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

March 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/designate 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. Death of a young person: Zoe

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.

5. The level and process of the review

This was a comprehensive review. The team reviewed records covering the period of nine years from Zoe's return to Ireland with her family until her death when she was a young adult. The relevant documentation consisted of records within the HSE and HSE funded agencies. Two team members interviewed family members and relevant staff and also undertook site visits.

The composition of the review team was:

- Dr Helen Buckley, Chair of the National Review Panel
- Marion Reynolds, Independent Social Worker, Northern Ireland (until 31st May 2011)
- Clare Gormley, Principal Clinical Psychologist/Area Manager, HSE
- Paul Murray, member of the National Review Panel

The review team wishes to record its appreciation for the support and assistance provided to it by the liaison manager with the relevant HSE area.

6. Terms of Reference

The review team agreed the following terms of reference to guide it in its examination of the services provided to Zoe and her family.

(i) To examine the role played by the Children and Family Services of the HSE, and HSE funded services in Zoe's case, in particular to:

- determine the level of compliance with local and national policies and procedures; and
- Identify elements of positive practice.

(ii) To consider events in the period prior to Zoe's death.

(iii) To prepare an objective report including an executive summary for presentation to the Child & Family Agency, which identifies opportunities for learning arising from the review and makes recommendations.

The review team was mindful of the need to avoid hindsight when considering decisions made relating to the care of Zoe, her siblings and her children and therefore sought to consider decisions made in the context of what could reasonably have been expected of practitioners and managers at the time of their intervention.

7. Zoe

Zoe was an energetic young woman who made friends easily. She had been very close to her own mother, and was very happy to become a mother herself, albeit at a very young age. At the time of her death, her main goal was to make a stable and loving home for herself and her family, despite the adversities that she faced in terms of poverty and unstable accommodation. At times, Zoe was reluctant to engage with the services offered to her.

8. Background to Social Work Department's Involvement with Zoe

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. She quickly 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. At that point Zoe, who was 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 and it became apparent that her behaviour was not being controlled or guided by her guardian. Zoe subsequently became pregnant and gave birth to her first child Tanya at age 15. She had been in a relationship with the father of her baby, here called Simon, for about two years at that time. Zoe had two more children, one of whom sadly died from congenital complications. While her parenting skills were considered to be adequate, she found it hard to settle into any accommodation that had been arranged for her. She remained in the same relationship, though her partner spent some time in prison. 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.

9. Summary of Zoe's needs throughout the period under review

Zoe's most apparent need as a 10 year old child was to be safeguarded in respect of physical abuse by her mother's partner as well as exposure to domestic violence and parental alcohol misuse. From a young age Zoe took on a parenting role within the family and acquired a pseudo maturity which consequently meant that at times she was allowed to make life choices inappropriate to her age and life experiences. She also learned to dissemble and avoid help from services.

In her early teens, Zoe still required protection but she also needed to be cared for in an age appropriate manner and to have boundaries to guide her behaviour. Following her mother's death, when Zoe was a young teenager, she remained in the care of her mother's partner while her siblings remained with their foster carers. She adopted a life style of living from house to house, withdrawing from school and not engaging consistently with services provided to support her.

From the age of 15 years until her death, Zoe had three pregnancies. Following the death of her second child, she had a need for therapeutic and emotional support to be provided by psychology/ CAMHS or her social worker. In the main Zoe was the sole carer of her children due to their father's periods in custody or periods spent living with different family members.

Zoe had limited support from positive role models and tended to use services intermittently. She had a cumulative history of physical abuse, exposure to domestic violence, extensive alcoholism within the family, experience of care and multiple pregnancies at a young age. She lost her mother while very young and her second baby died. As a result, her psychological needs were significant and indicated a requirement for individual long-term psychotherapeutic support in combination with practical support, to assist her to find adequate accommodation and cope as a young parent.

10. Chronology of the involvement of the HSE Children and Family Services Social Work Department (SWD) and other services with Zoe and her family

Late childhood and early teens

When she was 10, Zoe returned to Ireland from another jurisdiction with her mother, her mother's partner, here called Fran, and her siblings. The family's first contact with social services was a few months later, when Zoe's mother sought help for her alcohol misuse. During their mother's inpatient treatment, the children were cared for by their mother's partner. They were enrolled in the local primary school where Zoe was assessed as an 'able' child who presented with no management problem.

