National Review Panel

Review of the death of Lennie, a young person known to the child protection services

September 2015

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1. Introduction

This review has been carried out in accordance with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* issued by the Department of Children and Youth Affairs in December 2014. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Children in care;
- Children known to the Agency's social work department or an Agency-funded service; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.
- In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:

    - A child protection issue arises that is likely to be of wider public concern;
    - A case gives rise to concerns about interagency working to protect children from harm; or
    - The frequency of a particular type of case exceeds normal levels of occurrence.

2. National Review Panel (NRP)

A national review panel was originally established by the HSE (now replaced by the Child and Family Agency) and began its work in August 2010. The NRP consists of an independent Chairperson, a Deputy Chair, and approximately twenty independent members with 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 receives administrative support from the Child and Family Agency. When a death or serious incident fitting the above criteria occurs, it is notified through the Agency to the office of the CEO and from there to the NRP. The CEO 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

The process to be followed consists 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 will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, conclusions, key learning points and recommendations. Depending on the nature of the case, one of the following types of review will be conducted.

Major: to be held where contact with the Child and Family Agency 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 two 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.

Comprehensive: to be held where involvement of the Child and Family Agency 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, key learning points and recommendations.

Concise: to be held where the involvement of Child and Family Agency 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, key learning points and recommendations.

Desktop: 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 one panel member with oversight from the chair. 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, key learning points 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.

Internal: Under *Children First: National Guidance for the Protection and Welfare of Children*, all areas should conduct a review where a child in receipt of services has died. Internal reviews should be sent to the Chair of the National Review Panel. In certain circumstances, e.g. where the death has been from natural causes, or where the death or serious incident has more local than national implications, the internal review, once quality assured by the National Review Panel, may suffice and the NRP will not conduct one.

4. Child Death or Serious Incident

This report concerns the service provided by the then HSE Children and Family Services to a young person, here known as Lennie, who died not long before his 18th birthday. His death was the result of hanging. The intention behind the incident was not clear and it was considered by staff that knew Lennie and by the coroner that it may not have been fully intentional as he had a history of self harm attempts and impulsive behaviour.

5. Lennie

Lennie was a member of the travelling community. He had spent his early years in another jurisdiction and came to Ireland with his mother and older siblings when his parents separated. He was described by staff that knew him as very engaging with many positive qualities. He had been diagnosed with ADHD at an early age so found it difficult to concentrate and could be very impulsive. He spent periods in detention schools and in HSE residential facilities and was living in a wrap around care arrangement at home when he died.

6. Level and Process of Review

An extensive local review was conducted into the events prior to Lennie's death within two years after it occurred. The review was based on documents and case records belonging to the Children and Family Services social work department, all relevant files maintained by the units in which Lennie resided, and relevant records of the local Child and Adolescent Mental Health Services. Given the breadth and depth of the internal review, it was not considered necessary for the National Review Panel to conduct a separate review and pursuant to the level of review guidelines outlined in Section 3, namely the internal review, this report represents an anonymised summary of the internal review, which has been restructured to fit with the NRP template. The conclusion, key learning and recommendation have been revised to reflect recent structural and policy reforms in the child protection system. The local review has already been disseminated in the area where Lennie received services. It was conducted by the local area manager, a consultant child and adolescent psychiatrist and a clinical risk manager. This anonymised and restructured version was written by Professor Helen Buckley, chair of the National Review Panel.

7. Terms of Reference

The local review team adopted the following terms of reference to:

- Establish precisely what happened and whether systems failures occurred in relation to the death of Lennie
- Identify the causes of any failures and to outline actions that will reduce the risk of similar incidents occurring in future.
- Provide the family of Lennie with an explanation of the events that led up to his death including recommended actions aimed at preventing the occurrence of similar incidents in future.

