National Review Panel

Review of the death of a young person known to Children and Family Services

December 2012

National Review Panel

Review Report on Tom, a young person who died having spent the years up to his 18th birthday in the care of the HSE

1. Introduction

This review has been carried out in accordance with the HIQA *'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care'* issued in 2010'. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Deaths of children in care including deaths by natural causes.
- Deaths of children known to the child protection system.
- Deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991.
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service.
- Serious incidents involving a child in care or known to the child protection service.

2. National Review Panel (NRP)

A national review panel was established by the HSE in May 2010 and began its work shortly thereafter. The panel consists of an independent chairperson, a deputy chair, and approximately 20 independent persons who have 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 is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the NRP. The National Director 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

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. 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 was to be produced which contained a

detailed chronology of contact by services with the child and family, an analysis thereof, conclusions and recommendations. When the HIQA guidance was developed, it was envisaged that the NRP might need to review up to two deaths *per annum* and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

(i) Major review: to be held where contact with the HSE services 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, it included multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three 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.

(ii) Comprehensive review: to be held where involvement of HSE services 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 and recommendations.

(iii)Concise review: to be held where the involvement of HSE 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 and recommendations.

(iv) Desktop review: 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 the chair or deputy chair of the NRP. 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 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.

(v) Recommendation for internal local review: to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Death of young person: Tom

Tom was a young adult when he died. His inquest recorded 'death by misadventure' and noted no suspicious circumstances. At the time of his death, Tom was in receipt of aftercare services from the HSE.

5. Level and process of review

This was a comprehensive review of services delivered by the X Health Board and HSE. Tom was in receipt of services from infancy until his death. The review team consisted of Michael Bruton, Paul Murray and Bill Lockhart (chair). All the team are independent of the HSE and had no previous knowledge or involvement with Tom. The review consisted of an analysis of X Health Board and HSE files relating to Tom and his family, written submissions and face to face interviews with fifteen staff and managers from a range of agencies, including the HSE and a number of voluntary organisations. Members of Tom's family were invited to meet with the team or send submissions but declined to do so.

6. Terms of reference

- To examine the service provided by the HSE Children and Family Social Services in the case.
- To identify any barriers that prevented services from working together to uphold Tom's rights.
- To determine compliance with local and national policies and procedures in the case.
- To identify elements of positive practice.
- To identify opportunities for learning arising from the review.
- To reach conclusions and make recommendations.

- To prepare an objective report for submission to the HSE.

7. Tom

Tom had been in care from an early age. Most persons who knew him said he could be charming, witty and easy to get on with but was weighed down by his sense of not belonging, without a sense of permanence to anchor him.

8. Background and reason for referral to HSE Children and Family Services

Tom had a number of siblings, some of whom were older and some younger. Tom's family first came to the attention of the social work department (SWD) when he was an infant due to an alleged episode of alcohol misuse by his parents and domestic violence between them. As a result Tom spent time in residential care and being cared for by relatives. The relationship between his parents ultimately ended and Tom had no further contact with his father. Tom's mother, Tara, continued to exhibit a chaotic lifestyle characterised by an inability to control her drinking and by the neglect of her children. Members of her family continued to care intermittently for Tom and the other children, particularly while she received treatment for her drink problem. This situation continued for two years with Tom's mother continuing to drink excessively with a concomitant inability to provide adequate care for her children. A meeting between the SWD, Tara, the public health nurse and Tara's addiction counsellor resulted in a voluntary agreement that the children should continue to be cared for by relatives.

Unfortunately, due to the illness and subsequent death of one of the family members caring for Tom, the placement ended after a year. Tom, who had been very close to this family member, was deeply upset at the death. He had been moved into a short term placement in mainstream foster care at this point, but this placement also ended due to illness in the foster family. Another family member came forward at this point to offer long term foster care to Tom and some of his siblings. The SWD was satisfied that the extended family member and their family would provide a suitable foster home for the children. It had the advantage that it facilitated contact with the other members of the extended family and kept the siblings together. Tara, Tom's mother, had by then left the country and died while Tom was still quite young. The second relative placement lasted until Tom was in his mid teens, when it unfortunately disrupted. He subsequently had a number of short term stays in residential units up to his death.

9. Services Involved with Tom

- [X] Health Board social work department and later the HSE.
- Public health nursing in early years.
- Gardai in early years with biological family because of alleged domestic violence and neglect of children and later with Tom because of criminal behaviour.
- Child guidance referral because of suspected attention deficit disorder.
- Mentoring/support programme run in the community by a voluntary organisation.
- Family counselling services run by a voluntary organisation.
- A number of residential units managed by both the HSE and voluntary organisations.
- Education Welfare Service – referral made by HSE.
- Youthreach – a number of referrals to different Youthreach locations.
- Aftercare services, both managed and funded by the HSE, including independent hostels for the homeless and those with addiction problems.
- Irish Prison Service and Probation Service.