Following a report to the SWD that Zoe and her sibling had been physically abused by her mother's partner and that the children were exposed to domestic violence, a child protection investigation took place. The reported concerns were acknowledged by Zoe's mother and Fran. Zoe and her siblings were subsequently placed in voluntary care with relatives, but returned home after a very short period. Their mother had committed to prevent contact between the children and Fran, but breached this agreement and allowed it to occur. A child protection conference recommended placement in care, citing the reasons as: domestic violence; physical and emotional abuse of the children; their mother's inability to protect them from abuse and mother's misuse of alcohol.

Zoe and her sibling were again placed in voluntary care with relatives one month later and on the breakdown of this placement after six weeks, were placed in mainstream foster care. Comprehensive assessment of each child's needs was recommended, as well as supervised contact. A Child in Care Review outlined a plan to return Zoe home once her mother's drinking had been addressed and a barring order against her partner had been acquired.

Some months later, plans were put in place in for Zoe's mother and Fran to undertake parenting training at a community based family support service and for Fran to attend a men's group in

order to address his aggression. This was with a view to returning the children to their care. While there was limited compliance with the undertakings imposed by the SWD, it was considered that there was sufficient progress after six months to start increasing the children's contact with a view to a planned return home. This was to include phased overnight stays. In the meantime, Zoe was extremely anxious to return home, and her pressure to return home increased once overnight access commenced.

Six months later, the SWD decided that the earlier plan to return the children home should be implemented as Zoe's mother and Fran were coping quite well and changes had been made, though there were still some concerns about parental drinking and domestic violence. Zoe and one of her siblings were returned home. Concerns quickly re-emerged about both drinking and domestic violence. However it was not considered that a child protection plan (CPP) would be required to manage the children at home. Zoe had been referred to a psychology service but after seven months on the waiting list, the referral was cancelled by the SWD as she was by this stage attending a young women's group run by a local community based service.

Child protection review conferences were held at regular intervals. A few months later, the concerns about domestic violence and drinking were still prevalent and it was noted that the family were not engaging fully with the services offered to them, including the parenting guidance. It was also noted that Zoe was taking on a caring role in respect of her younger sibling while at the same time exhibiting challenging behaviours. A child protection plan was recommended by a child protection conference. Shortly afterwards, the younger siblings were re-admitted to care on emergency care orders. Zoe remained at home and there is no evidence that consideration was given to removing her from her mother and partner's care despite the problems at home which had necessitated the removal of her siblings. However, as time passed, concerns grew about Zoe's behaviour, non school attendance, and her mother's drinking which tended to place Zoe in a caring role. As a consequence, the question of a planned admission to care was eventually considered, albeit that Zoe wished to remain at home and had found the previous placement difficult. However, before this could happen, Zoe's mother became critically ill as a result of her alcohol abuse and died. Zoe was considered by the SWD to be adequately cared for by Fran at this time.

Early to mid teens

Following Zoe's mother's death, the SWD agreed that Zoe could remain living with Fran. Minutes of a subsequent case conference indicate that the decision was heavily influenced by the consistent wish of Zoe not to be taken into care. It was decided to closely monitor the situation and review if necessary. It was considered that a CPP would be required and that the most expedient legal solution would be an application for guardianship by Fran. Guardianship of Zoe was granted to Fran and a subsequent case conference decided that a CPP was no longer required as Zoe's school attendance and engagement with the young women's group were satisfactory. However, new issues emerged during the following months.

Over the following year, Zoe missed a lot of school. Her lack of engagement with services, including the young women's support group and the instability of her living arrangements were also causing concern. She appeared to be quite distressed during this time and counselling was arranged for her. After one year of guardianship, Fran reported to the SWD that he could not control Zoe's behaviour and requested that she be placed into care. She was tending to stay out overnight, moving between friends and relatives. Zoe told school and social work staff that she did not want to be in her guardian's care, but did not want to be in residential or foster care either. Plans were made for her to move in with a relative, but this arrangement broke down quickly, and Zoe went back to live with her guardian with the agreement of the SWD on the basis that some of her relatives would lend support. A few months later, the SWD became aware that Zoe was moving between various houses and Fran was expressing serious concerns about her. Zoe made a number of allegations against Fran, claiming that he was hitting her. Fran was confronted with these accusations and denied them, saying that he was aware that he should not physically chastise her. Zoe ultimately stayed for a few weeks with an adult whom she claimed to be a friend of her mother's. This person agreed to foster her when requested to do so by the HSE.

