National Review Panel

Review undertaken in respect of a death experienced by a young adult (Sam) who had been in the care of the State until his 18th birthday

October 2015

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. Young Person's Death

Sam was killed in an accident when he was 19. The review is being conducted because he had been in care up to his 18th birthday and was subsequently in receipt of aftercare services up to the time of his death. Sam's parents are called Joni and Jim for the purposes of this report.

5. Level and process of review

This was a desktop review as the facts of the case (including the circumstances leading up to the death) are clearly recorded, and there is no immediate evidence that the death or outcome was affected by the availability or quality of a service. The review team consisted of: Professor Helen Buckley, chair of the NRP and Mr Frank Martin.

The review covers a period of approximately 18 years prior to the death of Sam with a particular focus on the years when Sam was in voluntary care and when he was subsequently in an aftercare programme. The methodology adopted was a review of the extensive Health Board/HSE/Child & Family Agency social work records, psychological reports, school reports, copies of correspondences from various agencies dealing with the case, reports from PHNs and psychological and psychiatric reports. The files/records consisted of ten folders containing extensive and comprehensive copies of case notes, correspondence and reports from Health Board/HSE/ Child & Family Agency staff, educationalists, psychologists and various medical personnel.

Based on the case files provided, the review team compiled a chronology and analysis of the case from the date of the original referral to the Health Board/HSE to the death of Sam. Having read the case files, the review team members requested some additional material associated with Sam's aftercare period. These additional requested files were provided by Child & Family Agency staff Children and Family Services.

For the avoidance of doubt, where the review team has described the circumstances of any person mentioned in this report, the review team has based those descriptions on information contained in the relevant documentary records furnished to the review team. The review team is not to be taken as expressing any view on the veracity or otherwise of any such item of information.

6. Terms of Reference

- To establish and determine the events leading up to Sam's death and to determine whether any action or inaction on the part of the Child & Family Agency Children and Family Social Services had been a contributory factor in the death of Sam.

- To examine the quality of the Child & Family Agency (formerly the HSE) child protection service in the context of compliance with statutory obligations, procedures, policy directions and key professional standards of good practices and protocols.
- To consider issues of interagency and intra-agency cooperation and communication.
- To prepare and provide an objective report to the CEO of Child and Family Agency

7. Details of young person

Sam was 19 when he died. As a young child he was described as anxious, physically neglected and nervous but as he matured he became more settled and was described as a person with a friendly pleasant personality who developed some mature insights into his behavioural problems. In school he was assessed as in need of learning supports.

8. List of services involved with Sam and his Family (his siblings and parents)

The following is the list of the main services involved (directly and indirectly) in Sam's case.

- Child & Family Agency (formerly the Health Board/HSE) Social Work Department. This was one of the principal services involved in this case.
- HSE Public Health Nursing Service
- *An Garda Siochana* was involved at various times. Firstly, when investigating domestic violence/parental child neglect accusations when Sam was the alleged victim. Secondly, when Sam was being placed into voluntary care. Finally, they were involved in the investigation of Sam's fatal accident.
- Family GPs with whom Sam had limited contact
- School Staff
- NEWB staff
- Child and Mental Health Services
- Youth Advocacy Programme

- A specialist assessment service for young people at risk

9. Background

When Sam was between two and five years, years multiple concerns were reported to the local health board SWD from PHNs, area medical officers, the ISPCC, extended family members and neighbours. These mainly concerned his parents' alcohol use, domestic violence, alleged physical abuse and general neglect. The case was opened and closed on different occasions with different levels of engagement from the family with different services. According to records, the SWD had been advised that there was insufficient evidence for removal of the children, and were trying every possible option to improve the situation. Sam was eventually received into voluntary care when he was eight years old and placed with a relative where he remained until he was 18 and subsequently received aftercare services until shortly before his death.

10. Brief Summary of Sam's needs

Sam suffered neglect and physical abuse as a young child, he was undernourished and living in a very unhygienic environment where poor supervision meant that he had a number of accidents. As a two-year-old he was diagnosed by his GP as evidencing foetal alcohol syndrome. As he grew older, he developed very challenging behaviour. He also had learning difficulties.

As a consequence, Sam required a safe hygienic environment free from parental corporal punishment. He needed love, care and affection and proper supervision and psychological supports. He also had mental health needs. In particular, he required academic supports given his very poor literacy and numeracy levels. Sam suffered from a tremor as a young child which was diagnosed as nervous in origin.