8. Background and reason for contact with child protection services

Lennie and his family were members of the travelling community. They were first referred to the SWD in the area when he was almost nine years old. He had recently arrived in Ireland with his mother and siblings and the family had been known to social work services in the jurisdiction in which they formerly resided due to domestic violence and parental alcohol misuse. The family had a history of frequent moves. The reasons for the first referral after their arrival in Ireland were anti social and violent behaviour and non school attendance. Lennie was assessed by a HSE community psychologist and found to be in the borderline

mild learning disability range. He was also referred to CAMHS and diagnosed with 'severe ADHD'. Lennie had become known to an Garda Síochána before he was 11 because of anti social behaviour. At later stages, Lennie made allegations which indicated that he may have been sexually abused by several different people during his life. He was first allocated a social worker just over two years after the referral but had been attending CAMHS in the interim. Getting and maintaining school placements was a recurring challenge for Lennie, and while all the evidence indicates that he had a close relationship with his mother, his behaviour was beyond her ability to manage. He spent time in detention centres and in High Support care, and made his first suicide attempt when he was 13. He received services from CAMHS over a number of years.

9. List of Services involved

Lennie received services from the following:

- HSE Social Work Department (SWD)
- HSE community psychology services
- Child and Adolescent Mental Health Services (CAMHS)
- PHN with responsibility for members of the travelling community
- Liaison teacher for members of the travelling community
- An Garda Síochána
- Probation and Welfare
- A remand centre
- A detention centre
- A High Support Unit
- A mainstream residential unit
- A wraparound mentoring service
- A parenting assessment centre (where he stayed with his mother)
- Outreach services from a residential service

10. Chronology of service provided to Lennie

9 years

Lennie was first referred to the SWD in his local area at almost nine years old and his family had been in contact with social services in another jurisdiction becuse of familial domestic violence and alcohol misuse. The referral concerned the children's behaviour. A decision was made to allocate the case and it was put on a waiting list where it remained until it was

allocated two years later. Around the same time as the decision to allocate the case to a social worker was made, the family's GP referred Lennie to Child and Adolescent Mental Health Services (CAMHS), where they were seen after approximately seven weeks. Additional material provided by the PHN for the Travelling Community indicated that the children were not attending school and that there was conflict within the family. Lennie was diagnosed with a borderline learning disability and was recommended to have further cognitive and behavioural therapy and to attend a special school. At a later assessment he was diagnosed with ADHD and was prescribed medication. He continued to attend CAMHS on a monthly basis. He was referred to a summer camp later that year but dropped out.

10 years

Shortly after Lennie's 10th birthday the Gardaí sent a referral to the SWD reporting that he had caused serious and expensive damage to a property; the Gardai believed he was at risk of entering the youth justice system if his anti social behaviour continued. There is no evidence of a response from the SWD but the CAMHS notes from later in the year indicate that he got into further trouble with the Gardaí for theft and was suspended from school around the same time. His ADHD medication was increased.

11 years

Just after Lennie turned 11, he was allocated a social worker (Social Worker 1). Later in the year, the family moved to another part of the county and Social Worker 2 was allocated. Lennie went to a different school and attended the special unit there. His attendance became erratic and the school asked the Gardaí for assistance.

12 years

Around the time he turned 12, Lennie reported that he had been sexually abused by a local man but he later retracted his allegation. A strategy meeting some weeks later involving Social Worker 2, the school staff and the PHN agreed a new school schedule, school transport, behaviour management, contact with CAMHS re his medication and liaison with an Garda Síochána. His medication was increased a short time later in view of his hyperactivity at home and school and the CAMHS nurse therapist started behavioural work with him. The social worker requested the psychology service to do parenting work with his mother.

Lennie's school absconding and petty crime continued and he was referred to a mentoring service. Around this time, his mother told Social Worker 2 that Lennie had been abused by a

man in the area in which they previously resided. This matter was referred by the SWD to an Garda Síochána and a file was later sent to the DPP who decided not to prosecute.