Preliminary checks on this family were subsequently undertaken by the SWD. It also became known during the summer that Zoe was pregnant by her boyfriend Simon. She made contact with the maternity social worker, who referred her to a community based teen parents programme and she subsequently moved back to her guardian's care and attended Youthreach

very briefly. In the meantime, the SWD once again initiated plans to place her in foster care and also made an application to a pre-natal unit for her. Zoe was at this point just over 15 years old and was very positive about her pregnancy. She subsequently moved into the pre-natal unit having made a claim about a physical assault by Fran, which was again denied by him. The period during which she stayed in this unit was regarded as her most stable time for several years.

The SWD remained in contact with Zoe and plans were made for a pre-birth conference and a parenting assessment. There were ongoing concerns about the instability of Zoe's living arrangements, her non–take up of services, her claim that her guardian drank a lot and her allegations that he had assaulted her. Zoe expressed a wish to live with Simon's aunt when the baby was born, but the SWD had concerns about this option.

Zoe's first child is born

The pre-birth conference, held a month before the baby's birth, decided to develop a CPP for the baby. This conference recommended that Zoe undertake a parenting assessment. It also recommended that an application for further supported accommodation after her baby's birth should be followed up, with a contingency plan to consider Simon's grandparents as short term carers. When baby Tanya was born, Zoe's initial parenting skills were positively affirmed by hospital staff. Zoe was discharged to a residential child care centre with her baby for parenting assessment purposes, but found it difficult to settle. At one point, she left the centre and went back to Fran's house with the baby. The SWD immediately acquired an emergency care order in respect of Tanya who was placed in foster care for a short period pending Zoe's agreement to return to the child care centre with her. During their stay at the centre, Zoe and Tanya were seen regularly by the PHN. At each PHN visit, Zoe's parenting skills were considered satisfactory. A CPP remained in place for Tanya. Zoe declined the option of a mother and child fostering placement. In early summer, a review case conference decided to maintain the child protection plan. In the meantime, Zoe and Tanya moved to a low support hostel with social work monitoring. Over the summer and autumn, Zoe tended to disengage from services and frequently stayed away from the hostel overnight with her baby. This behaviour pattern led the SWD to seek and acquire a supervision order in respect of Tanya.

When Tanya was a few months old, Zoe disclosed her second pregnancy. While her parenting of Tanya was generally considered satisfactory, Zoe was herself unsure of her ability to manage two children as well as her relationship with Simon, and these concerns were shared by the SWD.

Two child protection review conferences were held over the following six months and noted concerns about Zoe's lack of engagement with services. It was agreed that the CPP would remain in respect of Tanya though the supervision order was allowed to lapse. Under the child protection plan, Zoe and Tanya were to remain in the hostel until her second baby was born. It was also recommended that Zoe and Simon should attend a family centre to develop their parenting and budgeting skills, and that they should engage with the PHN. It was noted that Zoe was very committed to making a home for herself, Simon and their children. A pre-birth conference outlined concerns that the children may suffer neglect, but decided that a CPP was not currently required for Tanya. The same recommendations prevailed with the addition of attention to the family's housing needs and further child protection assessment when Simon returned to be part of the family. At the time of the child protection conference, Simon was detained in a youth justice facility for various offences.

Birth of Zoe's second baby

Sadly, Zoe's second baby, Susan, was born with congenital abnormalities and died after a few weeks. Zoe, Simon and Tanya were supported by the SWD to spend time together with the baby during that time and managed what was undoubtedly a very difficult and sad experience with courage and commitment.

The case subsequently remained open to the SWD for 'family support' and Zoe was offered counselling which she declined. Zoe eventually sourced private accommodation with Simon and Tanya and still received outreach support from the hostel. Though the last child protection conference had recommended a child protection assessment in the event that Simon rejoined the family, none was undertaken.