11. Chronology of contact between Sam and the Child & Family Agency/Health Board/HSE

Early childhood

Prior to Sam's birth, the then Health Board Social Work Department (SWD) was involved with his family due to the chronic school absenteeism of one of the children as well as unexplained physical injuries to another of the children. The SWD closed the case prior to the birth of Sam after two home visits were completed and Joni, his mother, refused to engage with the SWD regarding alcohol use. The file records that Joni was intoxicated on the night of his birth and her alcohol use continued to be a recurring major problem for the family. There is evidence in the social work files that multiple referrals to the Health Board/HSE SWD Child and Family Services were made at this time by the PHN, Area Medical Officer, a nursery, the Gardaí, primary school teachers, Childline, extended family members and neighbours. The file under the category "Contact Sheets" begins with a file stating: "Take out old file, visit and assess". A medical social worker referred the family to the SWD as a result of Joni's visit to the Emergency Department with a head injury while in an intoxicated state.

Although the files make no reference to the case being formally allocated, a social worker here known as Social Worker 1 was centrally involved in this case for the next few years. Joni's alcohol abuse was the central paramount issue of grave concern. Addiction counselling was frequently suggested but Joni either prevaricated about this option or she agreed to attend counselling session but failed to subsequently attend. Home Help and Mother and Toddler services were offered by Social Worker 1 but also declined by Joni. The PHN and Social Worker 1 visited regularly and liaised together very regularly about this case. The focus was primarily on addressing Joni's addiction.

When Sam was three he was admitted to a children's hospital with a suspected non-accidental head and face injury. The hospital made a referral to the PHN and Social Worker 1 who made separate home visits within a few days. Sam's mother, Joni, claimed that his head/face injury occurred while she was absent from the family home. Social Worker 1 pointed out that leaving the children without adequate supervision was inappropriate and unacceptable. The social work team leader also visited Joni to impress upon her the repercussions of drinking alcohol on her health. She agreed to attend a counsellor with Social Worker 1 in the family home; however this proved an unsuitable venue and later appointments were missed.

The social work record indicates that Sam was diagnosed by his GP with foetal alcohol syndrome. He was manifestly underweight and presented as an anxious nervous child, was described as 'grubby' and was dressed inappropriately.

When Sam was aged four, Joni told the PHN during one of her home visits that her husband regularly physically abused her. Subsequently, a referral to the SWD from the PHN was received in relation to parental domestic violence. Social Worker 2 was then allocated to the case. Her notes in the file indicate that while the case was previously allocated, there was no indication of when it had been closed. In any event, the SWD reopened the case and noted that domestic violence was not explicitly mentioned previously in the files. Social Worker 2 offered Joni support to deal with the domestic violence and assisted her to obtain a Safety Order. Social Worker 2 further arranged for the Gardaí to read the Safety Order to Sam's father, Jim, in the family home. Some months later she assisted Joni with her successful Barring Order District Court application and helped with her application for financial assistance to the Community Welfare Officer. Comprehensive social work records show that Social Worker 2 visited regularly at this time and facilitated the children's access to their father, Jim. She also offered a family support worker to work with Sam for 1-2 hours per week but this was declined. Social Worker 2 also arranged for a medical referral of Sam to the Area Medical Officer (AMO) because he was experiencing tremors. The AMO examined Sam in the family home and concluded that: "The tremors appear to be anxiety related tremors associated with emotional upset rather than a physical cause". Jim returned to the family home some months later after Joni applied successfully to the court to cancel the Barring Order. Reports on file say that the couple had 'resolved' their difficulties.

Reports on file indicated that the PHN continued to regard Sam as undernourished with poor attendance at school. Sam's Nursery also reported to Social Worker 2 that Sam's frequently had physical injuries. Plausible explanations were proffered by the parents and accepted by the SWD.

Five to eight years old

The family eventually accepted the offer of a family support worker (FSW). The FSW took the children to school three days per week and according to the records, the children were frequently late or absent on the other days. When the FSW reported that Joni was frequently drunk when the children came home from school, Social Worker 2 once again tried to engage her in addiction services, this time in a residential programme. However, this was unsuccessful and the SWD convened a meeting with Sam's

relatives in which they agreed to care for him two hours per day. It appears that no real improvement occurred in the home circumstances following this and when Sam was seven years old the SWD sought legal advice regarding the possibility of obtaining a Care Order for Sam and his siblings. The file notes that at this time the "house was in chaos, no socks, jumpers, coats or shoes were available to the children when preparing to go to school". It also notes that a Garda had been allocated to the case at this stage.