10. Summary of Tom's needs and how they were met

Several incidents in Tom's life were likely to have made an indelible impression on him and given rise to specific needs. As a very young child he was witness to the chaotic lifestyle of his parents. The first opportunity for constancy in his life came with the first family fostering arrangement but that was disrupted by the illness and death of one of his relatives. He was also affected by his mother's death and his sense of abandonment may have been accentuated by the earlier desertion of the family by his father. He therefore had a need for stability and security. He needed therapeutic intervention to address the impact of the early trauma he had experienced.

During Tom's long term placement with relative foster carers, anonymous allegations were made to the SWD that he was being excessively chastised. When approached by his social worker Tom said that these allegations were true. At this time, his physical safety and emotional welfare may have required attention.

It is likely that the breakdown in his relationship with his long-term relative foster carers was a determining event in Tom's life and may have led to the beginning of or deterioration in his substance abuse. Tom's primary need after the placement breakdown was for a stable

placement. Constant moving from one residential unit to another was detrimental to Tom's wellbeing and inevitably influenced his deteriorating behaviour. He clearly needed firmer boundaries than those operating in the open residential units where he stayed. Frequent absconding, drug taking and other unacceptable behaviours led to his being discharged from one unit after another so that his need for stability and security remained unmet.

11. Chronology of contact between Tom and his family and HSE Children and Family Social Services

Phase 1: Early childhood

Tom's early childhood was characterised by a number of episodes whereby his mother Tara drank to excess, took overdoses of medication and was a victim of domestic violence from her partner. As a result, the children spent periods of time being cared for by relatives, interspersed with periods of being cared for by their mother. Reports were made to the SWD by the Gardai, the PHN service, a mental health social worker and a community based family support service concerning Tara's neglect of the children while they were in her care. Overall during this time, it appears that the case was opened and closed intermittently by the SWD, and there seemed to be a general reluctance on their part to become involved. And at one point the SWD advised Tara that the Gardai would be the most appropriate service to deal with the domestic violence to which she was subject.

During the following months, Tara had a number of hospital admissions, including one for an overdose, during which time the children were cared for by family members. A family support worker and a child care worker were allocated by the SWD to work with the children, but Tara was unwilling to engage with them. Ultimately, a number of Tara's siblings came together and called to the SWD. They expressed concerns about the welfare of the children and criticised the SWD for their lack of action and for their over-reliance on the extended family as carers.

Following a case conference, a voluntary agreement was signed by Tara whereby she agreed to enter treatment while the children were cared for by relatives in a formal fostering arrangement. The records do not show whether or not these relatives were fully assessed under the Child Care Regulations 1995. However, on discharge from treatment, Tara was unable to resume care of the children and they remained with the same relatives for a year until the illness and subsequent death of one of them ended the arrangement. As a consequence, Tom had three changes of placement during the following year. The first was with a respite foster family, the second was with relatives for a short period and the third with mainstream foster carers, here known as the D family. In the meantime, tensions became high in the wider family, leading to a decision by Tara to move abroad.

During his stay with the D family, it was noted by his foster carers that Tom tended to seek negative attention just when things were going well and was affected by uncertainty about his future. Tom's foster mother raised the possibility that he may have attention deficit disorder and a referral was made to the child guidance service. While he was living with the D family, Tom visited his mother on a regular basis outside of the jurisdiction where she was now living with a new partner.

The following year the foster care placement with the D's ended due to the serious illness of one of the children in the family. A supported lodgings placement was organised for Tom and his siblings with another set of relatives, here called O and Q. The records do not show why a supported lodgings arrangement was used. It may have been easier to put supported lodging arrangements in place quickly.

Phase 2: Late childhood and early teenage years

Concerns began to emerge about an older sibling's behaviour, followed by issues about Tom's behaviour. In a referral letter to a family therapist the social worker referred to Tom as being hyperactive, having a short attention span, taking cigarette lighters, having a fascination with fire and having problems controlling his anger.

Tom's mother died the following year. Despite this Tom was noted as doing very well and playing sport.

