National Review Panel

Review undertaken in respect of the death of Zoe, a young person, with a previous history of being in care and known to the child protection system

Executive Summary

March 2015

Introduction

This review concerns a young woman, here known as Zoe, who died at a young age. She was a mother of three children and was known to HSE Children and Family Services. Zoe had been in care for periods of her life, and had also lived in sheltered accommodation around the times when her children were born. The case was closed by the Social Work Department some months before her death.

Background

Zoe had lived outside Ireland with her mother, her siblings and her mother's partner, here called Fran, and returned with them to Ireland when she was 10 years old. When she was 11, she became the subject of child protection procedures due to her mother's alcohol misuse and subsequent neglect of Zoe and her siblings, domestic violence between her mother and Fran, and physical abuse by Fran. Zoe was subsequently placed in care with her siblings and was returned to the care of her mother and her mother's partner within a year. Conditions at home soon worsened due to her mother's misuse of alcohol and deteriorating physical health which led to Zoe missing school to care for her. Later that year, Zoe's mother died. The HSE had previously planned to place her in foster care but at that point Zoe, who was then 13 years, asked to remain in the care of her late mother's partner, Fran. The SWD acceded to this request and shortly afterwards guardianship was acquired in respect of Zoe by Fran, who was encouraged to take this action by the HSE.

Initially Zoe appeared to have settled well with Fran. However, emerging problems were soon identified, her school attendance became erratic, she made several allegations against Fran and it became apparent that he was not able to manage her behaviour. Zoe had three pregnancies while she was still under 18. She had been in a relationship with her boyfriend, here called Simon, from her early teens and they remained involved until her death. Zoe cared for her first child, here called Tanya, in different sheltered and semi sheltered situations with the support of her social worker, child care workers and PHNs. Her second child, Susan, sadly died from congenital complications; Zoe and Simon received a lot of assistance and support from social work services around the time of the baby's death. Her third child, here called Leigh, was only a few months old when Zoe died. While her parenting skills were considered to be adequate, she found it hard to settle into any accommodation that had been arranged for her and tended to dis-engage with services. Her partner lived with her from time to time and spent periods in prison in between. The SWD closed the case over two months prior to Zoe's death, after which she received support from the staff of the emergency accommodation in which she was living.

Review findings

The review has reached the following conclusions:

- The review found no connection between the quality or availability of services to Zoe and her very sad death. It found that staff invested considerable effort to work with Zoe and her family when the case was first referred and later. Their practice was inhibited by the tendency of Zoe and her mother to mislead and dissemble in an effort to avoid engaging with social work personnel.
- The review has found good examples of assessment in this case, but also found examples where it was weak or absent and served to limit decision making and care planning. This was despite considerable efforts to collect and share information and meet with all the services involved in the years between the family's first contact with the service and Zoe's death.
- The review found the quality of management and participation in child protection conferences was high, but noted that non adherence to previous conference recommendations was not always discussed or addressed.
- The review team considers that the goal to keep the family together during Zoe's early teens continued to shape practice even when fuller information became available that little progress had been made in their home situation.
- From the time of her mother's death, Zoe received considerable individual attention from services and was given the opportunity to have her voice heard. However, the review has concluded that some of the decisions made had an adverse impact on Zoe's development, particularly the failure to provide secure boundaries for her. Overall, it found that Zoe's wishes rather than her best interests determined decisions about her care status.
- The review found that Zoe's children's welfare and safety was kept under continuous review and commends the efforts made by the SWD to support Zoe during and after her pregnancies.

Key Learning Points

While the review found no direct link between the quality of services and Zoe's very sad death, it highlights the following points for reflection and learning

- While the SWD was alert at an early stage to the dangers posed to Zoe and her sibling from physical abuse and domestic violence, it did not always consider in detail what it was like for

the children to live with parental alcohol abuse. Problem drinking was central to the difficulties experienced by this family, and research shows that as well as physical abuse and violence, children living with harmful parental drinking suffer from severe emotional distress, lack of care, support and protection (Hope, 2012)[1]. The learning here is that staff need to take account of the cumulative impact of parental alcohol misuse on families, and should plan on sustainable change rather than on short term improvements.

- Early decisions to rehabilitate Zoe and her siblings with their mother were not revisited as more information became available to suggest that agreed conditions were not being adhered to. Munro (2008)[2] has highlighted the reluctance of professionals to revise their judgements, which she describes not as a weakness, but a fundamental problem of human reasoning. She suggests that the only solution is for child protection workers to be aware of how they are likely to err and consciously try to counteract it. This can be achieved through supervision, chairing of meetings and also through constant self-challenge. It is important in a case like this that the analysis of information that collected at the outset is used to identify the needs of each child and their parents' ability to meet their identified needs. Progress towards identified goals should be regularly reviewed and contingency plans should be identified and acted upon if required.

