Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review in respect of the death of a young person previously in the care of Tusla

Executive Summary

Barry

Resubmitted: February 2025

1. Introduction and Background

This review is about a young man here called Barry, who died aged 20. Barry had been in and out of the care of Tusla for a number of years prior to his death.

As a young teenager, Barry was first referred to Tusla social work services due to his mother's difficulty with addiction. He was very attached to her, and his wish was always to live with her. During his early to mid-teens, Barry lived with various relatives under private arrangements. At this time, the SWD considered him to be no longer at risk because he was safe. However, none of the arrangements lasted and he was constantly drawn back to his mother who was unable to manage her own drug problems and tended to provide and then withdraw her consent for care. A CAMHS assessment at this time had identified Barry's overall intellectual functioning to be at the borderline level.

When Barry was 16, the SWD became more actively involved and linked him with education, youth, and addiction services. Barry's extended family expressed commitment to caring for him and attended family welfare conferences but were unable to manage him and family placements ultimately terminated due to his behaviour and drug use. A social work assessment judged him to be vulnerable, with limited insight into the impact of his actions including drug use and criminal activity. He spent a short time in foster care, but this broke down and he remained in his mother's care while the SWD sought an alternative placement. At this time, his name was listed on the CPNS following a child protection conference and the case was escalated to senior management. Barry attended an addiction service and while he was reported to be cooperative, he continued to misuse drugs.

No suitable Tusla placement was found for Barry, and all his residential placements were run by private companies. He was first admitted to Residential Unit 1 and settled well initially, though reportedly became unsettled after access visits with his mother. He was considered to be making some progress at first, but a combination of events meant that the placement terminated. These included a serious assault and theft which led to him being charged. He disclosed that he had been using drugs while in the unit. When the placement ended, he stayed in the care of a relative until a short-term placement was found for him shortly afterwards in Unit 2. During this time, Barry faced further charges to do with possession and intent to supply drugs and became very anxious about court appearances. He was then admitted to Unit 3 and while he was initially considered to be doing well, he became involved in a number of significant incidents including aggressive behaviour and absconsions and eventually became withdrawn and disengaged with services. He was put on probation by the courts and moved to Unit 4 which was intended to be a long-term

placement. He was considered to be doing well in Unit 4, although there were further significant incidents including numerous absconsions and he did not adhere to the terms of his probation order. At that time, Barry was still facing the earlier charges and was considering fleeing the jurisdiction to avoid a custodial sentence. His absconsions escalated and, after three months in Unit 4, he went missing for almost a year. Comprehensive efforts were made to find him but were unsuccessful. When he returned, his case had been closed by the SWD as he had turned 18, and he was allocated an aftercare worker who initiated an aftercare plan with him. Shortly afterwards, he was remanded in custody and remained there for seven months. His aftercare worker met him before his release and made further plans with him. While he seemed determined to improve his situation, he was still facing the earlier serious charges and decided to leave the country because he could not face another spell in prison. Two days after he arrived in another jurisdiction, he was found dead.

2. Review findings:

The review team was impressed by the commitment and concern for Barry exhibited by professionals, as evidenced in the files and expressed at interview. Notwithstanding this, it has noted a number of shortcomings in the service provided to him over the years. Early responses to Barry's situation were short term and reactive, and in the opinion of the reviewers, the continuous breakdown of private family care arrangements as well as reports of Barry's overdoses and drug use should have elicited a stronger and more coordinated response from the SWD in line with official guidance. This may have enabled a more effective and safer plan for his care at an earlier stage and possibly pre-empted or lessened the occurrence of later poor choices on his part.

Early social work assessments were not sufficiently in depth to address the impact of his cognitive limitations or difficulties in his attachment to his mother. Further social work and clinical assessments were not conducted as required and recommended. This meant that opportunities to identify appropriate responses to his overall needs and particularly his drug misuse were lost. While the decision to return him to his mother's care in the absence of a suitable placement was pragmatic, it was not based on thorough assessment of his potential safety.

Social work contact with Barry when he was in residential care was, for the most part, regular and consistent. His aftercare worker displayed diligence in her efforts to help Barry plan for his future.

The quality of recording in case records was mixed and at some points they lacked the depth of analysis that was required. Transfer summaries were compiled to a high standard in relation to two

of his moves. Residential care records were also of a high standard. Overall record management was not up to standard, with evidence of missing records and some disorganisation.