Legal advice provided to the SWD concluded that the SWD at this stage did not have sufficient grounds for removal of Sam but advised Social Worker 2 to 'exhaust every option' within the family. The option of a Supervision Order was also discussed but not actively pursued. A Case Conference was called followed by a Family Group Conference at which Joni agreed to attend an addiction course and promised not to collect the children under the influence of alcohol. It was also agreed that if Joni arrived at the school inebriated then her husband, Jim, was to be contacted to collect the children. An extended family member agreed to care for Sam for two hours per day. On request, Jim gave up work to care full-time for the children. However, this did not last long and he returned to work.

At the end of that year, a new social worker (Social Worker 3) was allocated to the family. She conducted announced and unannounced visits and observed that the children were allowed to smoke, on occasions to drink alcohol and that they used abusive language with their mother. Contrary to the instructions given by the Social Worker 3, Joni continued to arrive at the schools to collect the children on occasions when she was observed to be drunk.

It appears from the records that no improvement occurred, and following an investigation by the Gardai of an allegation of non accidental injury and subsequent discussions between the Gardai and the SWD, the children were eventually removed by the Gardai under Section 12 of the Child Care Act. Their parents then agreed to a voluntary placement in care and they were placed with their relative on an emergency short-term fostering basis for some months. Social Worker 4 had become involved at this point. The file records show that that the SWD team determined that if Sam's parents withdrew their consent for the voluntary consent status then the Health Board would seek a Care Order to ensure his continued care and protection.

Sam's relative was unable keep him at the time because of her own family situation and he was then placed with an approved foster family. The record indicates that his parents were to be given two years

to improve the home situation but ultimately refused to engage with the service. Sam and his sibling had weekly supervised access with their parents. Access was facilitated on the basis that there was a slim possibility that he might return home and contact would preserve a sense of identity with his family of origin. A new social work team leader (SWTL 3) and social worker (Social Worker 5) took over responsibility for this case at this juncture.

Eight to thirteen years

Statutory reviews took place on a regular basis while Sam was in foster care. During this period, there was no evidential change in Sam's parents' behaviour such as to facilitate the return of Sam to the family home and a risk free environment. File records of the SWD state that Sam's parents failed to make observable improvements in their respective lifestyles. Nevertheless, the foster and birth families had a positive relationship with each other. Sam's behaviour in primary school at this time was of great concern as he assaulted classmates, teachers and the school principal. The primary school had serious concerns about Sam's emotional, cognitive and academic development. It is noted that they showed a high level of commitment to him. When Sam was 12, his Care Plan concluded that his placement needed to progress to long-term care as there was no evidence that his parents were addressing their relationship difficulties and alcohol problems. It stated as follows: "There is little prospect of [Sam] returning home and he is now considered to be in the care of the Health Board. A subsequent Care Plan concluded that the parents' inability to engage constructively and positively with the SWD and other services made available to them would result in Sam's being in care until he is 18 years old. Counselling if required was to be provided for Sam and parental access to be provided on an on-going basis in order to maintain parent-child relationship.

Thirteen to eighteen years

Sam's placement ended when he was 13. The termination was due to his challenging behaviour, including threatening his foster carer with a knife. He was placed back with his relative on a short-term basis pending a more long- term placement. He was referred to a specialist assessment service where it was concluded that his problematic behaviour masked serious educational deficiencies and recommendations for his secondary education were made. The assessment noted that Sam presented as "an immature child of low ability…he will need a structured and protective secondary school environment…he would benefit from speech and language therapy as he presents with a severe

receptive and expressive language impairment… he does not appear to understand the consequences of his actions or behavior". The ultimate core recommendation of the report was that for a special school with limited numbers. No foster placements for adolescents were available at the time, or any residential option. His relative agreed to foster him. While Social Worker 5 had reservations about this placement mainly because of overcrowding, it was felt that it would meet Sam's needs in many respects. The placement was made long-term on a supported lodgings basis which paid at the foster care rate and with the same type of support. A statutory review care plan was agreed whereby attempts would be made to get Sam involved in extra-curricular activities and support would be provided to the primary school in applying for a full-time special needs assistant for Sam. It was also agreed to support Sam's relative's application for transfer to a larger house.

