Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review of the death of a young person known to HSE/Tusla services: Simon

April 2019

1. Introduction and background summary

This review concerns a young person, here named Simon, who died tragically in his late teenage years as the result of a road traffic accident outside the jurisdiction, some months after he had left state care in Ireland. Simon was a member of the Traveller community. He was, in the words of one informant, 'always pulled between two worlds' in his experience of the care system. The review team heard that he was a young person who had a strong personality, and was articulate, determined and resilient. Almost everyone spoke of him as very likeable. Simon was also very conflicted from an early age. He was impulsive and capable of defiance and outbursts of anger, and felt that he needed to be always challenging boundaries.

The evidence on file establishes that Simon's early childhood years were spent in a family background characterised by high levels of instability, deprivation and neglect. He was described by several informants as 'damaged' by exposure to neglect and abuse in his early years. He was made the subject of interim care orders as a young child, and later to a full care order. He was accommodated in respite foster care, in one long term foster placement, in residential care and in youth as well as adult justice settings. The review has identified at least twenty short-term foster placements provided by the social work department (SWD) for Simon between his fourth and sixth years, as well as additional short term placements in other parts of the country when he was younger. Simon was an eldest child, and all of his siblings have been placed in state care (in Ireland and in another jurisdiction). The issues which define this case are those of the child/young person's conflicted identity, management of parental opposition to the SWD, the impact on the case of a 'medium term' care order, Simon's dis-engagement from education, and his criminality which escalated in his later teenage years.

On the occasions when Simon first came into care as a young child he needed a response from services to provide him with safety and long-term emotional and psychological stability to redress early childhood trauma and to support him to manage the issues of identity which were so important to him. His birth parents were fundamentally opposed to him remaining in the care system. His best opportunity to achieve the stability, re-assurance and certainty about his future was in his long-term foster placement, where he lived until he was an adolescent. This foster placement required and received a great deal of support to deal with his complex presentation. It also required legal protection to minimise the efforts of his birth parents to undermine it, which was not available. It took a number of years for the District Court to issue a full care order leading to legal uncertainty in the management of this case. Simon formed a lasting relationship with his foster

parents despite difficulties relating to behaviour but continued to struggle with unresolved issues of identity and connectedness to his birth parents. As he grew older emotional regulation, anger management, management of boundaries, bullying and difficulty in interaction with peers were ongoing and progressively more serious issues for him and he dropped out of school. Simon's foster parents described how the management of a sexual abuse allegation by the authorities contributed to the destabilisation of his placement. By the time of the end of his foster placement, there is evidence that he had begun to actively model some of the criminal and anti-social aspects of his birth parents' lifestyle. A placement by the SWD in an open residential care unit was unsuccessful. The type of placement that Simon required at this stage was a secure, intensive, residential environment in the care system with dedicated educational provision and tight management of parental contact. This was not available at the time. Simon was subsequently able, without the permission of the SWD, to re-join his parents for substantial periods of time, in another part of the country. This coincided with increased involvement with An Garda Siochana and the justice system. He spent one period in youth detention, some periods of time in homeless accommodation sourced by the SWD, and later served a sentence in an adult prison before his discharge from care.

2. Findings and Conclusions

The overall conclusion of this report is that the chances of a good outcome for Simon in his life were greatly reduced because of his early experience and that the actions taken to mitigate this, firstly by the SWD and later by the Court, were problematic. The difficulty was compounded by the input of parents who were actively hostile to any role by the SWD and were determined to undermine the efforts of committed foster parents create stability for him. There is evidence of commendable efforts by social workers and other professionals to manage the case in very trying circumstances. However, effective care planning was distorted by too much emphasis on family re-unification at the early stages. The negative influence of Simon's parents was ultimately allowed by the authorities to prevail, enticing him into anti-social behaviour and criminality and a career in the justice system.

The specific conclusions of the report are as follows;

- There is a great deal of evidence that Simon suffered from significant trauma in his early childhood years because of the family history of child abuse/neglect and criminality.
- There was delay by the SWD in seeking a full care order on Simon when he first came to the attention of the SWD. The SWD strategy to work towards family re-unification in his early years despite ample evidence of neglect/abuse and of parental hostility was extremely risky.

