy approach.* New York: W.W Norton

[9] Byrne, J. & McHugh, J. (2005) Residential child care. In P. Share & N. McElwee, (Eds.) *Applied social care: An introduction for Irish students* (pp.313-320). Dublin: Gill and Macmillan

[10] https://www.oco.ie/app/uploads/2013/05/11873_Education_Care_SP1.pdf

Low engagement with child welfare services from fathers has been identified in studies as an issue resulting in limited resources for children's care and possibly poor assessment and management. Sometimes, mothers may act as gatekeepers in blocking access to fathers for a variety of reasons[11]. Whilst there is limited evidence about what works in engaging men, there are some encouraging pointers from family support and child protection practice contexts. These include early identification and early involvement of fathers; a proactive approach including insistence on men's involvement with services and the use of practical activities[12].

- **Relationships with parents**

Research has shown that many parents can feel challenged and unsupported by the child welfare system. Although workers may strive to develop a positive relationship with parents this can be affected by a number of factors such as their early life experiences, mental illness, substance abuse, social marginalisation, perceptions of power and authority and feelings that they are unable to cope. Models of intervention such as motivational interviewing and solution focused approach may prove helpful[13]. Supervision and support are essential for workers faced with threats and assaults.

15. Recommendation

Tusla, in conjunction with the HSE and other relevant parties, should develop a national policy and strategy to address the mental health needs of children and young people in care. This should include **c**onsideration to the development of a dedicated mental health service for children in care that can provide a holistic and therapeutic attachment-informed work which should not be merely based on service provision to children with a diagnosis of mental illness.

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[11] Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. and Tolman, R. (2012) Engaging fathers in child welfare services: A narrative review of recent research evidence. *Child and Family Social Work*, 17 (2): 160-169. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2012.00827.x/abstract

[12] Maxwell, N., Scourfield, J.,Featherstone, B.,Holland, S. and Tolman, R. (2012) Engaging fathers in child welfare services: A narrative review of recent research evidence. *Child and Family Social Work*, 17 (2): 160-169. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2012.00827.x/abstract

[13] Robb. L. (2014) Resistance, a complex challenge for practice, WithScotland.org file:///C:/Users/HP/Documents/ann%20netbook/docs%20june%202014/nrp/current%20reports/LS/resistance-a-complex-challenge-for-practice.pdf