When Lennie was 12 years and five months, he reportedly tried to hang himself just before he was due to appear in Court for a trespassing charge. This information was conveyed to the CAMHS service by the PHN. A strategy meeting was held a few days later and various options discussed, including sending Lennie back to his previous school and also providing respite with the mentoring programme. Very shortly afterwards, Lennie was referred by the Court to a remand centre for assessment. The assessment which was carried out at the centre confirmed that he had ADHD and Conduct Disorder and recommended a continuation of the CAMHS involvement. A conference held in the remand centre, which was attended by Social Worker 2 and Team Leader 1 recommended that Lennie would be better off at home with continued supports and on probation than to be detained as his needs were primarily welfare related. The Court agreed with the recommendations and Lennie returned to live with his mother. It was recommended that a review would be held in a few months time. A referral was made to a mentoring programme and arrangements were made for him to go on a Time Out programme. Ultimately he was not accepted by the mentoring programme because of his behaviour. A Court Officer for the Special Residential Services Board[1] had recommended a case conference and suggested that consideration be given to placing him in a specific HSE high support type centre but there is no evidence that these matters were given consideration.

13 years

There is very little documented about Lennie for the first six months after his thirteenth birthday, though there are letters from the Educational Welfare Service seeking a strategy meeting as per the recommendations from the previous year. The meeting appears to have been held when Lennie was 13 years and seven months, and recommended that he move into a residential placement as his mother could not cope with his behaviour. His disruptive school behaviour was also noted, despite special arrangements having been made for him. At this point, Social Worker 3 had become involved with him, supervised by Team Leader 2. Social Worker 3 requested and was granted permission to develop a package of support for Lennie. At this point, he had been prescribed Risperidone, a drug often used to treat psychotic and bi-polar disorders; his mother was worried about him mixing it with alcohol.

[1] The Special Residential Services Board was established on a statutory basis through the Children Act 2001 and later abolished in 2010. During its existence, the board had a remit to co-ordinate and advise the courts on the appropriate placement of children in children detention schools.

14 years

Just after his 14th birthday, Lennie was charged with burglary and again remanded in a different detention school. The social work case notes indicate that Social Worker 3 conveyed concern to her team leader about his placement, which was considered to be unsuitable by the staff in the detention school on the basis that he was mixing with other young people with serious criminal records. Social Worker 3 did not believe it was in Lennie's interests to go home and reported that she was working on a Special Care application and an interim plan. There is evidence of discussions with his psychiatrist, who was also concerned about Lennie's alcohol use and its impact on his willingness to take his prescribed medication. High support was considered for him on his release from detention. A planning meeting was attended by key professionals and it was agreed that applications would be made to units offering high support and the possibility of specialist fostering would be considered. It was also suggested that Lennie's mother's parenting ability should be assessed.

Shortly afterwards, Lennie appeared in Court in his home area and was sentenced to one year in a detention school. While he was serving his sentence, his mental health needs were addressed by the services in the detention school. Social Worker 3 left her post, and Social Worker 4 took over the case. She attended meetings in the detention school and it was generally agreed that specialist fostering would be the best solution for Lennie on his discharge. Social Worker 4 developed a business plan for private foster care though ultimately a decision was made to place Lennie in a HSE High Support Unit. The recorded reason was because budgetary restraints meant that plans for specialist fostering would have to be put on hold. At this point he was almost 15 and it was envisaged that he would stay there until he was 17, at which point he would be prepared for independent living.

15 years

Lennie completed his sentence shortly after his 15th birthday and went to the High Support Unit. He was re-referred to the CAMHS service for medication (which he ultimately refused to take). After a short period, staff in the High Support Unit expressed concern about his absconding behaviour and his Probation Officer agreed to apply to the Court to have a curfew imposed. However, due to his refusal to adhere to boundaries, he was discharged home three months later. The same supports as previously were put in place, i.e. he returned to his previous school, he had contact with Social Worker 3, he continued to attend and get support from the CAMHS team and the community psychologist.

A few weeks later, Lennie alleged sexual abuse by a relative. This relative subsequently committed suicide and it was considered necessary for Lennie to leave the country for his own protection against possible retaliation within the family. He went to live with his father in another jurisdiction. While he was away, another sibling alleged that Lennie had also been sexually abused by an older sibling. Social Worker 4 talked to Lennie on the phone about this allegation and he said he did not want to press charges. It was agreed that his sibling would not be allowed live in the family home if Lennie returned. Lennie did return, three months later after his father cold no longer tolerate his behaviour; his sibling was still at home and ultimately a barring order was secured, though Lennie's mother felt she would be unable to prevent him from returning.

