Painéal Athbhreithniú Náisiúnta
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a young person who was in care of Tusla

Shannon

Executive Summary

November 2025

1. Introduction and background

This review concerns a young person here called Shannon, who sadly died by suicide when she was 14 years old. From the time of her birth, her parents had addiction and mental health problems which resulted in neglect of their children. Later, an allegation of child sexual abuse against her father came to light. The family was provided with support services over a number of years but did not consistently engage and, after supervision orders had been granted and lapsed, Shannon was received into the care of Tusla when she was ten. She was described as a lovely, intelligent and caring young person who liked sports, art, music and fashion and was also subject to mood swings and a high level of emotional need. She had some literacy and language difficulties, and, in her early teens, her mental health started to deteriorate. She needed help with all these matters and was referred to appropriate therapeutic services.

Shannon had a number of placements, starting with an informal family placement when she was eight which followed further allegations of child sexual abuse by her father against a sibling. There were also concerns about past sexual abuse allegations within the relative placement though it was considered safe by the SWD. When her mother revoked her consent for Shannon's current living arrangement, she was received into voluntary care of Tusla and placed first in an emergency foster placement and then with a second foster family, during which time she disclosed previous neglect and physical abuse by parents. She was described at this stage as distressed and angry. She had an educational psychology assessment, which noted some learning difficulties, and she was linked with speech and language therapy. She had some access meetings with her family, although her parents were inconsistent with their attendance. When Shannon became unhappy about the way she was treated by her foster carers, the placement ended. She moved to a new placement, which she liked, and met with her mother intermittently, though a lot less than previously. In the meantime, the SWD had initiated care proceedings, and a full care order was granted after some delay.

When Shannon was 13, her father died. This had a profound effect on her and she became highly distressed. She attended CAMHS briefly and was later admitted to hospital on two occasions with symptoms of PTSD, and suicidal ideation. In the meantime, she re-engaged with CAMHS, and additional support was provided to her foster carer, with whom she had lived for two years. After a further hospital admission for self-harm, Shannon requested a change of placement. She spent a short time with another foster carer and wanted to stay, but for a number of reasons it was not deemed suitable, and she moved to a fifth foster placement. Because of its location, she was referred to a new CAMHS team. Shannon found it hard to settle in her new placement. She was struggling in school and

feeling low. She had not seen her mother for some time but kept in touch with her and other relatives through social media.

Shannon was attending CAMHS at this time and was waitlisted for a psychology service. She disclosed flashbacks of child sexual abuse but was unsure of the perpetrator. She was referred to a specialist assessment service. Soon afterwards, Shannon insisted on a further change of placement and was moved to an emergency foster home, from where she went to her seventh foster placement. Residential care had been considered but was unavailable at the time. She settled well initially and had some supervised access with her siblings and extended family. Over the following weeks, her moods fluctuated and her behaviour in the foster home became challenging. Although she continued to attend CAMHS, the location of her new placement meant that she needed to transfer to a third CAMHS service. Her current service discharged her once a transfer request had been made but the third CAMHS service ultimately decided that Shannon did not meet the eligibility criteria for their service and recommended long term psychotherapy. Appeals of this decision and efforts by Shannon's foster carers and the SWD to obtain a private mental health service for her were unsuccessful. In the meantime, she was linked with the specialist child sexual abuse service but requested a break from it.

For the last few months of her life, Shannon appeared more settled although was refusing to engage with support services. Sadly, she took her own life and letters that were later found indicated that she had been planning it for several weeks.

2. Review Findings

The review has found that once Shannon was received into the care of Tusla, social workers were committed to her wellbeing and did their best to support her. However, it has noted some deficits in the early responses to referrals about the case, and some missed opportunities to assess risks to the children at an earlier stage. It has also found that while later allegations of child sexual abuse were addressed appropriately, there was less clarity about the response to allegations made when Shannon was younger. While her NEPS[i] assessment led to appropriate interventions, there was a dearth of social work assessments which could have provided greater elucidation of Shannon's needs and led to a more robust and protective stance which would have lessened the time that Shannon spent in a neglectful and abusive environment. The review also notes that the delay in obtaining a full care order was unhelpful for a child dealing with a lack of certainty about her future.

Despite many challenges, the various social workers involved did their best to maintain good working relationships with Shannon's parents. Shannon always had a designated social worker, and there is

evidence that her views were sought and her wishes considered on many occasions during the time she was in care.

