Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review undertaken in respect of a death experienced by a young person who had been in care: Ed

Executive Summary

April 2017

Introduction and background

This comprehensive review concerns the death by suicide of a 21 year old young person who had been in care since infancy and had been adopted by his foster carers when he was 17. Ed's mother, here called Anna was a member of the travelling community. She was unable to care for him and it was her wish that he would be adopted by a family from the same community. Ed was placed with a foster family some distance away from his place of birth and four different social work departments were involved in the delivery of services to him and his carers. SWD A was the department which placed Ed in foster care. SWD B was the department that supported the foster carers, SWD C was the local social work department in the area where Ed and his carers lived and was responsible for other children placed with the foster carers, and SWD D provided a tracing and information service and was contacted by Ed at a later stage in his life.

Services provided to Ed and his carers

Ed settled well with his placement and according to the records, his early years were stable. SWD A retained responsibility for Ed's placement but there were long gaps during which he had no allocated social worker and contact with him by SWD A was very sporadic even when a worker was allocated. Statutory reviews were not held from the time he was very young until he was 14 years old. This lack of service meant that it took several years for SWD A to obtain his birth mother's consent for adoption and a considerable delay in completing the process. In the meantime, Ed and his family were left for a long period with the misunderstanding that his adoption had already been effected. It also meant that opportunities to gradually give him information about his own family in an age appropriate way were lost. Ed was ultimately adopted by his foster carers when he was 17, and his case was closed to the SWD when he turned 18.

Over the following three years, Ed's behaviour became very violent and threatening at times and evidence of a serious mental illness emerged. He was treated by his local mental health service, who suspected that he was developing a psychosis. He expressed suicidal thoughts at times. He was prescribed medication and attended his GP and psychiatrist but did not wish to engage with the community mental health team. At the same time, he began the process of trying to find out information about his birth family, commenting that he had always wanted more detail but had been too shy to ask when he was younger. He contacted the social work services in this regard, but there was confusion between the various departments as to which one was to provide follow up, which resulted in inaction on the matter. A Freedom of Information Officer who had also been

contacted by Ed became very concerned at the content of his letter to her, which mentioned suicidal ideation. She believed that he needed expert help and actively pursued his request for a service with SWD A until an arrangement was made for an aftercare coordinator to meet with him, but his death occurred before this came to fruition. Neither the mental health service nor the SWDs were aware of the degree of involvement that both organisations had with Ed.

Review findings

- The review found that Ed had been appropriately placed with a family from his own cultural background. It also found the delays in finalising his adoption were unacceptable and impacted negatively on him and on his carers. As a child in care, Ed was left without an adequate service for many years; reviews were held so infrequently that neither he nor his foster carers were given any opportunity to discuss concerns that may have arisen. While it is acknowledged that SWD A was a long distance from Ed's foster home and had large numbers of unallocated cases, there was a breach of regulations and basic good practice. SWD A held on to the case instead of transferring it in a timely way, and one of the reasons proffered was their lack of confidence that it would be prioritised for allocation following transfer. In addition, the review found that neither SWD B nor SWD C provided adequate support to the family. The lack of support meant that the impact of Ed's deteriorating behaviour on his family or the other children placed there was not adequately understood.
- The review found that there was a failure to provide Ed with adequate and timely information about his background commensurate with his developmental stage. By the time he actively sought details about his family he was an adult and the provision of a service to him was not straightforward, as exemplified by the misunderstanding between departments about who had responsibility. Ultimately, and despite considerable efforts on the part of some staff, he received a poor response to his requests for information.
- There was a lack of communication between the SWDs and a misunderstanding about each other's roles and responsibilities.
- Ed was involved with the adult mental health services because he suffered from a serious mental illness. He was also involved with the statutory child protection and welfare services but neither had any information about his involvement with the other. While each of these sectors operate separately, a degree of information exchange between them would have alerted each of them to significant events in Ed's life and possibly led to a more holistic response.

Learning Points

This report has attempted to communicate the complexities of this young person and to reflect the challenges faced by those who tried to work with him. It has identified areas where lessons can be learned as follows:

- Children in care need an opportunity to develop a relationship with their allocated social worker so that their views and wishes can be heard. This involves engaging with them in a meaningful way on a consistent basis. A child in care needs to be 'psychologically held' by the professionals involved. In order to get to know a child it is necessary to build up a sense of trust and this requires time and regular contact. Workers need to be given space within their workloads to meet with the child regularly to ensure that the required work is done.
- It has long been recognised that children in care need information about why they come into care and about their family background. Their past history confirms who they are and provides them with a sense of identity which in turn helps enhance their self-esteem. Information should be shared in an age appropriate way throughout a child's life. A lack of information can create fantasises. The child's understanding of his/her information needs to be regularly reviewed. As the Tusla Alternative Care Handbook (2014, p. 221) points out 'It is difficult to grow up as a psychologically healthy adult if one is denied access to one's own history'. There is a need for provision of a responsive post–adoption service to facilitate this
- There is a need for regular and consistent visiting by SWDs in order to support and supervise the foster family. Regular reviews of foster carers are also required. Such practices ensure that the family are fully supported in their fostering task and allows for ongoing monitoring of family dynamics. Visits should focus on addressing relationships and emotional well-being of family members as well as the practical day to day issues. When there are a number of SWDs involved in a case, there is a need for clear, written plans about roles and areas of responsibility for each worker so as to avoid confusion and gaps in service.
- Careful consideration should be given to the placement of any additional children in a foster family and the timing of any further placements. The number of children placed in a family should be limited and the likely impact of such placements on both the foster and birth children needs to be evaluated. In addition, the ability of the foster carers to meet the needs of all the children in their care must be continuously monitored.
- Certain children in foster care are eligible for adoption subject to court decisions and forthcoming adoption legislation in Ireland (Adoption Amendment Bill 2016) is likely to make this an increasing possibility. Once the conditions for adoption exist and it is the wish of

both the child and the prospective adoptive parents, the process should be initiated without delay. Adoption of vulnerable children is known to improve physical, emotional and cognitive outcomes for children and gives them advantages in respect of educational and social domains. Research indicates that the sense of permanence and security experienced by foster children who are adopted can enhance their welfare[1]. It follows that the earlier in their lives that this can be effected, the greater the benefits for the child or young person.

- Whilst confidentiality is an integral component of the therapeutic relationship, it cannot be unlimited in nature. It must be guided by the concern for the safety and wellbeing of the individual and others. Professionals providing mental health services should make every effort to obtain full information regarding the young person's history, their current level of functioning and their involvement with other services so as to ensure that the totality of their needs are identified and addressed. This requires sharing of information with families and between agencies. According to *A Vision for Change (2006)*[2] this principle of partnership should be evident both at an individual level through care/ recovery plans and at a wider level including all stages of service provision and policy development.

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Chair, National Review Panel

[1] https://www.nspcc.org.uk/globalassets/documents/consultation-responses/nspcc-scotland-2012-response-scottish-government-debate-adoption-permanence.pdf

[2] *A Vision for Change: Report of the Expert Group on Mental Health Policy* accessed at http://health.gov.ie/wp-content/uploads/2014/03/vision_for_change.pdf