FINAL REPORT

National Review Panel

DESK TOP REVIEW

Q

Bill Lockhart

June 2011

Executive Summary

Introduction:

This desktop review is concerned with a young adult, here called Q, who was found dead following an accident while he was sleeping rough. Q had been in care from the time he was six years old up to his 18th birthday. The timescale of the review is from when Q's family first came to the attention of the social work department in the mid-1990's until his death in early 2011.

The terms of reference were:

i) to examine events leading up Q's death and determine whether action or inaction on the part of HSE Aftercare Services had been a contributory factor;
ii) to examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice;
iii) to provide an objective report to the HSE.

Method:

The methodology adopted was a review of HSE records only, with the option of consultation with staff for the purposes of clarification. No interviews were held with staff or family members. The review was conducted by the deputy chair of the NRP, Bill Lockhart.

Findings:

- The review concluded that there was no direct link between the incident and any action or inaction on the part of the HSE Children and Families or Aftercare Services.
- There is clear evidence from the files that the [X] Health Board acted appropriately in taking Q and his siblings into care on the grounds of parental neglect. It then found relative foster carers and proceeded to have their suitability assessed and approved by the Placement Committee. In doing this it met its statutory duties and complied with recognised good practice.

- There is no doubt that Q's family had complex needs and were difficult to work with. The decision to look for relative foster carers and for Q and his siblings to be brought up within the wider family circle is in keeping with good practice. However, it did carry its own risks. Sometimes relative foster carers can resent monitoring by the social services - seeing it as a form of unnecessary intrusion into private and family matters.

- As Q reached adolescence and then young adulthood a comprehensive assessment of Q, his needs and development as a person was lacking - except for a psychological assessment which was undertaken after he left care and was already in prison.

- There is no evidence in the files that any social workers acted inappropriately or negligently. They were facing a formidable challenge and always reacted appropriately. Whether they could have acted more proactively is difficult to assess. The failure to have a structured and on-going assessment and analysis process was a structural/management shortcoming.

- Social workers did meet with Q prior to statutory reviews and were assured by him that he was happy and that everything was going well. It is during this period that one senses that social workers were not well attuned to Q's needs and were not picking up signs of concern. Social work skills could be enhanced through training in motivational interviewing and other person centred methods of working.

- By the time social workers realised the extent of the breakdown with the foster family Q was already heavily involved with alcohol, drugs and criminal behaviour. There was then a quick deterioration which led to Q being placed in custody on several occasions. By this time aftercare services had become involved as the main contact between the HSE and Q. Again there is no evidence that a comprehensive assessment of his needs had been built up. Aftercare social workers did offer and provide services to Q but he was often reluctant to accept them. Lengthy periods elapsed when there was no contact. One has a sense of opportunities lost where a more proactive approach – particularly during the time he was in custody could have borne more fruit.

- There were at least two occasions when inter-agency conferences may have been appropriate. The first was when Q was collected from the Garda station when he was 16. An inter-agency meeting with Garda and education services may well have revealed a number of issues of concern and pointed to deterioration in Q's behaviour – mostly relating to his use of drugs and alcohol but also highlighting high levels of anxiety and trauma in his life. The second occasion was in the period coming up to his release from a lengthy prison sentence. This may have led to a more comprehensive package of support being put in place including an up-dated mental health assessment.

- There is ample evidence in the files that the Social Work Department responded to requests for help in a practical manner. Examples include offering Q advice and support on accessing a medical card and social welfare. Relationships between Q and his social workers appeared to be positive. The Social Work Department fulfilled its basic statutory duties, although there are times when it may have been more proactive. The lack of a comprehensive assessment process is a serious managerial shortcoming.

Key learning points:

- The use of relative foster carers is appropriate in many cases but carries its own risks; sometimes these can resent and resist social work monitoring which they may perceive as unnecessary interference. Social workers need to be particularly vigilant in such instances by using other sources of information, such as from education, GP and other relevant parties.

- Social workers often find it difficult to engage with "hard to reach" families. In such instances specialist training would assist them in improving their investigative skills with individuals and families. It would assist them in identifying signs of concern and help them to probe more deeply in such circumstances.