Shannon had seven foster placements altogether, some of which were supplied by private providers. Some were of very short duration and served as transition periods to longer term arrangements. The review has found some conflicting accounts of the placement that Shannon complained about and a lack of clarity as to whether her concerns were properly addressed. Later, there was a question over whether Shannon was deliberately sabotaging her placements. In general, the review has noted positive support offered to the different foster carers, particularly by one of the private providers.

Shannon was linked with three CAMHS services, most extensively with the second one which discharged her when she moved to a different catchment area. The third CAMHS service offered advice and consultative meetings in response to the referral made to them but ultimately considered that Shannon was ineligible for their service, as her self-harming behaviour did not constitute a moderate to severe mental illness. This was a source of frustration to the SWD, which was unable to source private mental health services for Shannon. The reviewers note the mismatch between the expectation of the SWD and the standard operating practice of CAMHS, an issue which has arisen in a number of previous NRP reviews. It also notes the service gap for young people who self-harm.

There was evidence that SWD management had active oversight of the case from the year before Shannon was received into Tusla care, and appropriate oversight once she was in care. Regular Statutory Child in Care Reviews took place, and there were positive relationships between the SWD, foster carers and fostering link workers. However, Shannon was in relative placements on two earlier occasions, and the review has noted the lack of guidance available to social work staff in respect of private arrangements.

3. Conclusions

The review team acknowledge the loss and impact that has been experienced by Shannon's family, the professionals and foster carers involved with Shannon. It is clear that Shannon was very much loved. The review has reached the following conclusions:

- From a very early age, Shannon faced a number of challenges due to her family circumstances. It is clear that she and her siblings lived in a chaotic and severely neglectful and abusive environment for much of the time whilst in their parents' care. The harm was cumulative in nature. At this point, there was an insufficient focus on the lived experiences of the children.

- Shannon was significantly negatively impacted by her early experiences. She developed complex problems, which manifested in self-harm and suicidal ideation and an inability to settle in her placements which prevented her from attaining a stable and fulfilling life.
- The application for care orders by the SWD was unnecessarily protracted by the unavailability of relevant records. The lengthy process prior to obtaining care orders was a source of anxiety for Shannon and her siblings.
- Following Shannon's admission to care, social workers showed a high level of commitment and did their best to ensure her needs were met.
- The foster carers involved with Shannon from Fostering Agency 2 were very committed to her and provided her with a good quality of care.
- This case illustrates a point noted previously by the NRP that services for young people who have complex mental health needs including suicidal ideation but do not have a diagnosed mental illness are inadequate.
- There was evidence of good inter-agency co-operation by many services for much of the time.

4. Key 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:

- It is known that neglect is the frequently notified child harm in Ireland.[1] This case reflects research relating to neglect undertaken by Lutman and Farmer[2] where they document, 'Important Problems Not Addressed and Neglect Marginalised'. These include factors such as parental alcohol or drugs misuse, domestic violence, mental health problems and lack of parenting skills. They note that the lack of action to address these difficulties result in children experiencing many adverse experiences. Other factors include a lack of therapeutic help, lack of follow through, giving parents too many chances, lack of parental engagement and inappropriate case closure.
- The issue of neglect can be such a nebulous and challenging area for social work staff and other professionals to deal with. A greater focus on the issue of neglect and the impact of

[1] *Buckley, H. (2012) Using Intelligence to Shape Reforms in Child Protection. Irish Journal of Applied Social Studies. Published by Social Care Ireland Volume 12 Issue 1 Special Issue on Child Abuse Reports.*
[2] *Farmer, E. & Lutman, E. (2014) Working Effectively with Neglected Children and Their Families – What Needs To Change?. Child Abuse Review, Volume 23, Issue 4, https://doi.org/10.1002/car.2330*

cumulative harm on children is crucial. Horwath et al.,[3] noted that, 'understanding the views and experiences of the child is particularly important for social workers in cases of child neglect because the cause of harm is rarely linked to one specific incident; rather, it is the cumulative, day-to-day adverse effect of poor parenting on the child that is so damaging. Thus, without considering the child's day-to-day experiences, their perceptions of that experience and their wishes and feelings one cannot begin to identify effective interventions'. This could be achieved by training and the setting up of discussion groups for social work staff and other professionals to raise awareness and understanding of the issue. The Extension of Community Health Care Outcomes (ECHO) could be used as a useful resource to facilitate this.[4]