Over the next nine months, Zoe ran into financial difficulties; she wanted to move to different accommodation but was unable to gain a refund of her deposit because of unpaid bills. She was not eligible to receive another deposit, so was unable to rent again and sought financial aid from voluntary organisations. Social work supervision notes from that time state that the social worker was to await the outcome of Zoe's house move before again reviewing the situation with a view to case closure.

Zoe became pregnant with her third child when she was 17. The record of a social work visit during her early pregnancy noted that Tanya was clean, appropriately dressed and appeared happy and playful. Zoe stated her intention to move to alternative private accommodation once her debts were cleared. Social work supervision notes record that crèche attendance for Tanya was to be encouraged, after which closure of the case was to be considered and discussed with the team leader and principal social worker. Zoe was having problems paying rent at this time, and it appeared likely that Simon would have to return to a juvenile justice facility, leaving her as sole carer of the children. Zoe had to leave her accommodation as the lease expired. She left substantial unpaid bills and went first to Simon's family and subsequently to a homeless centre. Simon stayed with his relatives.

Birth of Zoe's third child

Later that year, Zoe had to leave her accommodation because there were concerns about Simon's behaviour, particularly one incident which resulted in his being considered a risk to other residents. Zoe reluctantly moved to a women's refuge on a short term basis. This service was unable to offer her accommodation for a longer period because she was not considered to be a victim of domestic violence. A professionals' meeting held shortly afterwards recommended supported accommodation as the most desirable option for her and Tanya. Concern was expressed that Zoe was 'exhausting services in [local area] resulting in lack of options' and it was also noted that she had missed two recent ante-natal appointments. The social worker unsuccessfully advocated on her behalf with the community welfare officer in order to source financial assistance to enable her to move into private rented accommodation. Staff at the refuge helped her to apply for temporary sheltered accommodation and also assisted her in attending hospital appointments. The following month, she gave birth to her

third baby, Leigh, on the day that she was due to move into short term sheltered accommodation. She was discharged to her new apartment. Zoe and Leigh were visited by the PHN who had some difficulty in finding her at home. There are records on the baby's health and wellbeing and a standard post natal examination was conducted with Zoe.

By the following month, Simon had moved into the apartment but was in and out of custody. Towards the end of the year social work contact tapered off and the SWD considered that things were still going well, Zoe was physically and mentally healthy and she claimed that she was receiving good support from Simon's family, but still having problems managing her finances, having to borrow money frequently. The social worker discussed the possibility of case closure with Zoe, with an undertaking to stay in touch to manage Zoe's contact with her siblings. A closing summary sheet was completed and signed off in the social work department. The summary noted that Zoe appeared to be managing well with the children; that her boyfriend was likely to be given a custodial sentence; that the PHN had no concerns about the children but that Zoe was not engaging with her GP. The staff who managed the accommodation had apparently agreed to follow this up. When the SWD closed the case, Zoe's only support was from the staff at the accommodation where she was residing.

Some months later, Zoe told staff at her accommodation of her worries about managing the children on her own, as Simon was still in and out of custody. She was given support and offered a crèche place and was visited by housing staff every day. She was considered to be doing well. She had intended to use her maternity grant as a rental deposit and managed to save it for several weeks despite being under financial pressure. However, she ultimately gave some of this to Simon after he was released on bail. Tragically, Zoe died a short time afterwards.

11. Analysis of the involvement of HSE Children and Family Services

The review team analysed information in respect of Zoe and her family in the context of the facts known to, or available to, staff when decisions were made, to avoid the use of hindsight.

11.1 Assessment

The review team found a number of good examples of assessment, particularly pre-birth assessment work during Zoe's first and second pregnancies. The social work reports prepared for a number of child protection conferences were clear and informative. At critical points, however, the review team considered that the standard of assessment in relation to the safeguarding of Zoe and later of Tanya was not sufficiently robust. There were three examples of where case conferences recommended assessments which were not subsequently conducted. The first was when the Zoe and her siblings were first received into care. The second was when Zoe was placed with Fran, her mother's partner, following her mother's death. The third was when Simon re-joined Zoe and Tanya in their sheltered accommodation.