- As can often happen behavioural concerns and other issues can emerge from early to mid-adolescence – especially in children who may have suffered trauma and attachment issues. This highlights the need for structured and ongoing assessment, drawing evidence from a range of sources.

- Times in custody and/or involvement with the criminal justice system may provide opportunities for joined up working and support between HSE and criminal justice services. These opportunities should be grasped as the person may be more amenable to offers of inter-agency support when in custody.

Recommendations:

1. Social workers' investigative skills should be enhanced by training to enable them to probe more deeply with "hard to engage" families and individuals.

2. The Social Work Department should consider introducing a regularly up-dated "master file system" containing key information which will be easily interrogated in the event of emergency or critical incidents.

3. The Social Work Department should consider introducing a comprehensive assessment tool informed by interdisciplinary input.

4. Protocols should be introduced between HSE services and the prison authorities to enable interagency therapeutic packages of support to be delivered whilst clients are amenable in prison. This should include social work, mental health and alcohol/drug abuse services for young people entitled to after care support.

Signed: Bell Lockhart
Deputy Chair

Signed:
Chairperson, National Review Panel

Date: 28-07-11

1. Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care' issued in 2010. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious incidents involving a child in care or known to the child protection service

2. National Review Panel (NRP)

A national review panel was established by the HSE in May 2010 and began its work shortly thereafter. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection, social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the Assistant National Director's Office and from there to the National Review Panel. The Assistant National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consisted of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report was to be produced which contained a detailed chronology of contact by services with the

child and family, an analysis thereof, and action plan. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious conclusions, recommendations and an incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

1. **Major review** to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.

2. **Comprehensive review:** to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations.

3. **Concise review:** to be held where the involvement of HSE services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.

4. **Desktop review** to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are

apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

5. Recommendation for internal local review to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Death of Q

This review is concerned with the death of a young adult, here called Q, who was found dead following an accident while he was sleeping rough. Q had been in care up to his 18th birthday. The timescale of the review is from when Q's family first came to the attention of the social work department in the mid-1990's until his death in early 2011.

5. Level and process of review

This was conducted as a desktop review. The methodology adopted was a review of HSE records only, with the option of consultation with staff for the purposes of clarification. The review was conducted by the deputy chair of the NRP, Dr. Bill Lockhart. The records consisted of nine folders, supplied by the HSE, containing copies of correspondence, case notes and reports.

6. Terms of reference

i) to examine events leading up Q's death and determine whether action or inaction on the part of HSE Aftercare Services had been a contributory factor;

ii) to examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice;

iii) to provide an objective report to the HSE.

7. Q

Q was the middle child of three who grew up in foster care with relatives. He was placed with his siblings, and had regular access with one of his parents; the other parent left the country. Q left school when he was 15 years and did some casual work. When he was 17, his placement broke down and he spent the following three years living part of the time with one of his birth parents, but also spent time in prison and sleeping rough.

8. Background and reason for referral to HSE Children and Family Services

Q was taken into the care of the health board at six years of age, because of parental domestic violence, neglect and concerns about physical abuse.

9. Services involved with Q

1. The principal service involved in the case was the **HSE Children and Families Social Services** and prior to that the relevant Health Boards – these include social work services, Public Health Nursing, fostering and aftercare services.
2. **G.P.** in the period leading to Q being admitted to care.
3. **An Garda Síochána** who were involved from an early stage during the period of Q's parents' marital disharmony and in the proceedings leading to him being taken into care aged 6 and again because of Q's own behaviour from the age of 16 onwards.

4. **School** – up to age 15 and which sent reports in earlier years to child care reviews.
5. **Youthreach** who provided Q with post school educational opportunities.
6. **Irish Prison Service** during custody and a drugs counsellor working with Q in custody.
7. **Probation and Welfare Service** during the period when Q was in custody.
8. **Q's solicitor** - who provided a strong advocacy service for Q during and after custody.
9. **Independent clinical psychologist** – who carried out a comprehensive psychological assessment at the request of Q's solicitor when Q was in custody.