- The District Court decision to make an initial 'mid-term' order (until his thirteenth birthday) was viewed by professionals and Simon's carers as a flawed and wrong decision, which had significant implications for his well-being. However, the review team was told at interview that this decision was not appealed by the SWD because it only had a modicum of success with similar applications previously.
- The inability of the SWD to manage, restrict or control parental contact had a huge bearing on the outcome for Simon. Whilst it made some attempts, through the District Court and An Garda Síochána, to restrain parental interference, it otherwise acted as though it was powerless to address the levels of parental attrition. This issue needed to be escalated through all available administrative and legal means. This problem was compounded by weak care planning by the SWD.
- Simon's foster placement worked for a number of years with good support from social workers and other professionals. The foster parents tried very hard to integrate Simon into their family and community whilst validating his Traveller identity but they always struggled to overcome outright parental hostility, as well as Simon's interest in his parents' criminality. The placement was weakened by the uncertainty generated by the 'mid-term' care order, by pressures emanating from Simon's issues in educational settings, by his resentment at being singled out for psychological inputs, and by the management of the sexual abuse allegation. These intensified as he got older.
- The basis for matching Simon's first residential placement to his assessed needs is not recorded and is unclear; there is no evidence of a comprehensive matching of assessed needs to purpose and function; and the outcome of this decision for Simon was very poor and greatly increased his risk level.
- The management of a sexual abuse allegation implicating Simon as a very young child was very problematic, and constitutes a breach of good practice. Simon (aged 7 at the time of an alleged incident) was not notified as a victim and was interviewed as an alleged perpetrator some eight years later. Guidance required the SWD to implement child protection procedures at this time to assess his needs as a child, which it failed to do. The recording of the incident is very poor, and the outcome is not recorded.
- The successful integration of Simon into education was central to the aspirations of his foster parents. There was insufficient co-ordination of formal planning between the SWD and his schools to support this.

- There is limited evidence of effective communication, care planning, risk assessment, safety planning between the two SWDs during long periods of Simon's residence away from his home town.
- Care planning took place but was limited, lacked rigour and structure, and was not implemented to address crucial episodes of change and transition. The agencies with responsibilities for youth offending and youth justice needed to be more centrally involved in his care planning at the time when he was designated as 'missing'.
- There is evidence that the structured environment in youth detention had some positive outcomes for Simon. The lack of availability of a secure care placement when he was assessed as meeting the criteria was a major systemic shortcoming, and there are questions about the subsequent decisions that he did not to meet the criteria. The SWD was unable to provide a structured environment in a care setting which could manage parental contact. His exposure to further parental influence resulted in the inevitability of further intervention by the criminal justice system.
- Social work input to Simon at casework level was sustained. Simon did not like social workers, but there is much evidence that his social workers were resilient, remained very committed to supporting him and tried to do so as best they could. There was instability and gaps in first line and senior management support.
- Most other professionals displayed knowledge of and commitment to Simon, despite systemic obstacles already highlighted
- There is good evidence of inter-agency communication at operational level, but shortcomings were very evident at care planning level.
- Simon's tragic death had a significant impact on many of the professionals who worked with him, which has been compounded by an absence of information about the circumstances in which he was living at that time, and about the fatal incident

The conclusions of this report raise governance issues which are wider than any single agency and relates to the legislative and judicial environment which ultimately shaped the management of the case. Themes which emerge as central to Simon's case are those of a) permanency planning for children in settings which do not include family, and b) the management of parental contact. Neither sits easily within the constitutional context of child care law and practice in Ireland. The Child Care Act 1991, which requires courts to regard the welfare of the child as the first and paramount consideration, is subject to the Constitution, which guarantees the rights of the family. At the time care proceedings in Simon's case were before the District Court, the 31st Amendment to the Constitution, which recognises the rights of children as individuals (as distinct from their rights

derived as a member of a marital family), had not been made. Part of the rationale for the Constitutional amendment was to guarantee the rights of children as independent rights' holders, in order to allow the state to intervene where necessary to uphold these rights. The argument that the bar for intervening was set too high, by the privileging of the status of the marital family had been made in several high profile child protection and welfare inquiries [1]