During the following year, it was necessary to get passports for Tom and his siblings so that they could go on holidays with their foster carers. It was agreed that the HSE would seek a full care order in order to obtain the legal capacity to sign the necessary documentation. Shortly after this was completed, Tom's foster mother expressed her concern that he was hanging around with an unsavoury group, and possibly smoking hash. Tom denied this. Around the same time, he was suspended from school for a short time for mitching. A statutory Child in Care Review held the next year described Tom as *"a bright young boy [with] a lot of potential to achieve whatever he sets his sights on in the future"..."an affable boy who is full of energy frustrated by what he perceived as tight controls placed on him by his carers. Tom is a boy who likes to spread his wings and thereby tests his carers' boundaries... He has an open personality and is witty. He is good company and is well rounded in his general knowledge. He has a very good relationship with the family therapist."* A separate report for this review *noted "Tom feels outnumbered by the number of girls in the family and he tends to be a scapegoat in the family and while his behaviour commands the carers' attention, their reaction can be disproportionate to the act."*

The social work files record that around this time an anonymous allegation was made to the effect that Tom had had been physically chastised on a number of occasions by his foster carers. This was followed up by the SWD and confirmed by Tom. The file records that the

foster carers were confronted with this information during a social work home visit, but it does not show the outcome of the meeting. The social work files record that a child protection plan was to be developed; however, there is no evidence that a plan was either developed or put in place. The records do not show whether a child protection conference was convened as a result of the allegation and Tom remained with his foster carers. The review team was unable to conclude, on the basis of available evidence, whether there was substance to the allegations of excessive physical chastisement. Later that year, a separate fostering link worker was assigned to the family for the first time in many years. It was around then that Tom's sibling left the placement. The social work notes record: *"this is likely to be a cycle of breakdown unless the foster parents reflect upon their parenting style and their response to what is pretty normal childhood development. They need to develop a greater sense of understanding of child development."* By the end of the year, the social work file records Tom as saying that he felt unwelcome in the house and admitted that he "sparked" off one of his foster carers a lot.

Phase 3: Teenage years to age 18

The following year proved to be a very significant one in Tom's life. The social work file records that concerns about the relationship between him and his foster carers were the subject of a number of discussions among professional staff. It was agreed that a family therapist would work with Tom on his behaviour and that the fostering link worker would work with the foster carers on parenting and related matters. In addition, Tom was referred to a mentoring/intensive support programme run by a voluntary organisation. In the meantime, the foster care team leader and social worker met the foster carers to restate the contractual arrangement between carers and the HSE with particular reference to the National Standards for Foster Care. However, the relationship between Tom and his foster carers continued to deteriorate and ultimately, he left the foster home without warning.

Initially, Tom went to stay with a combination of friends and family, following which he was placed in a number of different residential units on an emergency basis. These placements were problematic; he frequently absconded, normally returning shortly afterwards. He declined to attend a number of review meetings which had been convened to discuss his placements. While some of his relatives were willing to have him to stay at weekends, none was willing to foster him full time. Tom's social worker wrote to his line manager, outlining Tom's *"steep decline educationally, socially, emotionally and psychologically"* since his entry into the homeless service. The social worker outlined that *"This child's welfare is being seriously compromised by the apparent systemic failures of the HSE to provide an appropriate placement for him. Urgent action is required."* (source: Social Work Files).

No other foster carers were sourced and Tom remained within the residential care services, becoming more involved with substance misuse. His relationship with school was

characterised by long periods of positivity and appropriate behaviours, followed by periods of attention seeking, giving verbal abuse, being involved in graffiti drawing and displaying overtly sexualised behaviours. A risk assessment undertaken in spring of the following year by Tom's social worker noted a *"significant difficulty in finding a foster placement ...he needs a safe placement that can offer him a sense of security and permanency. Tom is increasingly involved in high risk behaviour including staying out late at night and drinking to the point of intoxication and using hash. There is a risk that Tom will rapidly descend further into the juvenile justice system...he is spiralling out of control and is unable to make positive choices for himself at this time. Much of his presenting behaviour is borne out of a sense of abandonment, literal and psychological."* (source: Social Work Files). It appears that the breakdown in the fostering arrangement and unavailability of other members of his extended family as long-term carers, further compounded by his orphan status had left him feeling isolated and alone.

A psychiatric report was provided at that point and recommended, *inter alia*, that Tom should be given the opportunity to maintain regular contact with his siblings and that other options regarding his future care should be explored. It noted that Tom had expressed a wish to live in foster care as part of a family unit. In a statutory review undertaken at that time, Tom made clear that he wanted to move on as soon as possible. He is quoted as saying that he was "*not used to the madness of [his placement]; people wrecking the place; batteries being thrown through windows; not very homely; doors always locked.*" (source: Social Work Files).

It was considered by all parties that Tom's situation had deteriorated enormously since he left foster care. Grinds were proposed to enable him to catch up with missed school and a move to a nearby school was suggested. Staff were concerned that Tom regularly returned to the unit under the influence of alcohol and hash, although he denied these allegations. He was also described as being bullied by other residents and being sucked into the challenging behaviours of other residents in order to avoid victimisation.