10. Summary of Q's needs and how they were met

Q was a young man of considerable potential, yet very vulnerable. He had suffered a very chaotic and traumatic early childhood - characterised by paternal domestic violence, alcohol abuse and neglect. He was taken in to relative foster care as a child. When he entered adolescence a number of his needs were not recognised. He had witnessed a number of traumas in childhood and adolescence and began to misuse alcohol and drugs. He dropped out of education and drifted into criminal behaviour to support these habits. Later psychological assessment in early adulthood suggested that he was at great risk of significant psychological disturbance but at that time did not have a major mental illness or personality disorder. He spent lengthy times in prison and was vulnerable to homelessness right up to the time of his death.

11. Chronology of contact between Q and his family and HSE Children and Family Social services.

1996-2003

Files disclosed a litany of contacts during the mid- 1990's involving the family, Gardaí, public health nursing, school, GP, and social work services. Most related to parental drinking, domestic violence and child neglect. Following a series of Emergency and Interim Care Orders the Health Board was granted Care Orders for all three children until they reached their respective 18th birthdays.

Records showed an application from relatives to become foster parents and a letter from the Placement Committee approving them in late 1990's; a detailed fostering

assessment report is in the files. The files also evidenced fairly regular contact between social workers and the children but most of this relates to parental access. The files also contain reports of joint Child Care Review for both children, held approximately every two years.

2003-2008

When Q was 12, he and his older sibling were admitted to hospital suffering from the effects of an overdose of alcohol given to them by children in the street. Q refused to return to foster carers alleging physical abuse. He stayed with his father whilst allegations were being looked into by the social work department. Q later retracted allegations and moved back to live with foster family. Later that year the foster family, without warning, left their home to live in two mobile homes. The social work department were not informed of the move and had to search out the family. A few months later the foster family moved again without telling the social work department. Q and his sister were moved by the social work department to other relative foster carers until the accommodation issue was sorted out.

Three years later when Q was 15, one of the children of foster family was seriously injured in an accident and was left disabled with many health problems. This had a very big impact on foster family. Q dropped out of education around this time but the issue was not taken up by Social Work Department until six months later when an attempt was made to get him back.

Later that summer, when Q was almost 17, he was introduced to the aftercare service at a Child Care Review in preparation for leaving care at 18. He did not see his need of this service and responded reluctantly. Within ten days of that Child Care Review it became apparent that Q was getting into trouble with the law. His social worker, here called Social Worker A, picked him up from the Garda station. He was very agitated and resistant to any help from Social Worker A. His foster mother indicated that things were fine between her and Q and that she would have a chat with him about his arrest.

The next spring, when Q was 17, his father contacted Social Work Team Leader B to say that Q had been 'thrown out' of his foster home. Social Worker A intervened at this time and was informed by Q's foster mother that he had been giving her a lot of trouble. Social Worker A spoke to Q and he disclosed that he had been experiencing trouble with his foster mother and felt unwanted by her. Social Worker A intervened

and received the full cooperation of Q and his foster mother. He agreed to remain with the foster family and abide by their rules.

The files revealed that Q had a further conversation with Social Worker A the month before he turned 18. He explained that he had been 'thrown out' of home by his foster mother a couple of months earlier and had been staying with friends and sleeping rough. That same month he was remanded in custody for a short period and then released to live with his father. His father alleged to Social Worker A that the past 14 years had been "hell" for Q as his foster parents never wanted him and had been motivated by income.

Social Worker A researched addiction supports for Q at this time, but when he appeared in court he was sentenced to six months in custody. Social Worker A liaised with Q's Probation Officer C with respect to him receiving addiction services while in custody. Q was not keen to engage with addiction services and stated that when in custody he would have no access to drugs/alcohol and that this would be his way of dealing with his drug/alcohol problems.

Social Worker A visited Q in custody five weeks later and was told by Q that he was seeing an addiction counsellor and giving clear urines. He also advised that he was in court the following week facing further charges. Social Worker A recorded that she had advised Q about the aftercare services and that an aftercare social worker would be available. Q received a further six months custodial sentence at his court hearing.

2008 - 2010

The next month Social Worker A left her post and the case was transferred to Aftercare Social Worker D. Q turned 18 that month and his care order expired.