The amendment notwithstanding, the recent report of the Child Care Law Reporting Project (2015)[2] draws on a number of judgements in the superior courts, as well as the European Convention of Human Rights, to state the principle that removing children from their families is a measure of last resort and, if they are removed, the re-unification of the family must generally continue to be under active consideration. This case has illustrated the implications for one child, and for the SWD tasked with his care planning, of this principle in practice. The review team has concluded that the SWD's planning for family re-unification in Simon's case was not appropriate to his needs, that the inability of the SWD to restrict parental contact was extremely destabilising for him, and that a key decision of the District Court in accordance with the principle (the 'mid-term' order) was poorly synchronized with SWD care planning. The report has identified other shortcomings in the performance of the SWD but in the final analysis parental influence and family re-unification were dominant themes which shaped the negative outcomes for Simon

2. Key Learning Points

This report has documented a number of adverse factors in this case related to the complex issues of identity, hostile parental influence, weak management, and counter intuitive court direction. The decisive influences on the direction of the case lay outside the control of the individual professionals. It is important to reflect, however, that committed child care practice can be sustained and is valued despite systemic and managerial weaknesses, which this case demonstrates.

- **Managing acute parental conflict:** This review has demonstrated how negative parental influence had such a major role in undermining care planning. SWDs have parental responsibility for the population of children subject of Care Orders and the management of conflict with parents is a recurrent theme of practice. It is a recommendation of this report that Tusla develop guidance to assist SWD practitioners and their supervisors to manage parental contact and access based on the best interests of the child, where the possibility of

[1] Buckley H and O'Nolan C (2013) An Examination of Recommendations from Enquiries into Events in Families and their Inter-actions with State Services, and their Impact on Policy and Practice, Dublin. DYCA.
[2] Coulter C Final Report of the Child Care Law Reporting Project (2015) C1

parental change is minimal, and where parents are not compliant with care planning for the child, and to escalate such cases internally, where necessary.

- **Peer Sexual Abuse Allegations:** The review team has noted in the report that guidance in Children First in relation to peer abuse has consistently stated that child protection procedures should be conducted for both the victim and the alleged abuser, and should be considered a child care and protection issue for both children. Following the allegation made by his sibling, good practice would have required Simon's needs as a potential victim to be assessed, child protection procedure to be implemented (if appropriate), the investigative process to be documented on his file, and his needs relating to the incident to be considered in subsequent child in care reviews.
- **Linking Care Planning for the changing needs of the child:** The review has described how Simon's needs and circumstances, and his care plan, were subject to frequent change throughout most of his care career. The review team was concerned about the interpretation of the 1995 Child Care Regulations by the SWD, evident throughout this case, that an annual review met the SWD's obligations. Whilst the basic statutory requirement is for an annual formal review, care planning must be seen by practitioners and managers as an active and responsive process, and its frequency should be determined not just by minimum statutory compliance but also by the assessed and changing needs of the child. Care plans are built around core factors which include the child's placement, health, psychological development, education, contact, identity, self-development, all of which require multi-agency co-ordination. Significant changes in any of these factors may require the plan to be changed or adjusted, and good practice requires that this is mandated at multi-agency child in care reviews convened according to the needs of the case.
- **Education/Care Planning Interface:** The management and maintenance of Simon in school was a critical and challenging requirement, which needed really close co-ordination between the SWD, his schools and other education providers and his foster carers. His foster parents attached a great deal of significance to school as a means of giving him a stake in society. It is widely reported in educational literature[3] that the earlier the exit from school the greater the negative impact, including poor mental health, social exclusion and over representation in the prison population. It is also recognised that 2nd year in post primary is the year in which unacceptable behaviour (especially among boys) is most likely to manifest itself[4]. The report has stated that education professionals needed to be closely and actively involved in regular care planning, so that his management in the school setting could be best

[3] Byrne & Smith 2010; Lally 2012
[4] Smith E 2006 *The experiences of second year students:* ESRI

synchronised with the efforts of his foster parents to deal with him in the home, and with the attempted therapeutic and other counselling inputs set up by the SWD.