16 years

Shortly after his 16th birthday, Lennie twice tried to hang himself following arguments with his mother and was subsequently removed from the family home and placed with a relative. He later returned home, having been assessed by CAMHS as not currently at risk of suicide but at risk of his own impulsivity. A child protection conference was held within a few days and a number of measures were proposed including recommencing Lennie on his medication (which he had been refusing) and controlling his use of other substances. Similar supports to those previously provided were proposed, including investigation of a specialist residential place. It was planned to have regular core group meetings to facilitate multi agency management of Lennie. He was not listed on the Child Protection Notification System. He had been expelled from school, and referrals were made to alternative educational services.

Some staff changes occurred at this time, Social Worker 4 went on sick leave and the case was allocated temporarily to Social Worker 5 and Team Leader 3 was replaced by Acting Team Leader 4. Lennie was removed from home following another suicide attempt and a violent incident with his mother where he threatened to kill her. He was admitted under Section 12 of the Child Care Act 1991 to stay with a relative for a few days before returning to his mother. During the same week, the consultant psychiatrist from CAMHS expressed his concern in writing to the Principal Social Worker that Lennie's needs were so acute that they could not be met by community services. He suggested a series of regular meeting to see if the risks could be managed more effectively.

Over the next few months, incidents involving Lennie's anti social behaviour continued and he was eventually placed in a residential centre for assessment; however this centre was not suitable and the SWD considered applications for residential centres outside the jurisdiction.

Due to threats made by Lennie in response to the various options offered, planning for him became very complex and an arrangement was made whereby Lennie and his mother were both placed in a setting away from their home with a care worker from the residential centre to provide parenting support and counselling. Problems arose within a short time with Lennie's behaviour including aggression, breaking and entering, using drugs and allowing the sibling that was barred to enter the dwelling. A note from the care staff indicated that he took an overdose of his prescribed medication but there is no evidence of this on the social work file.

Within a few weeks, Lennie had to leave that accommodation with his mother after accidentally setting fire to a room; they returned home with a care worker.

A few weeks later, Lennie was admitted to an emergency mainstream residential unit in another town and a crisis management plan was developed to deal with any likely incidents. Additional respite supports were put in place. In the meantime, Lennie's appointments with the psychiatrist were increased from monthly to weekly. However, after a very short time, the staff in the residential unit expressed concern about their ability to manage Lennie, this was later supported by a HIQA inspection report which recommended extra supports to manage him. Lennie went on a few respite breaks over the following weeks, but his behaviour continued to be disruptive, including episodes of self harm and he was considered to be de-stabilising other young people in the unit. His medication was revised and he was prescribed a mood stabiliser.

Within a short period, it was decided that the placement was unsuitable and meetings were held with management to consider all other options. An interim plan was developed for a home support package, staffed by the unit where Lennie had previously resided with his mother. The psychiatrist again made the point that Lennie needed a placement with a high level of individual support and containment, with skilled psychiatric and therapeutic interventions available. A longer term plan, on similar lines, was proposed by Social Worker 4 in a business plan, with very clear and comprehensive aims. A Family Welfare Conference was held, and the unanimous recommendation was for the HSE to apply for a Special Care Order. Lennie's mother did not feel she could care for him, and the family did not think that the wrap around service proposed was suitable and felt that if the special care application was unsuccessful, Lennie should be placed in an appropriate HSE residential setting.