According to files, Q was granted bail two months later and returned to live with his father. He faced further court charges. There is a letter on the files from Q's solicitor advocating for accommodation support for Q. Aftercare Social Worker D recorded ongoing contact with Q and his father during this period.

The next summer, when Q was almost 19, he received a three year custodial sentences for charges going back to the previous year. Further correspondence was received by the Social Work Department from Q's solicitor advocating for an aftercare service for him whilst in custody. The next day Social Worker D and Team Leader B jointly replied in writing to the solicitor explaining that while they agreed that Q would benefit from therapeutic intervention during his period of incarceration it was the role of the institution to provide this service.

There is correspondence from Q's solicitor some two weeks later referring to a psychological report. Q had been seen the previous month seen by a clinical psychologist, at the request of his solicitors, with a view to producing a report for court. This psychological report contained much information previously absent from the files. The report summarised that Q could do much better in life if the opportunity presented. It commented that he was at great risk of significant psychological disturbance but at that time did not have a major mental illness or personality disorder.

The next month Aftercare Social Worker D left her post and was replaced by Aftercare Social Worker E two months later. From late summer of that year (after receiving the solicitor's letter and a copy of the psychological report which Q had asked to be sent to his Aftercare Social Worker D) there is no record in the files of any contact between the aftercare service and Q until the following autumn – a period of around 15 months.

2010-2011

Aftercare Social Worker E had occasion to be in contact with Q's father about another matter and made an inquiry about Q. The aftercare social worker was informed that Q was due to be released from prison the following month. Aftercare Social Worker E made an arrangement to visit Q in custody to plan for his release. Q said that he was going to live with his father and did not want to accept accommodation proposed by Aftercare Social Worker E. Q mentioned that he was facing a further court appearance a couple of months later relating to offences committed a couple of years earlier.

Aftercare Social Worker E gave Q information and advice of a practical nature including ways to go about getting social welfare, medical card, and how to access emergency accommodation. The aftercare worker agreed to be available to Q to support him through making applications and later sent him information with contact details, recommending that he make contact upon release.

After his release Q made contact with Aftercare Social Worker E and asked for help in getting his medical card. He moved in to live with his father. An arrangement was made to meet the following week to complete the medical card application and housing forms. Q did not attend this meeting and was not contactable by telephone.

About six weeks later Q's father contacted Aftercare Social Worker E to say that Q had been beaten up and was homeless. His father's own circumstances had changed suddenly and he was no longer able to offer Q accommodation.

His worker agreed to attend a meeting with Q at the town council offices the next day at 2p.m. The worker was told that Q would be staying with a young male friend that night. The next day, just before 2pm, the aftercare worker received a phone call from Q's father to say that apparently Q had been found dead the previous night. At the time of conducting this review it is not known if there are any suspicious circumstances concerning his death.

12. Analysis of involvement of Health Board/HSE Children and Family and Aftercare Services with Q

12.1 Initial response: Appropriateness of Care Orders

There is clear evidence from the files that the [X] Health Board acted appropriately in taking Q and his siblings into care on the grounds of parental neglect. It then found relative foster carers and proceeded to have their suitability assessed and then approved by the Placement Committee. In doing this it met its statutory duties and complied with recognised good practice.

12.2 Assessment

It would appear that a comprehensive assessment of Q, his needs and development as a person was lacking - except for the psychological assessment which was undertaken after he left care and was already in prison. As noted earlier this psychological assessment contained much new and relevant information which may have been available had a comprehensive assessment been carried out by the [X] Health Board/HSE.

12.3 Compliance with regulations

12.3.1 Early protective action

The protective action taken to ensure Q's safety demonstrated compliance with the child protection guidelines in operation at the time.

