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

Executive Summary

October 2015

Introduction and background

This desktop review was conducted in respect of a young adult, here called Sam, who died when he was 19. Sam had been in the care of the health board/HSE from the time he was nine years old until his 18th birthday. He was then allocated an aftercare worker and decided himself that he did not wish to pursue any vocational training. Sam remained living with his relative carers and his aftercare worker stayed in contact with him until he was killed in a tragic accident when he was 19.

Sam was known to social work services all of his life, though the case file on the family was not always open when he was an infant. He was diagnosed with foetal alcohol syndrome at an early age and was considered to have been neglected, along with his siblings. The primary concern in the family was his mother's problem drinking and she also alleged domestic violence and separated from Sam's father for a few months. Numerous services made reports about the children to the social work department (SWD) of the then health board. For a number of years, social workers tried to work with Sam's family and engage other services to improve the general situation for the children. However, despite many undertakings, his parents were reluctant to engage with treatment and support services and unable to make the changes necessary to meet his and his siblings' needs. Sam was placed in care when he was nine years old, firstly with relatives, then with mainstream foster carers and later with other relatives. He had regular Child in Care reviews, and regular contact with his birth family, to whom he remained attached. There is a lack of clarity in the records about the early allocation status of the case, but it appears from the case notes that the family always had an allocated social worker from the time that Sam was a young child and that the efforts of workers to meaningfully engage with him were successful.

Sam's second placement broke down due to challenging and aggressive behaviour. He was then placed with a relative, and an assessment in a specialist assessment service diagnosed an underlying learning difficulty which, it was believed, may have contributed to his behavioural and educational problems. Despite many efforts, the SWD were unable to secure a place in a special school for him. However, staff at the secondary school that he attended while living with his relative were extremely supportive to him and he was later successful in both his Junior Certificate and his Leaving Certificate Applied. He settled very well in his third placement and his behaviour ceased to present challenges. When Sam turned 18 he was allocated an aftercare worker who tried to engage him with vocational training but he declined all offers in this regard. He found a job that he liked and was working in this up to the time of his untimely death.

Findings

The review made its findings with regard to three phases of Sam's life. The first consisted of his early years. In the opinion of the reviewers, the SWD worked consistently with the family but appeared to be unduly optimistic, with insufficient reason, about the motivation of Sam's mother to control her drinking and for the parents generally to make the changes that were necessary in order to meet their children's needs. The impact of the adverse environmental factors on the children was not, in the opinion of the reviewers, adequately assessed. Essentially, this delayed the protective action that was later taken by placing the children in care.

In the second phase, during which Sam was placed with relatives and diagnosed with a learning difficulty, he experienced stability and received a lot of appropriate support which enhanced his wellbeing. The reviewers have noted some non compliance with regulation in respect of this placement, which is addressed in the key learning points and recommendation. The review has found that the quality of aftercare services provided to Sam was very good and it also commends the SWD for facilitating what appears to have been beneficial continued contact between Sam and his birth family. It also notes the considerable support offered to Sam by his secondary school, which assisted him in successfully completing his education after a difficult beginning.

Key Learning Points

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

- 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. 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.

- 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.

- 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.

- 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 findings summarised above, the review makes the following recommendation

15.1 Where supported 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