Assessment should provide information which is then analysed and used to inform intervention. The absence of assessment at key points undermined the reliability of decisions that were made about returning the children from care, and from time to time, about the necessity or otherwise for child protection plans (CPPs). When Zoe was younger, reliance was placed on self-reported and short term improvements in respect of her mother's use of alcohol, and the expressed wishes of Zoe to return to her mother and her mother's partner. The impact of the children's mother's alcohol use, her partner's use of alcohol and his alleged violence against their mother were not systematically assessed in terms of the safeguards needed to reduce risks to the children. The review team concluded that staff reached decisions which were not informed by knowledge of addiction or its impact on the family's functioning, particularly in relation to the care of the children.

Later, when Zoe was in the care of her guardian, Fran, and problems began to emerge about her behaviour, there was no assessment of how best to meet her needs. When Zoe moved into the home of a person who was allegedly a friend of her mother's, case records indicate that preliminary efforts were focused on approving this person as a foster carer for Zoe, rather than assessing how best to meet Zoe's needs.

The efforts made to have Zoe complete a parenting assessment following the birth of her first child, Tanya, are commended by the review team. The social work report for the child

protection conference several months later clearly and appropriately articulated the concern that Zoe would not engage with services without a supervision order in respect of Tanya. The review team had concerns about the failure to assess how Zoe's accommodation needs impacted both on her welfare and on her ability to parent her children.

11.2 Child Protection conferences

In total eleven child protection conferences were held in respect of Zoe. The minutes of all except for three of the cases were on file and were read by the review team. The reports for the conferences were also available. The process of organising child protection conferences appeared to be very efficient, and the minutes were clear and comprehensive. Minutes indicated that the chair was careful to elicit the views of all participants and ensured that the family members were helped to feel comfortable and enabled to participate meaningfully.

Recommendations from previous conferences were, in most cases, listed at the start of the minutes so that they were available for review. However, the review team noted some examples of where the recommendations from previous conferences had not been implemented, but were not, according to the record, discussed during the review conferences (for example, in respect of assessments which were due to be conducted). This, in the opinion of the review team, undermined some of the decisions that were made. The review team was also concerned about the information base on which key decisions were made at case conferences from the outset. In the early records examined there was no evidence of sustainable change by Zoe's mother or Fran to support recommendations made at the time that CPPs were no longer required. The social work report for a review child protection conference, when reunification was being considered, noted that Zoe's mother had no extended period of being alcohol free. There was also evidence about Fran drinking but a conference recommendation that his drinking needed to be assessed appeared not to have been implemented.

The review team noted that, at times, case conference recommendations were made which committed the SWD to a specific course of action at the same time as additional information would have been required. This meant that actions were sometimes embarked upon without supporting information. For example, a review child protection conference held shortly after Zoe was placed in Fran's care, recommended that Zoe wasn't in need of a child protection plan,

yet no assessment of Fran's parental capacity had been conducted. This was in the context where there were inherent risks in the placement, given the history of domestic violence between her guardian and her mother and of his previous, acknowledged, physical abuse of the children.

11.3 Decision making about Zoe's care status

The decision to remove Zoe and her siblings from the care of their mother and her partner when she was 12 years old was deemed appropriate by the review team and the SWD is commended for the efforts it made to place Zoe and her siblings together. There was no evidence in the records provided to the review of individual work with Zoe to address her attachment relationship with her mother and her anxiety to be home to care for her, which might have helped her to settle better with her foster family.

Prior to moving to mainstream foster care, Zoe and her siblings were in two placements with relative carers. The review team found no evidence of an assessment of the suitability of the relatives to care for Zoe, and believes that the absence of basic checks on family members potentially compromised the care experienced by Zoe during these placements.

The review team was concerned about the decision of the child protection conference to return Zoe and her sibling home especially as their mother was drinking during contact visits. The early reversal of the decision one month later in a conference is indicative, in the opinion of the review team, of the absence of assessment and robust decision making.

One year after Zoe had returned home, the situation at home was such that a review child protection conference recommended that she be admitted to care on a planned basis preferably with a relative. The subsequent delay and ultimate failure to return Zoe to care was of significant concern particularly as during that time Zoe had been missing school to care for her mother and was being moved around different houses to prevent her admission to care.