- Research has highlighted lack of recorded monitoring**,** limited response to referrals about risk and awaiting a trigger event before intervening[5]. Whilst services may be provided, more decisive action for these children (or even reopening the case) did not occur until they had experienced an incident of physical or sexual abuse, or there had been a particularly serious incident of domestic violence. A framework to assess neglect cases could be considered such as the 'Graded Care Profile' (GCP2)[6]. This updated tool from the NSPCC provides a structured, evidenced and strengths-based tool which assists practitioners to objectively evaluate and measure the level of care provided to a child across various domains such as physical care, safety, love, and esteem. It helps identify areas where the child may be at risk or experiencing inadequate care, allowing for targeted interventions and support.
- The use of social media can present benefits and challenges for all children and families but particularly for those in the care system[7]. Whilst it may facilitate children's contact with family members, it may also lead to difficulties. Simpson suggests that care plans should note the agreed expectations around the use of mobile devices and internet. Consideration should also be given to providing social media training to foster carers and staff and how best to manage this in terms of children in care and placements.
- Burns et al.,[8] raise many concerns regarding the use of private family placements including receiving, '… less support and oversight from state authorities than formal care placements,

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[3] Horwath, J. (2015) Child Visibility in Cases of Chronic Neglect: Implications for Social Work Practice Jan Horwath, Tarr. The British Journal of Social Work, Volume 45, Issue 5, July 2015, Pages 1379–1394, https://doi.org/10.1093/bjsw/bcu073

[4] ECHO is a learning methodology which uses videoconferencing to share knowledge, best practice and provide support to increase the capacity of resources. It uses a learning loop approach known as 'all teach all learn' where participants learn from each other by collaboratively problem-solving real-time experiences and sharing best practice. https://echonorthernireland.co.uk/project-echo-ni-2/ and https://hsc.unm.edu/echo/

[5] Farmer E and Lutman E. (2014) Working Effectively with Neglected Children and Their Families – What Needs To Change? Child Abuse Review, Volume 23, Issue 4, August 2014, https://doi.org/10.1002/car.2330

[6] https://learning.nspcc.org.uk/services-children-families/scale-up/graded-care-profile-2-gcp2

[7] Simpson, J. (2020) Children in care and their use of mobile devices and the internet for contact. https://www.iriss.org.uk/resources/insights/children-care-and-their-use-mobile-devices-and-internet-contact

[8] Ibid

and family members providing care under this model have no legal rights or responsibilities in respect of the child(ren)'. These authors argue that this places children in an uncertain position. There can also be a lack of independent oversight to ensure adequate resources and services for a child, and that care placements can 'drift' for lengthy periods of time where permanence and security may not be achieved.

- The current CAMHS service in both its structure and remit, does not meet the needs of children in care unless they present with a moderate to severe mental health disorder. Many of these children do not have a mental health disorder but instead present with psychological distress due to their lived experience of trauma from abuse/neglect and subsequent moves in the care system. They have unique, complex and usually severe needs that require long-term consistent therapeutic input. Within this context, there needs to be a new approach for providing mental health/psychological support to children in care[9].
- According to the 'Voluntary Care in Ireland' study[10] there are positives with voluntary care including the fact that, 'voluntary care agreements are less adversarial, time-consuming, and costly than court proceedings.' The negatives highlighted by the study include 'absence of independent oversight; are of unlimited duration; have potential instability (since parents can withdraw consent at any time); have weak mechanisms for child participation; and have an inferior resource allocation compared to court-ordered care placements.'

5. Recommendations

The review team make the following recommendations:

- Tusla, in conjunction with the HSE and other relevant parties, should develop a national policy, strategy and service to address the mental health needs of children and young people in care in order to provide holistic and therapeutic attachment-informed work. This should not be merely based on service provision to children with a diagnosis of mental illness. This service should follow the young person regardless of location of their placement. This would ensure that each young person is given the opportunity to engage in more long-term therapeutic support to address their complex needs.

[9] *McElvaney, R. & Tatlow-Golden, M. (2016) A traumatised and traumatising system: Professionals' experiences in meeting the mental health needs of young people in the care and youth justice systems in Ireland* https://www.sciencedirect.com/science/article/abs/pii/S0190740916300883
[10] *Ibid*

- Tusla should review its existing policy on private family arrangements and consider developing practice guidance in relation to such arrangements.

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[i] National Educational Psychological Service