Following this, Social Worker 4 wrote to the solicitor representing Lennie in the criminal cases, requesting him to ask the court to detain Lennie in the criminal justice system for his

own safety. This did not occur. A new social worker (Social Worker 6) was allocated and worked with Social Worker 4 over a month to transfer the case in an orderly manner. The SWD than began to apply for a placement outside the jurisdiction. A review child protection conference took place and reiterated some of the previous recommendations, including making Lennie's home safer and continued attempts to secure a long term secure facility with appropriate therapy. It also made recommendations about his education and indicated an intention to contact the Department of Education. Lennie remained at home with the outreach care package while a placement was being sought. Social Workers 4 and 6 arranged for repairs to be done to the family home, and an application for special care (in Ireland) was completed. Lennie initially refused to contemplate going abroad but later changed his mind. The (Irish) special care application was put on hold by the Special Care Admission and Discharge Panel pending a clinical risk assessment and details of a step down placement. The principal social worker responded with full information, confirming that Lennie was at risk from his own impulsivity and at risk of harm including suicide. It was also confirmed that Lennie had charges outstanding in the criminal courts. The application was then refused because of the outstanding criminal charges.

17 years

Lennie turned 17 at this time. His psychiatrist wrote again, to Social Worker 6, to say that a placement in the criminal justice system would not be helpful and would increase the risk to which he was subject. Social Worker 6 communicated this information to the Court and Lennie's case was adjourned.

Lennie made a further suicide attempt in the meantime and had another aggressive outburst at home. In view of the rejected special care application, an application was commenced for a placement abroad. Further problems arose in the family home over Christmas, when Lennie's sibling, who had been barred from the family home, visited and brought drugs which were later confiscated by the care staff.

Social Worker 6 visited after the Christmas break to try and reiterate to Lennie's mother that his sibling should not be allowed into the house.

On a date shortly afterwards, the key worker who was assigned as part of the care package arrived at the family home, as usual, and spent the day with Lennie and his family. The day appeared to go well, with an outing in the afternoon. That evening, Lennie spent time in the sitting room with his family. The care workers changed over for the night shift, and Lennie

went upstairs for a bath a short while afterwards. When the key worker went upstairs approximately forty minutes later, he found Lennie dead.

11. Analysis of services provided to Lennie and his family by the HSE

11. 1 Quality of practice

11.1.1 Initial response

The local review indicated that Lennie had to wait two years before a social worker was allocated to him. However, he was engaged during that period with the CAMHS service where his behaviour, which had been the subject of the original referral, was the focus of attention. As concerns about his antisocial behaviour and the risk that he would soon become embroiled in the juvenile justice system increased, he was eventually allocated a social worker and it appears from the evidence that he was never without an allocated worker from that time on. When Social Worker 4 went on sick leave, Social Worker 5 appears to have covered the case for the duration. The local review was critical of the fact that handover arrangements between workers (of which there were five) did not provide sufficient detail to ensure consistent carryover of assessment and planning, and while there had probably been numerous oral exchanges of information, these were not well documented.

11.1.2 Assessment

Lennie had numerous assessments in different settings including CAMHS. Before he came back to Ireland, he had been assessed for ADHD. His first comprehensive assessment was in a remand centre, and he was referred for a number of different assessments in different settings after that. There is no evidence, however, that the interventions later made with him were appropriate to his needs, so the ultimate value of these assessments is questionable. While there are several references to plans for the involvement of psychology services to assist his mother with parenting, there is no reference to a full assessment of her parenting capacity having been conducted in the Social Work Department. What is clear is that she frequently expressed her own inability to manage him.

11.1.3 Interaction with child and family

This review is based on the local review which was very detailed. It appears from evidence provided in it that the SWD were aware of events in Lennie's life at any given time over the six year period after his case was allocated, that there was frequent discussion about him between the different services involved, and that the SWD were in contact with him and his

family quite regularly. However, the local review indicates that home visits were not made frequently enough to ensure that change occurred or was maintained and that at times were not sufficiently focused or adequately recorded. Most of the interaction appears to have been centred on trying to find suitable placements and education for him, and unfortunately efforts to meet these aims were complicated by his multiple and sometimes criminal behaviour difficulties which were clearly beyond his mother's capacity to manage from an early age. It is never clear whether she successfully managed to parent him for any length of time but what stands out are her frequent requests for assistance and her acknowledgement of her own limitations. There is evidence that while she was not resistant to intervention and cared deeply about her children, she found it very difficult to abide by guidance in laying down boundaries for Lennie or his sibling. There were three different points when multi-disciplinary meetings recommended psychological intervention to help her improve her parenting but no evidence that these were effective or that she engaged with them. Yet, Lennie was left in her care time and time again as various arrangements for him broke down.