12.3.2 Child Care Reviews

There is evidence from the files that Child Care Reviews were carried out for Q and his siblings at least every two years throughout their time in care (although according to 1995 Child Care Regulations these should happen at least annually). Standardised pro forma were used to record the reviews. There is also evidence that foster carers were invited to the reviews, as were relevant professionals and the children when they were older. Birth parents were consulted and their views reflected. However, some of the reviews were sparsely attended. Most often reviews were attended by Q, his foster mother, social worker, fostering social worker and team leader. In the early reviews school reports were usually tabled by the school, although this seemed to die out as Q reached his teens. Most reviews also included a short questionnaire pro forma, completed by Q about his well-being, interests and objectives, tabled. This demonstrated the Q had been consulted about his views prior to the review. Similarly there were reports from fostering link workers about the views of the foster mother on progress and other family matters. However, there was a sense that some of the reviews were perfunctory and carried out to meet a regulatory function rather than including fresh assessment of need or analysis. Indeed some review reports were almost copies of previous ones with no evidence of new thought going into them. Some of the reviews were also joint ones for Q and his older sibling. Whilst one can appreciate the efficiency in terms of time and meetings and also the need to look at family needs holistically one would worry that the individual needs of the two children were neglected in the interests of efficiency.

12. 4 Quality of practice

12.4.1 Interaction with child and family

There is no doubt that Q's family had complex needs and were difficult to work with. The decision to look for relative foster carers and for Q and his siblings, to enable them to be brought up within the wider family circle and people they knew is in keeping with good practice. However, it did carry its own risks. Sometimes relative foster carers can resent monitoring by the social services - seeing it as a form of unnecessary intrusion into private and family matters (see Chapter 6 of Report of the Working Group on Foster Care – Department Of Health and Children, 2001, for a discussion of these issues). There is little doubt from the records that Q's foster carers saw things from this perspective. When social workers visited the family to inquire how things were going they tended to say "fine" and were not forthcoming - even in later years when relationships became very strained with Q. They withheld important information in relation to behaviour, school dropout and similar matters. They also moved accommodation on two occasions without informing the Social Work

Department even though they knew that they were required to do so. They tended to involve social work services in relation to grants and fostering allowances but did not confide much in relation to family matters. Likewise, Q tended to be conservative in how much he was prepared to share with professionals. He was hard to engage but did not refuse to engage. There can be little doubt that there was much going on in is life and that of his foster family that would have been of concern to social workers had they known.

Yet there is ample evidence that the social work services and later aftercare services did work hard with the family and frequently offered practical assistance when requested. In hindsight, a key issue is that quite a number of events occurred which were not beneficial to Q's welfare, of which social workers were unaware. If they had been aware of them, they may have intervened therapeutically earlier. Whether or not such intervention would have been accepted is a moot point. Yet on the one occasion when Q was offered an in-depth assessment he accepted and was forthcoming and co-operative. Of course, this was when he was in prison, his life was in a crisis and he was under considerable stress. In such circumstances it easier to accept offers of help. However, Q did ask that his psychological report be sent to his aftercare social worker, signifying an openness to engage at that point.

There is no evidence in the files that any social workers acted inappropriately or negligently. They were facing a formidable challenge and always reacted appropriately. Whether they could have acted more proactively is difficult to assess. As mentioned earlier the failure to have a structured and on-going assessment and analysis process was a structural/management shortcoming. Social work skills would have been enhanced through training in motivational interviewing and other person centred methods of working.

Perhaps, most crucially, an opportunity seems to have been lost when Q's solicitor wrote to the aftercare service asking for a support package to be put in place while he was serving a lengthy prison sentence. Given the complexity of his needs and his apparent willingness to engage this does indeed seem to be a wasted opportunity. Aftercare services did respond very quickly to the solicitor's letter, but merely to say that the responsibility for therapeutic intervention lay with the prison authorities while he was in prison. This may well have been the case but it also seemed to be an opportunity for interagency co-operation and to address needs in a joined up fashion.

As it was, the aftercare services had little contact with Q until just before his release. A longer planning process and preparation for release could have borne much fruit. One is, of course, aware of heavy workloads and pressures on aftercare workers and the difficulty of prioritising cases. Again the failure to have an up-dated assessment may have been a crucial factor in Q not having access to the support services which he clearly needed.