Management oversight of the case was evident, however there were some shortcomings, partly caused by staff shortages which resulted in delayed initial allocation, and a failed attempt to transfer the case. There was also a lack of response to Need to Know Notifications. While it is evident that frontline social workers received support from line managers, a formal supervision structure was not evident.

A number of policy matters impacted on the management of the case, the most evident of which were the lack of frontline resources, which led to an initial delayed response, and lack of suitable residential placements, which meant that Barry had to move a number of times. This did little to provide security or build trust between him and staff looking after him.

3. Conclusions

The review reached the following conclusions:

- There is no evidence that Barry's premature death was the consequence of any direct act, or failure to act, on the part of Tusla. Nor was Barry's passing predictable, since at the time of his death his aftercare worker was supporting him in his diligent efforts to turn his life around.

- Barry struggled with addiction throughout his young life. At 13 years old, his case should have received early allocation and comprehensive assessment given the grave danger that his relationship with his mother, an active drug user, posed to his safety, and the complex nature of his needs.

- Despite two initial assessments recommending further needs assessments, neither of these took place. The failure to refer to child protection meant that Barry was denied the benefit of an interagency protection plan that would have identified sources of risk, and strategies to protect him. He was not given the benefit of a child protection conference until just prior to his admittance to residential care, approximately three years after his first overdose and a few months after his second near-fatal overdose. In addition, a family welfare conference was not held until Barry was on the precipice of care, after continually returning to his mother. He remained in the care of his mother until a residential placement could be identified for him. Up until this point, as a child subject to informal private arrangements with family members outside of the care system, Barry did not have the benefit of a care plan or statutory reviews.

- Barry was not able to access Tusla residential care. His care was based initially upon informal private arrangements with family members and was subsequently subject to placement with private providers. The absence of secure relationships from an early age likely impacted Barry's emotional, cognitive and behavioural difficulties, and this was not assisted by the succession of extended family carers, duty and allocated social workers, and foster and residential placements.

- An early CAMHS assessment had identified Barry as having an intellectual disability. Despite this, no further psychological or cognitive assessment was commissioned by the SWD. While Barry underwent a successful medical detox, the underlying trauma which informed the substance abuse was never adequately addressed therapeutically. Without an understanding of his needs, social workers and carers were ill-equipped to determine what therapeutic inputs Barry required and to devise the tools that would assist them to respond appropriately to Barry's needs.

- While Barry was in residential care, there was an almost exclusive focus on behavioural issues affecting his safety and criminality rather than the formulation of long-term goals and planning in relation to other dimensions of his care, such as his educational, social, emotional and health needs. While the review team recognise that Barry's case was challenging, once he had settled into each residential unit, there were periods where these needs could have been addressed. While Aftercare Worker 1 provided intensive support to Barry, his untimely death meant he did not receive the full benefit of this work.

4. Learning Points

This report has attempted to reflect on Barry's life and the challenges faced by the staff who worked with him and his family. The review team has identified the following points for learning.

Threshold for Significant Harm

A strict adherence to the threshold for significant harm under Children First, where there was a lack of wilful parental abuse, contributed to the unjustifiable delay in Barry's case receiving early allocation and assessment. In the opinion of the review team, prompt initial assessments focused on a Signs of Safety definition of current harm, may avoid delays in intervention similar to that experienced by Barry. Correction of this anomaly would be achieved by the amendment

of the Child Protection and Welfare Practice Handbook to include an additional definition of child abuse categories, to include self-harm.

Multidisciplinary Assessment & Follow-Up

While Barry underwent two initial assessments, neither were multidisciplinary, and neither dealt comprehensively with his psychological, cognitive, and mental health needs, his family attachments, and the trauma underlying his drug- and risk-taking. There needs to be greater managerial guidance from Tusla on how social workers go about their responsibility to commission, in a timely manner, the wider multi-disciplinary assessments needed by children with more complex needs. The recommendations from the two initial assessments were also not followed up on. It should be recognised that assessment is not an end, but an ongoing process to develop meaningful strategies to improve outcomes for children.[1]

Care Planning

As a child outside of the care system, Barry did not have the benefit of a care plan or statutory Child in Care reviews. Once admitted into care, Child in Care reviews were convened as frequently as required. However, it was necessary that reviews match the risk and needs profile of his case with changes in his circumstances to manage major decisions such as placement changes and adjust his care plan appropriately. In addition, further Signs of Safety meetings throughout his residential placement would have assisted the SWD to review outcomes and build upon positive progress made.