The assessment report had recommended a particular special school for Sam, but his application was rejected. Subsequently, Social Worker 5 organised a referral of Sam to a child psychiatrist who concluded after examination of Sam that he showed symptoms of Attention Deficit Disorder, Oppositional Deficit Disorder and evidence of Dyspraxia and that he would benefit from occupational therapy. The psychiatrist report also recommended a special secondary school for Sam. It would seem that the purpose of having two formal assessments of Sam was to enable the Social Worker 5 get additional classroom support in schools or to enable placement of Sam in a special school that would meet his educational needs. Indeed Social Worker 5 stated that: "If needed, the HSE would fund another assessment for Sam". At this time, his primary school principal wrote to the SWD indicating his on-going alarm at the Sam's behavior which reached crisis point from the school's point of view. In direct response to this letter, the SWD held a meeting with the principal, the fostering link worker and the team leader. A plan of action for Sam was put in place. A further school meeting with the Social Worker 5 and a representative from the National Educational and Welfare Board met to discuss Sam's pending secondary school placement. Efforts were made by the SW team to obtain a residential placement in a specialised secondary school for children with mild intellectual difficulties but were not successful as the school declined to offer him a place on the basis that "his substantial emotional and behavioural needs outweighing his learning needs".

Sam began his secondary education locally and the school classified him as extremely academically weak. During this period, Social Worker 5 offered Sam's relative carer (foster carer/ supported lodgings carer) the option of a parenting course which was declined. Sam was offered additional counselling

regarding alcoholism in a family centre, which he completed. Social Worker 6 became involved at this stage. Weekly supervised access visits were facilitated by SW 6 (between Sam and his parents). However, many of the access visits were deferred due to his mother's degree of inebriation and/or the non-attendance by either parent. With the agreement of the SWD Sam was allowed to visit his parents' house on Saturdays, accompanied by his relative. However, the records show that in fact he frequently visited his parents' home without the consent of the SWD.

Case notes and files state that supervised access regularly occurred and were generally positive despite the fact that Sam's mother, Joni, was frequently inebriated. Sam was also permitted to have a regular overnight stay in the house of another relative. Sam's secondary school attendance record improved significantly during this period and his secondary school behaviour was not generally a matter for concern. Social Worker 6 recorded in a statutory review of Sam's case and a review of the carers, that there were now no serious concerns about Sam and his health, education and leisure activities. The reviews concluded that Sam now regarded his relative's home as his home and that supervised access would continue to be facilitated in his parents' home supervised by Social Worker 6.

The SWD made the decision that Sam's (now aged 16 years) access arrangements vis-a-vis his parents would no longer be supervised. According to the files, Sam appeared to have become "disengaged" from his mother given the seriousness of her addiction. Consequently, (as an alternative type of familial engagement) his relationship with his elder sibling grew significantly as he viewed him as a role model. Sam completed his Junior Certificate Examination and proceeded to study for his Leaving Certificate Applied. School absenteeism was not now a matter for concern for the school. His supported lodgings placement was occasionally problematic as his carer had a large family, so minor interpersonal difficulties arose frequently in the house, which the allocated social worker discussed and monitored. By this time, Social Worker 7 had become involved. There were some concerns raised about physical discipline and alcohol consumption in the relative's home; these were addressed by the SWD who were ultimately satisfied that they were not of significance. A larger house was provided by the local authority on the basis of extensive supporting documentation provided by the SWD. Significantly, it was also decided that Sam could visit his parents in their house unsupervised at weekends and could avail of regular overnight stays with his older sibling given the general positive circumstances as well as given the fact that he was now 16-years of age. From the detailed files on Sam, there are well-documented records of many home visits being made to the carers' home by various SWD staff.

Eighteen years

The Care Plan which was developed when Sam was 18 noted that "]Sam's] move to a stable fostering placement with [his relative] has had a very positive effect on his behaviour, peer relationship development, education and general well-being". The Care Plan further noted that "[Sam's] need for predictability and continuity of care is being met within the context of his present placement… He will need some form of aftercare until he has become self-sufficient". Sam continued to attend secondary school and school reports to the SWD indicated that his behaviour and attendance levels were unproblematic. His supported lodgings placement with his relative continued throughout this year. File reports state that Sam was happy living with his relative and her partner even though Social Worker 7 was aware of allegations that a lot of alcohol was being consumed in the house, a fact which was minimised by the assurances from the carers who said it was not excessive, but confined to appropriate occasions and did not impact on their parenting capacity. Social Worker 7 asked them to address that problem. Records show that Social Worker 7 regularly took Sam to recreational venues as a treat and used the opportunity to engage with him conversationally about his general well-being or otherwise. Sam regularly told her that he had no desire to return to his parents' home.