There is no shortage of evidence that the SWD tried many options to find appropriate accommodation for Lennie, and to provide supports for him when he was living in the community but none were sufficient to meet his needs. While detention in the youth justices system was considered unsuitable, there was no alternative option in mainstream, High Support or ultimately Special Care that could manage him or was acceptable to him. Paradoxically, while detention in a youth justice facility was deemed inappropriate, he was not considered eligible for Special Care because he had criminal charges outstanding. Although efforts were made to provide him with consistent schooling at one point by transporting him to a school with which he was familiar, it appears that his education terminated very early. It is acknowledged that provision of education was complicated by numerous family moves.

From the information provided in the local review, Lennie was a very troubled child and was vulnerable to sexual exploitation. His psychological needs were identified soon after he came to live in the jurisdiction, and it appears that the CAMHS service was committed to Lennie and to trying to meet his therapeutic needs. There is evidence that his psychiatrist frequently highlighted what he needed in terms of a stable and predictable environment.

The last arrangement that was put in place for Lennie was a serious attempt to compensate for the gap between the type of environment he needed and what was available for him. The local review pointed out that this placement was not sustainable in the long term and unfortunately, it was not able to prevent him from continuing the pattern of self harm that had been characteristic of his behaviour from his early teens.

11.1.4 Child and Family Focus

It is difficult to judge from the material available the extent to which services worked directly with Lennie, up to the last phase when it is clear that key workers were in close contact with him on a 24 hour basis. However, there are indications that his views were taken into consideration and efforts were made to find solutions to his problems that were acceptable to him. Likewise it is difficult to ascertain how much individual attention was paid to his mother and as the previous section has outlined, she appears to have been put under a lot of pressure to care for him when she had stated her inability to do so.

11.2 Management

11.2.1 Management oversight

At certain points, there is evidence that senior management in the local area ware aware of the challenges presented by Lennie's need for a particular type of accommodation. The SWD was given support to develop care packages, some of which did not ultimately come to fruition, e.g. the plan for specialist fostering. However, by the time the application for Special Care was rejected, all other options had been exhausted. The resulting dilemma seemed to have been held by the area without escalation at national level, despite the very serious risks Lennie was posing for himself and others. The local review has noted that the last package that was put in place for Lennie was unsustainable in the longer term, thus implying that no satisfactory resolution had been reached. Much of what happened in this case occurred before the establishment of the National Office of the Children and Families Services or any channel for communication of high risk cases and it is acknowledged that it would currently be easier to escalate and anticipate a response to a case such as this where a young person is vulnerable from his own self harming behaviour

11.2.2 Inter-agency meetings and conferences

A number of different meetings were held over the years during which Lennie was in contact with services. These included strategy meetings and conferences in the units where Lennie was resident. Most of these meetings concluded that he needed a stable and predictable

environment, but there is little evidence that their recommendations were implemented on a sustained basis.

11.2.3. Allocation of social workers

The local review noted the significant turnover of social workers in the area which meant that Lennie had six allocated social workers who were managed by five different team leaders. It also noted that in general, the social workers allocated to Lennie were recently qualified with limited experience and without adequate induction.

11.2.4 Supervision

While noting the inexperience of some of the frontline practitioners involved in the case, the local review highlighted the lack of documented evidence of regular structured supervision sessions.

11.2.5. Policies and protocols

The local review also noted a lack of policy and procedural frameworks to assist social workers in the delivery of services; it acknowledged that decision making and governance structures were not clear and noted the potential for poor decisions to be made. It was critical of the lack of procedure regarding the implementation of Children First and of the poor condition of social work records. The local review made a number of recommendations regarding training (in respect of Children First) record keeping and implementation of the HSE supervision policy. This review notes the recent restructuring of services within the Child and Family Agency and the introduction of new policies including standard business processes which address some of the needs identified. However, the lack of placement options was the central issue and while the review has noted weaknesses in practice, they were all underpinned by the system's inability to accommodate Lennie in a safe environment.