- **Overrepresentation of Children in Care in the Youth Justice System:** The movement of children from care into the justice system is a matter of some concern. International evidence suggests that are many reasons for the over-representation of children in care in the criminal justice system, including adverse childhood experiences which impact on behaviour; the fact that children in care may be channelled through the justice system more quickly because of systemic issues including the suitability of care placements and the fact that after-care supports are frequently insufficient[5]. In Simon's case, it is clear that when his foster placement broke down there was limited alternative provision capable of responding to a young person with his needs. The report points to the need to enhance diversion strategies for children in care who become engaged with the youth justice system through closer involvement of youth justice personnel in care planning and in residential care services.
- **Limitations of 'One to One' Therapies:** This review has reflected Simon's resistance to individual work with professionals and his belief, and that of his foster carers, that participation in this work differentiated him from his peers. This limitation was recognized by professionals who pointed out that his probable diagnosis of conduct disorder meant that one to one therapeutic intervention was limited. The subsequent use of non-directive therapy enabled better engagement with him. Practitioners need to consider the use of a range of developmentally informed techniques[6] to become attuned to the child's subjective experience (which can include areas such as drama therapy, music, movement therapy) and to strategies aimed at building supports - 'scaffolding' - around trauma.
- **Child Death – Support for Professionals**; The review team was struck in this case by a palpable sense of loss and distress, expressed by a number of those interviewed who had worked closely with Simon. SWDs and other agencies need to develop guidance and practice protocols to enable them to respond to the emotional and psychological needs of staff affected by the trauma of sudden death or serious injury to clients with whom their working relationships have been close.

[5] Blades, R., Hart, D., Lea, J. & Wilmott, N. (2011) *Care – A Stepping Stone to Custody?* London: Prison Reform Trust; Darker, I., Ward, H. & Caulfield, L. (2008) 'An Analysis of Offending by Young People Looked After by Local Authorities,' *Youth Justice,* 8(2), 134-148; Hayden, C. (2010) 'Offending behavior in care: is children's residential care a criminogenic environment?' *Child and Family Social Work,* 15(4), 461-472.

[6] For example – Louise Mitchell Bomber; 'Inside I'm hurting' Practical Strategies for Supporting Children and Heather Geddes, ' Attachment in the Classroom; The Links between Children's Early Experience, Emotional well-being and Performance in School'

4. Recommendations

4.1 Management of Contact

The management of parental contact is profiled highly in the report on this case, and two aspects are highlighted for action.

4.1.1. Inter-departmental Protocols for Implementation of Court Orders which Refuse or Restrict Contact: The Child Care Act 1991 enables a Court to make an Order authorising (SWDs) to refuse to allow a named person access to a child in care or to vary an existing order (37(3)(a) It is recommended that the Department of Children and Youth Affairs and Tusla develop guidance and protocols with An Garda Síochána and the Department of Justice to strengthen the implementation of Contact Orders by SWDs. This guidance needs to address circumstances such as described in this report, where enforcement and management of such orders has been rendered very difficult by the adverse actions of one of the parties, and where subsequent delay has undermined the best interests of the child.

4.1.2. Tusla Guidance on Managing Adverse Parental Contact: It is recommended that Tusla develop guidance to assist SWD practitioners and their supervisors to manage parental contact and access based on the best interests of the child, where the possibility of parental change is minimal, and where parents are not compliant with care planning for the child, and to escalate such cases internally, where necessary. The review team understands that Tusla has already begun to consider work on policy related to the management of access and contact.

4.2 District Court Liaison

This case has illustrated a significant tension between a case direction given by the District Court, and the consequences experienced by Tusla staff in the SWD, and by other professionals, in implementing the Court Order. The review team has noted that there is evidence in the Child Law Reporting project of variations in practice and understanding between the District Courts and Tusla in relation to care applications sought and granted[7] across the country.

It is recommended that;

4.2.1 Tusla ensures, in the first instance, through its monitoring and quality assurance processes, that all contentious cases are subject to due process of appeal, and are appealed rigorously.

[7] Coulter C Final Report of the Child Care Law Reporting Project (2015) C2 District Court Statistics p15

4.2.2. The Department of Children and Youth Affairs and the Department of Justice consider how to promote greater consistency of Court determinations in implementation of the Child Care Act. Examples of relevant areas include thresholds for care applications, quality of care planning and court reports, duration of Orders, management of parental contact. This should extend to the development of local forums for District Courts, SWDs and Guardians ad Litem to review areas of common practice.

4.3. Child in Care Planning

It is recommended that Tusla ensure that the following two specific issues identified in this report are addressed in its ongoing monitoring of the quality of children in care planning;

4.3.1 The participation of educational professionals in child in care reviews

4.3.2. The timely transfer of care management where children/young people move between SWDs. The review team notes that Tusla introduced a protocol[8] to address this issue in 2016, and the effectiveness of this measure for the better management of such cases should be reviewed.

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[8] Tusla National Case Transfer Policy and Procedure 2016