Sam's final statutory care review took place two months prior to his 18th birthday. The social work record states that "[Sam] understands why he is in care and expresses no desire to return home". He was advised that the aftercare option was available to him until his 21st birthday. During this period Sam had yet to make a decision regarding his career/work options.

Aftercare

Sam was allocated an aftercare worker (ASW 1), thus ending his formal contact with his allocated social worker as he had reached the age of 18). It was agreed that he would remain living in his relative's house and that she would continue to receive the assisted supported lodgings payment. A formal aftercare plan was drafted and signed by his relative and Sam. Sam successfully completed his Leaving Certificate Applied. He was subsequently advised by ASW 1 that the supported lodgings payments would cease if he failed to register on a full-time education/training course and/or if he failed to pursue an apprenticeship type course. However, during the months following his Applied Leaving Certificate Sam worked in a garage on a part-time/non-training type basis. The aftercare worker made direct contact

with vocational type colleges endeavouring to enroll him if possible in the area of mechanical engineering. The formal supported lodgings placement facility agreement ceased when Sam was 19 on the basis that he was no longer in full-time education and/or he was not in a full time vocational/training programme involving an apprenticeship under the direction of FAS (the formal educational body for apprenticeships' training). The aftercare social worker's report concluded that Sam presented as "a very content young man who was very happy living with his relative and family… he had no desire to move out into supported aftercare or private rented accommodation and [his sibling's family] wanted Sam to remain with them long-term. Everyone involved agreed that this was the most appropriate and natural place for him to be and did not want to undermine it in any way". *Leaving Care Needs Assessments Templates, Template forms 1 and 2* were filled out by Sam and his relative/carer.

Sam's mother had died a few months previously after a period of illness for which she was hospitalised. The aftercare worker observed that his mother's death directly affected Sam's motivation to apply for college courses. Given those circumstances, the aftercare worker opted not to pursue a proactive involvement with Sam in making applications for him for college places dealing with vocational programmes of a Post Leaving Certificate nature. She indicated that she wished to respect his wishes and his freedom to determine things for himself particularly now that he was an adult. She also met with Sam's father to discuss Sam's general future plans regarding employment and/or further education. The aftercare worker met Sam when he aged 19 years for a recreational event and her report noted that he was in good humour and was looking forward to Christmas.

Although Sam was no longer in a supported lodgings payments type situation, contact was still maintained with him by the aftercare staff through phone calls and text messages. The final telephone call to Sam from his aftercare worker was when he was 19 years and five months and again concerned the availability of a Post-Leaving Certificate mechanical engineering type courses and advice on the necessity for him to enroll in such courses. The supervision sheet in the aftercare file, under the heading "Decisions/Plans stated that: "Payments for the supported lodgings have ceased and [Sam] is going on Job Seekers… [aftercare worker] will encourage Sam to register for a course in September".

Tragically, Sam was involved in a fatal accident shortly afterwards. His relatives notified the staff of the SWD. The SWD staff was in subsequent regular contact with the family and also later attended the religious funeral service. The SWD continued to keep contact with Sam's family in a supportive (i.e.

emotional) role, making them aware that a child death review would be formally undertaken. One of Sam's relatives stated that "[Sam's]death could not have been prevented and it was just an accident".

12. Analysis of involvement

12.1 Initial response of HSE to this case

As outlined in the chronology above, there were different phases in the SWD response to the referrals of concern about Sam: his early childhood, his later childhood /adolescence and finally, his period in aftercare

During the first phase, many referrals were made to the SWD about Sam and his siblings, detailing his mother's consistent pattern of problem drinking and the neglect of the children. Although the children's nurseries and later on, their schools reported their neglected appearance and challenging behaviour, most of the focus of intervention was on their mother's drinking and was underpinned by an apparent confidence that if her alcohol drinking was controlled, her parenting capacity would be adequate. While there was a lot of interaction between SWD services and the family, there was limited assessment of the individual children's needs or of the parents' capacity to meet them. Nor were specific outcomes or timeframes identified. Practical supports were provided, but it is not clear what outcomes were expected in terms of improved parenting. Every record of meetings with the children's mother noted that there was a smell of alcohol on her breath, and attempts at rehabilitation were short-lived. Their father stopped working at one point to take care of the children but there is no evidence that his parenting capacity to meet their needs was assessed. Ultimately, allegations of serious physical abuse prompted the SWD to move the children into care. The review team has not sought to investigate this phase very deeply because it is not considered that events of that time had any direct connection with Sam's untimely death, but it is of the view that the children were left for too long a time in a deprived situation. There appears to have been an optimistic expectation that the situation would improve though this was underpinned by scant evidence of progress. In the first phase, on-going supportive services were offered and some were availed of. The initial assessment of the steps undertaken by the Health Board SWD is well-presented in the files. The SWD made clear evidenced-based observations that Sam and his family needed help. It appears from the outset that the SWD gave this case a high priority in terms of immediate child protection risk. The parents' initial non-compliance and non-

cooperation with the SWD was a constant challenge for the SWD and was not accepted passively. However, the primary focus was on the mother's incapacity and consequently the focus on Sam was almost secondary.