Communications

Barry expressed anxiety about his future and the insecurity of his living arrangements throughout his time in care. He required reassurance from the SWD in respect to transition arrangements and his aftercare planning. In the opinion of the review team, the residential care approval process needs to include a facility for a pre-placement visit by a young person, and aftercare planning should commence two years prior to a young person reaching the legal age of leaving care, as per the national standards.

Young Addicts

The social workers and other professionals in Barry's life did not fully recognise the complexity of Barry's issues relating to the 'hidden harm' of his mother's problem drug use. Tusla and

[1] Child Protection and Welfare Practice Handbook, Section 3.5

adolescent addiction services must plan their coordinated response to addressing the complexity of issues presented by these young people, to avoid outcomes like Barry's.

Private Placements

According to the Tusla Private Placement Protocols 2014, private placements are not considered part of core residential provision and should generally be considered for short/medium term use only. The young people placed in these centres should be referred to the relevant Regional Referrals Committee / Resource Panel as soon as their identified needs can be met within statutory and / or voluntary centres.[2] However, it has been noted in previous NRP reports (including Declan (2020)) that Tusla Residential Care is, in effect, not available to a significant cohort of young people engaging in high-risk behaviours and associations. This is a major gap in service provision and needs to be rectified if the agency is committed to ensuring that young people, like Barry, do not experience multiple changes from private placement to private placement.

Escalation

The need-to-know notification system for the escalation of individual cases, does not necessarily trigger or require further action by senior management. If 'case drift' is to be avoided, Tusla must create and resource appropriate management escalation systems that catch complex cases before it is too late.

Recommendations

1. The review team recommends that Tusla recognise that all children at risk of significant harm, whether from adults or as a result of their own behaviours, require access to equivalent robust multi-agency pathways for escalating concerns and managing case planning regardless of classification. Although the most recent Tusla Standard Business Process has modified the 'welfare' category to allow for different levels of seriousness and now allows for safety planning intervention where harm from any source is identified, a demonstrable practice lag endures, and greater work needs to be done at local and regional level to embed and support the implementation of this approach in the context of children who place themselves at heightened risk of significant harm. All practice guidance, including the Child Protection and Welfare handbook, and that contained in the

[2] Tusla Private Placement Protocols, September 2014, page 7

Tusla internal hub, should be revised, where necessary, to reflect this progressive safety planning approach.

2. The review team recommends that Tusla's social work business processes include specific policy and managerial guidance on how social workers commission therapeutic and multi-disciplinary assessments required by children with more complex needs. This should be supported by interagency protocols with HSE Addiction, Disability and Primary Care Services, as well as CAMHS, to ensure responsiveness to social work requests.

3. In circumstances where many young people with complex needs are unable to access CAMHS, since they are regarded as having an intellectual disability, rather than a treatable mental illness, the NRP recommends that Tusla publish clear guidance for practitioners on the pathways for young people to access required specialist learning and mental health supports.

4. Tusla Residential Care is not available to a significant cohort of young people engaged in high-risk behaviours and associations. Tusla's *Strategic Plan for Residential Care Services for Children and Young People 2022-2025* recognises the significant challenges in sourcing appropriate placements for children and young people with complex presentations, and an increasing demand for single and dual occupancy placements to provide the appropriate care environment to meet the needs of these children and young people. As such, recommendation 2 of this strategy calls for the increase in capacity across Tusla & Community & Voluntary Residential Care Services, including the implementation of semi-independent living arrangements. The NRP similarly recommends that Tusla fast-track the development of specialist residential care provision based upon an analysis of the needs profile of this population.

5. Despite Tusla's view that the need-to-know notification system is well established and functions properly, the NRP has found from several reviews that, in practice, it does not serve the purpose of a risk escalation tool. The NRP recommends that Tusla create and resource appropriate management escalation systems that flag complex cases involving multiple referrals, and devise crisis action guidance for alerting senior management.

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Chair, National Review Panel

8th July 2024