The review team notes that, following Zoe's mother's death, she remained with her mother's partner, Fran, despite previous allegations that he had been violent towards her mother as well

as allegations that he had used physical chastisement. His level of drinking remained undetermined.

The review team also questions the appropriateness of the decision to retain Zoe to her late mother's partner's care following her mother's death without the SWD having acquired powers under the Child Care Act 1991. The failure to impose boundaries on Zoe resulted in her needs for a stable home, education and safe and consistent care not being met. The review team considers that there was sufficient information from early in Zoe's placement with her guardian to warrant her re-admission to care.

Later, the positive use of legal measures, and the authority applied by the SWD to secure Tanya's safety, when Zoe left the mother and child facilities without agreement are commended.

11.4 Compliance with regulations

The SWD advised the review team that it had no local policy or procedures and complied with the requirements of Children First and the Child in Care Regulations*.* The review team were satisfied that most requirements of Children First were complied with. However, the protocol on joint work between the HSE and An Garda Síochána was not followed in respect of Zoe's allegations against Fran of assaulting her. There was also no reconsideration at child protection conference level of Zoe's need for a CPP in respect of these allegations.

The degree of compliance with Child Care (Placement of Children with Relatives) Regulations 1995 was patchy, particularly in relation to the requirement to assess relatives. Of particular concern was the absence of care plans given their importance to the setting of goals and the measurement of progress.

11.5 Quality of Practice

Over the nine years of involvement with Zoe, there were eight social workers, two of whom had relatively short term contact with the family, and four team leaders. In assessing the quality of

practice the following themes were considered: case planning, communication and child and family focus.

11.5.1 Case Planning

The initial decision to place Zoe in care after the allegations of physical abuse was considered by the review team to be appropriate. However, the placement with relatives without preliminary checks of existing assessment reflects a pattern of reactive decision making rather than proactive planning. The decision to return Zoe home at that time appears to have been determined by her own desire to return home, and the later decision to place her in Fran's care seems to have been similarly influenced by her wishes without sufficient consideration of her best interests. It would appear that even when Zoe made reports about Fran allegedly physically assaulting her, increasingly withdrew from education and stayed away from his care for lengthening periods of time, there was no revision of the plan to maintain her in his care.

Placing her in an alternative form of care, against her will, would certainly have run the risk that she might abscond or disrupt the placement and this undoubtedly made for a difficult decision on the part of the SWD. However, when this possibility is weighed up against the potential risks to her as a 13 year old in her placement with her guardian, who may have been well intentioned but not necessarily able to manage her behaviour or protect her, it is reasonable to suggest that greater efforts should have been made to find a placement that would meet her needs and motivate her to engage with it. It has been pointed out here that a thorough assessment of Fran's suitability was not evidenced, nor is it obvious how far and in what depth Zoe's best interests were identified and analysed at the time in order for them to be measured against her wishes in respect of this placement.

As outlined above, the review team considered the actions taken to protect Tanya during her early months were appropriate and provide examples of good practice. Zoe responded well when these boundaries were set and generally complied with requirements.

11.6 Child & Family Focus

There was evidence of extensive contact between staff from a range of agencies and Zoe's mother in efforts to elicit her engagement with parenting and addiction services and to motivate her to change her lifestyle. The review team consider that staff from all agencies worked consistently in a cooperative, transparent and inclusive manner with Zoe's mother and her partner. Unfortunately, the couple did not respond in a similar way. Zoe's mother resorted to concealing the extent of her drinking in an effort to have her children returned to her care. Staff therefore were working in a context of deception which made genuine partnership impossible. The review team considered that the mother's warm interaction with her children and their affection for her may have caused staff to minimise the impact of her drinking on her capacity to provide them with a safe and secure home.

While Zoe was in care, practitioners talked with her and elicited her thoughts and views on her access visits, her mother's alcohol misuse, her allegations against Fran, and her desire to go home. All during her life she received a lot of attention from the professionals who worked with her, many of whom went out of their way to help her. However, while the review team acknowledges that Zoe's voice was heard by professionals, it is also of the view that her wishes appeared to determine planning decisions even when there were potential risks to her of acceding to them.