In the second phase the then health board took the very important step of removing Sam. They intervened at the earliest legally permitted opportunity after obtaining legal advice. The intervention was proportionate. Removal of Sam from the family home to a place of safety i.e. foster care, was the action of last resort after years of alternative supportive services to the family. In retrospect, given the subsequent noticeable improvement to Sam's well-being while in care, it would seem that an earlier removal of Sam from the substantial risk-laden environment of the family home would have been desirable and necessary. Sam's care arrangement with his relative provided a stable family placement and had a positive effect on his behaviour, peer relationship development education and general well-being. In the third phase, the aftercare period, there was a formal document on file which documented the *Referral to Aftercare Service CCA8.* Aftercare was agreed by the HSE on the basis that Sam needed support with assistance in seeking future education (PLC- Post Leaving Certificate). He also needed assistance with general life skills. Secondly, Sam appeared to need encouragement to look after his health needs as well as needing assistance in budgeting and other practical skills especially when he might be earning a wage/salary or if and when he became entitled to Social Protection payments.

12.2 Assessment

Assessments made by the SWD/ Child & Family Agency staff were based on the various reports/referrals made to the SWD regarding parental child neglect, school truancy/absenteeism, parental abuse and parental alcohol dependency all of which had a direct and indirect impact on Sam's well-being as well as his bodily and mental integrity. As the earlier section has highlighted, the focus of intervention was weighted in terms of Sam's mother's alcohol misuse. While the negative aspects of her addiction were correctly ascertained, her capacity and motivation to change does not seem to have been closely examined or evaluated in terms of its implications for her parenting. As a result, her continual non compliance with either abstinence or counselling did not elicit anything beyond further undertakings which were then unfulfilled. An undue optimism about her ability to stop drinking seems to have prevailed over a number of years. It would appear that various social workers were far too willing to accept the tentative commitments of resolution by the parents that they would refrain from use of corporal punishment and desist from heavy use of alcohol. These parental commitments were readily

accepted without much evidential basis. It could be argued that there was not at this stage sufficient attention or intervention given the high degree of risk to the vulnerable children.

While the serious effect of parental drinking and neglect on the welfare of the children was tacitly acknowledged, there was less direct attention paid to the actual impact it was having on them in developmental terms. It could be argued, with the benefit of hindsight, that a more holistic approach to assessment would have raised concerns about how the children were affected personally and individually, and may have expedited their removal to care.

The later assessment of Sam's needs that was completed by the specialist service was more comprehensive and identified a very important fact, that his behaviour was masking a learning impairment. The SWD acted commendably on the basis of the report provided and made considerable efforts to meet his educational needs, which was very challenging at the time. The fact that he completed his Leaving Cert Applied is evidence of the value of this assessment.

12.3 Compliance with Regulations.

Children First: 1999 National Guidance for Child Protection and Welfare states that all child protection concerns must be followed up as soon as possible. *Children First* (chapter 9) also provides for joint Garda/HSE/ Child & Family Agency working collaboratively in investigating reports of child abuse. Sam's child protection issues were followed up as soon as possible. The Gardaí and the SWD/ Child & Family Agency worked jointly on this case at various stages. Early child protective action in this case appears to have concentrated initially on the dysfunctionality of the parents and their incapacity to parent adequately, thus leading to a loss of focus on the vulnerable children. Some periods of this case pre date the publication of *Children First*.

Supported Lodgings Service Scheme: Practices and Protocols, (undated Copy) Child and Family Agency stipulates the practices and procedures for the application of the *Supported Lodgings Service*. Sam's files do not contain the requisite documentation confirming that the required assessment of the Lodgings provider was completed. Additionally, the files do not contain (as required) (i) character references, (ii) Gardaí clearance documents, and (iii) no GP statement that the lodgings provider has no serious mental or physical condition that would prevent them from providing care to the teenager. There is no signed or unsigned contract for the provision of supported lodgings as required by the regulations. The regulations state that Supported Lodgings Services are: "only suitable for young people who require low

level of support on a daily basis". When first placed with his relative in supported lodgings, Sam required high levels of support. However, Sam's various SWs also provided support to his relative carers, offering training and support when necessary. These latter services are requirements contained in the Supported Lodgings regulations.