12.4.2. Child and Family Focus

During the period of family disharmony, domestic violence and physical neglect there is good evidence of a strong child and family focus by social workers. However, after Q was placed with family foster carers the intensity of focus reduced. Social workers appeared to accept assurances from the foster carers that everything was "fine". Indeed up to Q's early adolescence it probably was. Social workers did meet with Q prior to reviews and were again assured by him that he was happy and that everything was going well. It is during this period that one senses that social workers were not well attuned to Q's needs and were not picking up signs of concern. For example, Q was getting suspended from school because of his behaviour but social workers seemed to be unaware of this. When Q made the allegation of physical abuse when he was 12, this was "looked into" but when he withdrew the allegation matters appear to have been allowed to rest. Even when Q had to be picked up from the Garda station by his social worker this appeared not to ring alarm bells.

By the time social workers realised the extent of the breakdown with the foster family Q was already heavily involved with alcohol, drugs and criminal behaviour. There was then a quick deterioration which led to Q being placed in custody on several occasions. By this time the aftercare services had become involved as the main contact between the HSE and Q. Again there is a sense that no strong relationship with Q or a comprehensive assessment of his needs had been built up. Aftercare social workers did offer and provide services to Q but he was often reluctant to accept them. Lengthy periods elapsed when there was no contact. One has a sense of opportunities lost where a more proactive approach, particularly during the time he was in custody could have borne more fruit. Q did demonstrate that at times of crisis or when in prison he could be engaged. More intensive planning for his release from prison and joint working with probation and prison staff would, almost certainly, have been beneficial.

12.4.3 Quality of Record Keeping

There were nine files relating to Q, his siblings and wider family. While a great deal of information was recorded, the quality of recording varied immensely. There were many duplicate records across the files. It was difficult to follow sequences of events and there was no apparent logic in the manner in which records were kept. Some records were not fully dated or signed by the author. Quite a lot of the information held on the files related to payments of allowances to the foster parents and requests for other payments. This information was intermingled with quite detailed hand written notes by social workers relating to monitoring meetings with Q, his siblings and foster carers. There was also a considerable amount of information relating to access requests from Q's parents.

Some sections of the review record forms were not filled in at all and others were completed in a most cursory and abbreviated fashion. Given that these review records were the nearest documents to an assessment of need found on the files it would have been important to make sure that they were regularly updated and analysed to ensure that Q's needs were met. This may seem like an unnecessarily bureaucratic chore but it would have provided a framework for assessment and evaluation which otherwise appeared to be missing.

It is understandable that social workers and managers will hold files relating to different aspects of service provision. However, there was no one master file that would have provided access to an overview of the sequence of events, key incidents, and up-dated assessment of need and details of strength and risk factors. Anyone wishing to access information quickly or in an emergency would have had to dig through the files in order to find pertinent information.

The files did not contain any information on social worker supervision.

12.5 Management

12.5.1 Allocation

Q appears to have had consistent and continuous social work services throughout his period in care. Likewise his relative foster parents had good access to fostering link workers. This is evidenced in the files.

Preparation for transition to aftercare services happened just before his 17th birthday and appears to have been managed smoothly. There was a short gap between one

aftercare social worker leaving and another one being appointed. This happened when Q was in prison. This meant that there was no relationship built up between Q and his new aftercare social worker for a period of around fifteen months and this occurred just prior to his release from prison just after a lengthy sentence. This was regrettable. Joint working between the aftercare worker, probation and prison staff would have facilitated planning and therapeutic intervention.

12.5.2 Inter-agency meetings or cases conferences

There is good evidence of inter-agency meetings and case conferences during the period when Q was first taken into care. There is no evidence of any case conferences taking place after that. There were at least two occasions when such conferences may have been appropriate. The first was when Q was collected from the Garda station when he was 16. An inter-agency meeting with Garda and education services may well have revealed a number of issues of concern and pointed to deterioration in Q's behaviour – mostly relating to his use of drugs and alcohol but also highlighting high levels of anxiety and trauma in his life. The second occasion when an inter-agency conference could have been of benefit was in the period coming up to his release from a lengthy prison sentence. This may have led to a more comprehensive package of support being put in place including an up-dated mental health assessment.

