Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

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

Noah

Executive Summary

March 2020

1. Introduction and background

This review concerns the death of a young person, here named Noah who died at 16 years of age. Noah was one of a number of children born to his parents. His parents had a history of poor mental health and substance abuse; his father spent time in prison and died some years prior to Noah's death. The family had support from relatives who lived locally. Noah was described as a bright, confident young man who took good care of his appearance and was interested in sports and music. As a young child, Noah was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and was prescribed medication which he took for many years. As he got older, he stopped taking his medication and he needed to be re-assessed in CAMHS. He also suffered from asthma. In his adolescence, Noah experienced a number of difficulties. He suffered from low mood and aggression at times and needed to develop coping skills. His school attendance was poor for most of his teens. He passed his Junior Certificate but needed encouragement to continue his education.

2. Contact with HSE/Tusla social work and other services

A number of referrals were made about Noah from the time he was 12 years old, mainly concerned with drug use by his parents. Initially, support services were put in place but little progress was apparent and he and his siblings were listed on the Child Protection Notification System (CPNS) following a child protection conference. Noah's father died shortly after this and concerns continued about his mother's drug use, which impacted on the care of the children. Noah attended a school counsellor which he found helpful, but his school attendance deteriorated and he seemed depressed. He attended CAMHS and was considered low risk. Further child protection conferences were held and ultimately a decision was made to place all the children in relative care. Noah returned to his mother's care for a period but there were concerns about his behaviour and his mother's drug misuse escalated. He was again placed with relatives, but was unhappy about the location and went to live with a family in the community who applied to become foster carers.

From the time the case was first allocated within the social work department, Noah always had an assigned social worker though there were several changes of personnel particularly in the year before he died. He was involved with a number of services, including the National Educational Psychology Service, the National Educational Welfare Service, CAMHS and his GP. He remained in his placement though frequently expressed a wish to go home as he felt his mother needed him. During his 17th year, he was described as moody and restless with general

psychological difficulty. An assessment noted that he had self-harmed but did not have suicidal intent or psychotic features. His school attendance remained poor and he tended to miss appointments with CAMHS and was ultimately discharged because of non-attendance. He began spending a lot of time in his family home, and it was ultimately agreed that he could return there under a supervision order. An outreach worker and parenting supports were arranged but were withdrawn when they were declined by his mother. Noah was due to start classes in a local youth project when he sadly took his own life.

3. Review Findings

The review team acknowledges the loss that has been experienced by the family and the professionals involved.

The review found that once the case was allocated, the SWD did their best to support Noah and his family and put in place a range of professional services to meet their complex needs. However, his parents tended to dictate which services were acceptable. The review also found that the lack of a formal assessment early on meant that opportunities to identify and address some of the family's needs may have been missed. There was a limited focus on Noah's specific needs until he came into care. After that time, social work contact with him became more frequent and regular.

It was evident from the records that Noah had a consistent social work service although the high turnover of workers in the last year of his life must have impeded the potential for relationship building. It is also evident that the social workers and most of the other professionals involved tried to develop positive and respectful working relationships with him and his family. Unfortunately Noah faced a number of challenges due to his own difficulties and his family circumstances. His needs became more complex as he got older and his behaviour became more risky. There is evidence that there were some delays in engaging him with the CAMHS service. He received good support from his school counsellor but this was limited by the school year and affected by his poor attendance. When other services, including CAMHS were offered to him, he tended to not to avail of them, or to miss appointments, even with a lot of encouragement and support from his social workers.

Interagency working tended to be good on the whole, and a number of child protection conferences and reviews took place and were well attended. However contact between the social work department, the educational welfare service and the school counsellor appears to have been infrequent, which limited opportunities to address Noah's school absenteeism.

4. Key Learning Points

This report has attempted to reflect on the challenges faced by Noah and the staff who worked with him and his family. The review team consider that there are areas where lessons can be learnt.

- It is crucial that SWD is attentive to the needs of teenagers in families where child protection concerns are present. Adolescents' needs may be underestimated when greater focus is placed on the needs of younger children. According to Raws (2018:1) neglect 'can cast a long shadow on their present and future well-being, including their physical and mental health, involvement in risky behaviours and getting into trouble, educational achievement, and poor adult outcomes'.[1]

- The impact of poor school attendance is likely to be significant for a young person who will lack a daily schedule and structure as well as an opportunity to develop to his full potential. Besides offering a daily routine and structure, education affects all aspects of the development of young persons. Persistent absenteeism is recognised to be symptomatic of deeper environmental problems[2] and needs to be taken seriously when conducting assessments and planning interventions. The child welfare and education literature illustrates that school can have a compensatory effect on vulnerable children, providing opportunities to raise self-confidence and self-esteem and promote resilience[3]. Children who are persistently absent miss out on those positive factors, but are also at much higher risk of poor educational outcomes, early school leaving, restricted choices, unemployment and other negative life experiences including criminal activity, drug use and imprisonment

- As teenagers get older and their needs become more complex, their behaviour can become more risky. Risk factors comprise of static (e.g. gender, age) and dynamic (e.g. drug use, educational status and traumatic events) circumstances that may be outside the control of the individual. Managing risk is an on-going process and having a risk management plan in

[1] Raws, P. (2018) Thinking about adolescent neglect A review of research on adolescent neglect focusing on identification, assessment and intervention https://www.researchgate.net/publication/324728481_Thinking_about_adolescent_neglect_A_review_of_research_on_adolescent_neglect_focusing_on_identification_assessment_and_intervention

[2] Thornton, M., Darmody, M. and McCoy, S. (2013) Persistent absenteeism among Irish primary school pupils, *Educational Review* 4: 488-501.

[3] Gilligan, Robbie (2006) Adversity, resilience and young people: the protective value of positive school and spare time experiences**,** *Children and Society,* 14:37-47

place assists professionals to make informed judgements about the risks and the actions required (Tusla, 2014).

- Young people in care need to have the opportunity to engage in direct work on a regular basis. Tusla's (2014) 'Alternative Care Practice Handbook' refers to the importance of having a meaningful relationship with young people and how this requires both consistency and commitment. Workers need to be given time in their caseloads to achieve this.

- Tuck (2013)[4] has highlighted how professionals can be misled by intermittent incidents of disguised compliance which may contribute to an overly optimistic view of parental competences and their ability to change. Tuck suggests that workers should familiarise themselves fully with case histories, reflect on the lived experience of the child, and keep in mind parental motivation for avoidance. The HSE Child Protection & Welfare Handbook (2012) offers practical guidance on working with such families.

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[4] Tuck, V. (2013) Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy *Child Abuse Review*, Vol. 22, 1 (5–19)