12.4 Quality of practice

12.4.1 Interaction with the child and family

The first interaction with Sam's family predated the birth of Sam and continued up to and immediately after his death. In all, a total of 20 years of involvement with the family and the SWD were involved. There was ample evidence of a good working relationship being established with Sam, his family and his various foster families. The parents missed many appointment set for them at various stages over the years. Missed appointments by parents who are central parties to the process are detrimental to the ultimate resolution of a particular case. A question could be raised about the efficacy of office based, as opposed to home based appointments when a family clearly lacks motivation and there is a high risk of 'no shows'.

12.4.2 Child and family focus

File records confirm that there was a child and family focus. However, as stated previously above, there was, initially, an over-concentration of focus on the mother's alcoholism to the detriment of a more urgent focus that was objectively particularly required for Sam given the degree of neglect and abuse which he was suffering. Gaining the trust and involvement of children/young people when discussing sensitive personal matters can be problematic. The SWD deserves praise for the child-centered approach adopted in this case particularly when Sam was eventually taken into care. In general, Sam's needs were met by the various services produced by the SWD. The aftercare service was, in particular, exceptionally conscientious regarding Sam's well-being and future career management.

12.4.3 Quality of Recording

In general, the range of documentary information in the files is quite comprehensive and clearly recorded in the extensive files. Quality of record keeping was consistently good. The social work records and family support reports on this case were a mixture of handwritten and typed documents. They were legible and in chronological order. It would appear that almost all contacts, by home visits or

telephone calls were recorded and there appears to be copies of all correspondence in the files. Satisfactory minute taking was evident. The files contain many review forms for Sam's various social workers. An additional request for further documentation (dealing with the After Care period) was made and was subsequently provided very promptly. Home visits were recorded in detail. There are vast quantities of completed supervision sheet in the files.

Not all files were contemporaneous or near-contemporaneous. There is a great deal of repetition of documentation in the files.

12.5 Management

12.5.1 Allocation.

While there is some confusion in the earlier phase of this case as to its allocation status, there was continuity of allocation from then on. There is also evidence of good cooperation between the various social workers especially when there was transference. When in aftercare, Sam was allocated a fostering link worker.

12.5.2 Inter-agency meetings and conferences

The evidence from the files and records was that for most of the period under review there was significant interagency collaboration between the HSE/ Child & Family Agency and the various agencies consistent with good practice as outlined in *Children First (1999)*.

There were many interagency meetings undertaken as required given the circumstances of the time. Overall, the level of inter-agency cooperation (formal and informal) was of a good standard. There was evidence of appropriate information sharing. Child protection conferences, many statutory reviews were also held over the years allowing opportunity to share information. The aftercare social worker linked in with Sam's teachers in order to assist with his endeavours to obtain an apprenticeship in mechanical engineering. The level of communication between the various services was generally good. The communication between the Gardaí and the SWD at the time the children were removed to care was particularly exemplary.

The review team was impressed with the substantial support provided to Sam by the schools over the years. The school staff (primary and secondary) demonstrated a high level of concern about Sam and were willing to go to great lengths to maintain his school attendance as well as improve, his application and ability in the school curriculum tasks required. The schools and the SWD maintained regular mutual contact over the years. Collaboration was the hallmark of this interagency relationship. The fact that he successfully completed both the Junior Certificate Examination and Leaving Certificate Applied is testament to Sam's engagement with the various support services offered to him. The SWD was largely responsible for the monitoring and provision of many of those supports during those school years. Sam completed his formal education when he was 19 years of age with his Leaving Certificate Applied. Given his objectively confirmed diagnosis that he was an academically weak student, it is without doubt a great achievement for him to have stayed the course of his studies and ended with a formal second level academic qualification. The multiplicity of support services from the Health Board/HSE/SWD/ASWs during all of that time must have contributed to his persevering with his secondary school studies.

12.5.3 Supervision

The standard and frequency of supervision was satisfactory. Regular supervisory meetings were held and documented. During the aftercare period of Sam, supervision records were completed almost monthly.

13. Conclusions

The review has reached the following conclusions.

13.1 The review concludes that there was no direct or indirect connection between any action or inaction on the part of the Child & Family Agency services or Child & Family Agency funded services and the circumstances leading to the very tragic and unexpected death of Sam.