12.5.3 Supervision

There is no direct evidence of social work supervision contained in the files. There is evidence of social work team leaders being present at case reviews and one letter jointly signed by Social Worker D and Team leader B. This suggests that the team leader had some oversight of the case. It would be good practice for a senior manager to "sign off" care plans and reviews.

12.5.4 Policy

A main point of policy concern was the HSE's reluctance to becoming jointly involved with probation and prison staff in providing therapeutic services to Q while he was in custody. HSE aftercare services had been the main agency involved with Q from around his 17th birthday onwards; it was also likely that it would be the main agency providing services after his release. For this reason maintaining continuity and building a relationship with him when in custody would have been a sound policy decision.

12.5.6 Inter-professional and inter-agency cooperation

Throughout the files there are indications that better interagency and inter-professional working could have been achieved. Examples of this are the quite

lengthy period it took the Social Work Department to find out that Q had dropped out of education. Similarly, it would seem that Q's alcohol, drug misuse and offending were already quite far advanced before it was found out. Closer liaison with the Garda, GP, or education may have brought these issues to light earlier and given a chance for earlier intervention.

13. Conclusions

13.1 Q's death was tragic and condolences must go to his family. He was a young man of considerable potential, yet very vulnerable. He had suffered a very chaotic and traumatic early childhood - characterised by parental domestic violence, alcohol abuse and neglect. The Social Work Department acted appropriately in taking Q and his siblings in to care. They were placed with relative foster carers who appeared to resent social work monitoring and support. This meant, especially in his teenage years, that social workers were lulled in to sense of false security by assurances from the foster cares that everything was" fine". In fact there were a number of worrying signs which might have aroused concern and a more proactive approach. The foster family was under considerable stress following a serious accident to one of their children and also sudden and unreported moves of home.

13.2 There is a sense that the statutory Child Care Reviews were in some cases quite perfunctory and lacked depth, assessment and analysis. Social work records had numerous shortcomings. They were abundant in volume and duplication but lacked structure and ease of analysis.

13.3 A vital opportunity was missed to do "joined up" therapeutic work and preparation for release whilst Q was in prison. Q was reluctant to engage with services but not resistant.

13.4 There is ample evidence in the files that the Social Work Department responded to requests for help in a practical manner. Examples include offering Q advice and support on accessing a medical card and social welfare. Relationships between Q and his social workers appeared to be positive. The Social Work Department fulfilled its basic statutory duties - although there are times when it may have been more proactive. The lack of a comprehensive assessment process is a serious managerial shortcoming.

14. Key learning points

14.1 The use of relative foster carers is appropriate but carries its own risks; sometimes these can resent and resist social work monitoring which they may perceive as unnecessary interference (see reference at 12.4.1 above). Social workers need to be particularly vigilant in such instances by using other sources of information, such as from education, GP and so on.

14.2 Social workers often find it difficult to engage with "hard to reach" families. In such instances specialist training would assist them in improving their investigative skills with individuals and families. It would assist them in identifying signs of concern and help them to probe more deeply in such circumstances.

14.3 As can often happen behavioural concerns and other issues can emerge from early to mid-adolescence, especially in children who may have suffered trauma and attachment issues. This highlights the need for structured and ongoing assessment, drawing evidence from a range of sources.

14.4 Times in custody and/or involvement with the criminal justice system may provide opportunities for joined up working and support between HSE and criminal justice services. These opportunities should be grasped as the person may be more amenable to offers of inter-agency support when in custody.

15. Recommendations

15.1 Social workers' investigative skills should be enhanced by training to enable them to probe more deeply with "hard to engage" families and individuals.

15.2 The Social Work Department should consider introducing a regularly up-dated "master file system" containing key information which will be easily interrogated in the event of emergency or critical incidents.

15.3 The Social Work Department should consider introducing a comprehensive assessment tool informed by interdisciplinary input.

15.4 Protocols should be introduced between HSE services and the prison authorities to enable interagency therapeutic packages of support to be delivered whilst clients are amenable in prison. This should include social work, mental health and alcohol/drug abuse services for young people entitled to after care support.

Signed: Bill Lockhart
Deputy Chair

Signed Helen Buckley
Chairperson, National Review Panel

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