11.2.6 Inter agency communication and collaboration

A large number of services were involved with Lennie over the period under review but were unable between them to provide the type of response he required. The local review recommended a multi service management oversight committee to agree strategic approaches particularly where cases may be beyond the capacity of local services to manage.

11.2.7 Eligibility for Special Care

Lennie's need for a stable and predictable environment was known, past experience showed that he coped in such a setting, and it is clear that the lack of such a setting was a significant factor in this case. It is evident that at this time, a significant gap existed between the criteria as applied by the Special Care Admissions and Discharge Committee (he was ineligible because of outstanding criminal charges) and the needs identified by staff working with him (that he was at significant risk because of his own behaviour and needed to be detained for his own safety). It was generally agreed that detention in a youth justice facility would be unhelpful.

This represents a lacuna in service provision and the local review recommended that the criteria for application for special care should be reviewed to ensure that young people in need of containment and support are not excluded on the basis of outstanding criminal charges. It is noted that the most recent Tusla information booklet on admission criteria and referral guidance for special care outlines in Section 3 p. 9 'Where Special Care is not suitable'

> Special care is a specialised intervention within a group living situation and is not suitable, safe and/or in the best interests of the child/young person whose primary needs or presentation include, for example:
>
> - The need for detention as a consequence for offending behaviour[2]

In Lennie's case it was the view of most professionals working with him that detention in Special Care would better meet his needs than detention in the criminal justice system. The criteria outlined above suggest that discretion may be applied but are insufficiently clear with regard to how needs are defined, or whose opinions with regard to the child's needs would hold sway.

12. Conclusions

Lennie was a very troubled young person who had a long history of behavioural problems and exposure to family violence as a young child. As he entered adolescence his behaviour became more destructive. His impulsivity made it very difficult to keep him safe. This review found no direct link between the practice in this case and Lennie's tragic death. It found that staff tried over a number of years to try and find a setting that was acceptable to Lennie and in which he would thrive and develop. However, the review has also concluded that the lack

[2] *Special Care Services Information Booklet 1* (4th edition 2014)

of suitable placements for him added considerably to the challenge of keeping him safe. It also concludes that the lack of suitable accommodation coupled with Lennie's desire to stay at home with his mother resulted in unrealistic expectations being placed on her, despite her apparent frequent acknowledgement that she could not manage him.

13. Key Learning

There was evidence from an early stage that Lennie's mother was unable to manage his behaviour, or that of his sibling. Quite rightly, the SWD initially tried to support her parenting in order to keep Lennie out of the care system. However, the evidence indicates that while her motivation to care for him was high at the outset, his needs were significant and her capacity to change her parenting style sufficiently to cope with the challenges he presented was too limited. The learning point here is that decisions about out of home care need to be made when evidence indicates that the likelihood of change is low. Effective assessment means not only identifying a child's needs but also their parent's capacity to meet them. In addition to assessing the impact of various factors on parenting capacity, one of the key questions to ask is 'where is the parent/carer in the change process?[3]' and if the answer indicates that the carer is unable, for whatever reason, to change their previous parenting style sufficiently to meet the child's needs, then a plan needs to be made accordingly. The model of change outlined by Horwath and Morrison (2009)[4] provides a useful model to guide practice in this area.

14. Recommendation

The local review made a number of recommendations for the local area. Many of the issues raised now form part of the structure and policies that have been established by the Child and Family Agency. For that reason, they will not be replicated here with one exception, which is that the criteria for applications for special care are amended to provide more clarity on eligibility for young people with outstanding criminal charges.

Professor Helen Buckley
Chair, National Review Panel

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[4] Horwath, J. And Morrison, T. (2009) Assessment of parental motivation to change' in Horwath J. (ed) *The Child's World: Assessing Children in Need',* London: Jessica Kingsley