13.2 Sam's background was complex and problematic. The short-term and long-term actions taken and the continuous support services provided by the SWD probably resulted in Sam arriving at his late teenage years with a degree of maturity (regarded as a likable young person) with few, if any, clear manifestations or replications of his earlier behaviour problems so obvious in his primary school years

and his early teenage years. The SWD availed of ample opportunities to facilitate Sam's pathway away from being vulnerable and susceptible to chronic neglect and abuse.

13.3 The review has alluded to the undue optimism which appears to have allowed the SWD to accept repeated undertakings from Sam's parents, his mother in particular, that they would change their behaviour sufficiently to adequately meet the children's needs. It concludes that this optimism probably delayed his placement in care.

13.4 Sam's relative was given ample support by the SWD in the provision of supported lodgings for Sam. Legally, the relative was not his foster carer. The files do not contain any Garda clearance documentation for the relative's partner who resided with her and her children. An allegation of physical abuse was made by Sam against the relative's partner. It was dealt with summarily and the result inconclusive. The absence of a Garda clearance for the fostering relative is a matter of concern.

13.5 A commendable aspect of this case was the continued contact maintained with the family by the SWD team during and after the funeral. Files record the invaluable nature of this emotional support for Sam's relatives.

14. Key Learning Points

The review team has identified the following key learning points from this case.

14.1 One of the key learning points to emerge from this review is the importance of focusing on the child/young person who is the centre of concern at the earliest opportunity. In addition, the review team strongly supports the recent statement by Child & Family Agency in "*Threshold of Need Guidance for Practitioners in Tusla Social Work Practices* 7th April 2014, at p.1 where they state that: "It is important that all practitioners understand the needs of each individual child within their own context and realise that each child is unique and specific to them". It appears that the initial focus and emphasis of the various Social workers involved in Sam's case (for the first few years) was directed towards the mother's incapacities rather than on Sam's protection needs in a very vulnerable and high risk laden domestic milieu. Sam was known to services for a period of nine years before he was eventually placed in voluntary care.

14.2 The SWD responded to the early signs of child neglect. Sam's move into voluntary care was done at the earliest possible legally permissible opportunity. Legal advice was ascertained on the appropriateness and justification for Sam's removal into care.

14.3 Fostering contracts. Sam had fostering link social workers for the period he was with his relative. Yet he was not legally or technically in foster care. This "alternative ambiguous legal status" should have been clear in the files. It should have regularised legally. Supported lodgings accommodation documentation makes no reference to Garda Clearance Certificate having been issued. Garda clearance must be regarded as mandatory and be supplied in a timely fashion.

14.4 This case provides an example of the successful role of schools in supporting a vulnerable child in difficult circumstances. The teaching staff and school support staff were consistently supportive of Sam.

14.5 Applying the recently issued Guidelines from The Child and Family Agency in *Threshold of Need Guidance for Practitioners in Tusla Social Work Practices*' 7th April 2014, at p.2 this case could be classified as a Level 4 Intervention (Child with highly complex, acute and/or immediate risk of harm) at the time Sam was taken into care. The review team also concurs with the Child & Family Agency's statement in those Need Guidance Regulations that "A primary principle is that professional judgment takes precedence over Guidance", at p. 3.

One of the pivotal time-frames in this review is the last two years of Sam's life when he was in the Child & Family Agency SWD aftercare programme. The review team has had to consider whether or not Sam was technically and legally in receipt of formal aftercare services at the precise time of his untimely and accidental death. It seems that the understanding of the Child & Family Agency/SWD Child and Family Services was that as he was no longer entitled to and/or claiming the supported lodgings payments, all other obligations of the Child & Family Agency ceased. Nevertheless, there was ongoing contact with Sam and the aftercare staff.

This grey area is likely to be clarified in the Aftercare Bill 2014, due to be published. At present, the Child & Family Agency are rolling out their national policy on aftercare to ensure a national standard is in place and is being practised.

15. Recommendations

In line with the above report and conclusions, the review makes the following recommendation

15.1 Where support**ed** lodgings accommodation is provided for a vulnerable person by an adult relative, it remains imperative and ought to be mandatory that Garda clearance of all persons (over 18 residing in the household) be obtained as a prerequisite before the accommodation option becomes activated. In this case, Sam was provided with a safe and structured environment as required by the regulations. However, it is submitted that for the avoidance of doubt and in order to ensure due diligence in the protection of all children in the care system, the criteria for the application and granting of the supported lodgings should be strictly adhered to.

Dr. Helen Buckley,

Chair, National Review Panel