- There were examples in this case where decisions made at child protection conferences were overturned within a short period. The learning point here is that reversal of child protection decisions which had been made at child protection conferences should be regarded as an unusual event, and given particular consideration for the purposes of learning.

- Zoe became her mother's carer at a developmentally inappropriate time in her life. She continued to care for her mother until she died. Research has shown that while caring for a parent can have positive aspects, it can also restrict the young carer's social and educational opportunities and distort their transition into adulthood (Deardon & Becker, 2000; Gilligan and Halpenny, 2004)[3]. There is evidence that this was Zoe's experience; she missed a lot of

[1] Hope, A. (2012) *Hidden Realities: Children's Exposure to Risks from Parental Drinking in Ireland.* Alcohol Forum. http://www.drugs.ie/resourcesfiles/research/2011/NWAF_Realities_Report.pdf

[2] Munro, E. (2008) *Effective Child Protection,* London: Sage

[3] [3] Deardon, C & Becker, S. (2000) Young Carers: Needs, Rights and Assessments n J. Horwath (Ed) *The Child's World: Assessing Children in Need,* London: Jessica Kingsley; Halpenny, A.M Gilligan and Gilligan, R.. (2004)

schooling and ultimately adopted the role of home maker at an extremely young age. The report has highlighted that opportunities could have been used to work directly with Zoe on her relationship with her mother to lessen their mutual dependence and allow Zoe to settle into foster care.

- The decision of the HSE to encourage Fran to acquire guardianship of Zoe and to place her with him represented a risk, given the previous history of the case. The review team accepts that in certain circumstances, unorthodox decisions can often be constructive, but in this case the placement appears to have been made without the required assessment of Fran's suitability and capacity not only to care for a young person who had a history of challenging boundaries but to provide a safe and settled family life for her.

- One of the first signs that Zoe's placement with Fran was not working was the fact that she missed progressively more days at school. The learning her is that erratic attendance at school should be taken as a signal of a deeper concern, particularly when a child or young person is otherwise considered vulnerable

- The review has concluded that Zoe's wish to be free of the restraints of parental or state care was allowed to disproportionately shape the decisions made about her. The learning from this is that staff need understand the full context in which they are required to hear a child's wishes, so that their actions fully support the attainment of a 'best interest' choice.

- Zoe was difficult to engage. It is important that consideration is afforded to ways of better working with hard to engage young persons. This may be by working through those able to elicit co-operation from a young person. There was a good example of the foregoing in this case, where the maternity social worker used an opportunity to engage with Zoe after the death of her baby.

- Relatives of Zoe, and her boyfriend, who were interviewed by the review team commented that she was a bit low in the weeks prior to her death. The learning from this is that mothers, particularly when they are as young as Zoe, who are experiencing stress (in this case, a

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Caring Before TheirTime? Rsearch and Policy Perspectives on Young Carers. TCD, Children's Research Centre, https://www.tcd.ie/childrensresearchcentre/assets/pdf/Publications/caring_before_their_time.pdf

partner who was due to be imprisoned and uncertainty about housing as well as bereavement of a previous child), may be vulnerable to mental health problems. Standard screening should incorporate assessment of emotional well being.

- Previous reports by the National Review Panel have commented on the blurred boundaries between cases categorised as 'child protection' or 'family support'. Zoe was not yet 18 when her case was closed to child protection and left open to family support. In a case like this, where patterns of instability are interspersed with crisis, risk factors prevail and child protection plans have been activated in respect of both a young mother and her children, it may be over optimistic to assume that a short lived period of stability now becomes the norm. In cases such as this, where the services may be provided in the main by non-statutory organisations, it is important that an overview is kept by the SWD so that crises may receive a fast response.

Recommendations

- Child and Family Psychology Services/CAMHS require adequate resources to facilitate timely acceptance of referrals for young people with complex histories of trauma who require comprehensive assessment and intensive therapeutic work. It is acknowledged that the provision of mental health care to adolescents is outside the remit of the Child and Family Agency to whom these recommendations are made, so it is suggested that cases such as these are used as a rationale for negotiating services.
- At the time that this case was current, mental health and psychology operated alongside child protection social work services under the aegis of the HSE. The establishment of the Child and Family Agency in the meantime has meant that the boundaries between services are less permeable and it will be important not only to ensure that the mental health needs of young people are properly resourced by the HSE but that service level agreements are sufficiently robust to ensure collaborative provision between the two agencies.

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