Zoe was on a waiting list for psychology for seven months, and by the time a place was offered, she had engaged in a young women's group. The review team believes that the psychology service, if provided in a timely manner, would have been more appropriate to deal with the complex matter of Zoe's relationship with her mother, which was characterised by role reversal and parentification on Zoe's part. It is understood that the availability of the psychology service is outside the control of the social work service but was a responsibility of the wider HSE. Following her second baby's death, Zoe was offered bereavement counselling, as she had been after her mother's death. At the time, she chose not to avail of these offers but it is noted that during her third pregnancy, the maternity hospital social worker took the opportunity to discuss with her the loss of her baby and her mother and she appeared open to discussing both deaths. The use of this opportunity is commended by the review team.

It is notable that when case closure was initially being considered, Zoe was still under 18, was three months pregnant with her third child, was experiencing continuing financial difficulties and had no settled accommodation. The review team acknowledges that Zoe strenuously sought to limit her involvement with the HSE and the range of services which it funded. She achieved her goal when the SWD closed her case. She also managed to discourage other agencies from persisting with her by not answering her phone, missing or cancelling appointments and generally failing to engage with services. However, her ability to distance herself from the services was not matched by a reduction in her vulnerability and she might have benefited from a service specifically geared to meeting the needs of adolescents which may have provided an opportunity to engage her, as its focus would have been on her rather than on her parenting capacity or the children.

11.7 Quality of Management

In considering the quality of management the review team considered**:** ethos; supervision; policies and procedure, monitoring and audit and interagency work.

11.7.1 Ethos

From discussion with managers and the review of case files the review team found that the SWD placed a high priority on rehabilitating children with their birth parents, or placing them with kinship carers. There also appeared to be an emphasis on working on a voluntary care basis with parents. The review team believes that these priorities impacted on decision making. The fact that decisions were made in Zoe's case which afterwards had to be reversed, for example in respect of her care status, should have, in the opinion of the review team, triggered a fundamental review of the stated goals by the SWD.

11.7.2 Supervision

There was evidence of regular supervision of staff, using a pro forma record outlining the areas discussed and future action agreed. The review team viewed this process as a useful means of recording decision making points in the management of a case. It is noted that the Child and Family Agency has now adopted a standard supervision policy.

11.7.3 Policy and procedures

The SWD used a range of standardised forms to deliver on its child protection and statutory child care duties. The absence of *pro formas* to record CPPs and care plans was viewed as a shortcoming in the range of documentation provided to staff. It is understood that the implementation of standardised business processes has now addressed this deficit.

11.7.4 Monitoring and audit. The review team was advised that the SWD has no mechanism to monitor or to audit practice on a formal or regular basis. There is no sampling of cases to check compliance with requirements or the standard of professional practice. The absence of governance arrangements is a shortcoming which the review team feels should be addressed. In this case, the review team considers that audit or monitoring could have been triggered on a number of occasions due to the short shelf life of a number of decisions. It is noted that this was a recommendation of the Roscommon report published in late 2010.

11.7.5 Communication and interagency working

There were a number of agencies and professionals involved with Zoe during her childhood and when she became a parent. The review team reviewed HSE's and HSE funded agencies' records and interviewed staff. While at times recording in the SWD files did not contain all information shared with it by other agencies the review team did not identify any gaps in information which had the potential to adversely impact on the services provided to Zoe. Overall, the review team concluded that communication and working relationships between agencies were good.

12. Conclusions

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.

13. 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 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. These concerned decisions to place Zoe back in care and to either develop or drop child protection plans. 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's collusion with her mother's drinking and her desire to protect her from violence placed her in a position where she became a 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

[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

adulthood (Deardon & Becker, 2000; Gilligan and Halpenny, 2004)[3]. There is evidence that this was Zoe's experience; she missed a lot of 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 progressively missed more days at school. The learning here 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 to 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.

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[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) *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

- 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. Neither the PHN notes nor the social work record commented on her emotional state. The learning from this is that mothers, particularly when they are as young as Zoe, who are experiencing stress (in this case, a 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.

14. 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.

Dr. Helen Buckley

Chair, National Review Panel