Tom's behaviour continued to deteriorate in the residential centres. He fought with and was verbally abusive to staff, broke windows and was difficult to engage. The manager of one centre reported that Tom had carved his mother's name into his arm with a sharp object. By autumn of that year, a report for his statutory Child in Care Review recorded that Tom had started fires on six occasions, was sent home on his first day in school for being abusive to his teachers and had declined an offer of home schooling. About this time one of Tom's older siblings, who was also in the care of the HSE, proposed to care for him but the offer was not sanctioned due to the sibling's care status. Efforts to convene a family welfare conference were initiated, albeit against Tom's wishes, but eventually came to nothing as the wider family did not want to participate. A referral was made to the National Education and Welfare Board about Tom's non-attendance at school since the late winter. There was no response to this referral on the files.

Eventually, after a considerable and very unsettled period, arrangements were made for Tom to be placed in a residential service that was considered to be appropriate to his needs. Unfortunately, the arrangement proved unsuccessful. While he was judged to get on well, particularly when presented with limits and boundaries, Tom was also prone to argumentative and sullen behaviours for which he refused to accept responsibility. By late spring this placement had irretrievably broken down following an assault committed by Tom on another resident. Gardai were involved and a criminal prosecution was invoked.

Following that breakdown, Tom was again placed in a range of residential services for homeless young people. These intermittent placements, arranged on a daily basis, resulted in a period of instability and uncertainty. He was referred to Youthreach services in a number of centres but attended rarely. He regularly absconded from his residential placements. On the positive side, he appeared to enjoy contact with a respite service, and intermittently stayed with some of his relatives for short periods, usually weekends.

At a statutory Child in Care Review held some months later, Tom told his social worker that when he found out that his mother had died, he had cried so much that he felt he had 'cried over everything'. He acknowledged that he was not good at talking or expressing emotions and that anger was often a result.

The same downward spiral continued over the following months, characterised by instability of accommodation, drug and alcohol use and aggressive outbursts. Tom was involved in minor criminal activity and was ultimately barred from the centre where he had been living.

Tom eventually moved to live with the older sibling who had originally sought to act as his carer. This arrangement was fluid in that he would also stay with other unknown persons; during the following months he moved between his sibling, his girlfriend and residential care. A report for a programme in which he was participating around this time records Tom as saying that his girlfriend and his siblings were the people who most cared for him and loved him, and he expressed a wish to see more of his family. In the meantime his girlfriend had become pregnant. Tom's drug use continued, his attendance at Youthreach remained sporadic and he got into further trouble with the Gardai, eventually spending two weeks in custody.

Following his release, Tom accessed accommodation through the homeless service, and contact was made with him by an aftercare worker, with the principal focus on accommodation. He was placed in an emergency residential centre, but the same cycle continued, he would go absent, return under the influence of drink and/or drugs and his placement with Youthreach was jeopardised. His health was a cause of concern but he was unwilling to engage with therapeutic services. A statutory Child in Care Review was held in the spring and recommended that Tom get private supported housing. During the following months, Tom left the emergency accommodation, lived rough for a while, returned to a previous placement and again had to use emergency accommodation services.

Phase 4: Aftercare

After his 18th birthday, Tom formally left care, but his social worker remained very involved with him in trying to secure a structured and supportive service framework for him. Over the following year, during which time his girlfriend gave birth to a baby, Tom spent time in and out of various types of accommodation including friends' houses, custody, a probation hostel and an aftercare service where staff noticed a rise in his poly drug use involving crack, heroin, alcohol and cocaine. He appeared to have difficulties building relationships and was sometimes confrontational, though calming therapeutic crisis intervention (TCI) worked well in addressing this. Staff felt that positive relationships were established as a result of which Tom would address unacceptable behaviours and then apologise. Contact with Gardai increased with time, and although hinting of crime involvement, Tom refused to discuss anything about this with staff. However, he was articulate in expressing to staff the types of support he wanted or needed and he acknowledged that his drug use was a major problem. During this time, he also spent time with his siblings.

The rate of Tom's exclusions from the service for drug use and aggressive behaviour diminished with time. A case conference was held after he was again released from custody following a short sentence, and the aftercare service offered to support his efforts to stay drug free. A residential placement was sourced for him and additional staffing was put in place to assist in meeting his needs. However, the aftercare services were very concerned for his wellbeing and updated the social work department early the following year as follows: *"... I realise that the social work department has closed Tom's case but feel it is important to update you on Tom's situation at the moment. Tom is very vulnerable and is not linking in with services available to him. We have grave concerns in relation to his safety and to the fact that he has been homeless since turning 18. We are providing Tom with any services available but we are finding it very difficult to meet his needs due to his non-engagement with services."* (source: Social Work Files).

While Tom appeared to settle in to the new arrangements, his ongoing drug use presented difficulties. He left this accommodation in the spring and accessed hostels *via* the [1]Night bus service

The aftercare services advised the social work department that they felt Tom's drug use was increasing and that he might avail of a private detox programme if funded by the HSE. The principal social worker agreed to this in writing. Little contact was made with Tom until he started to re-access aftercare services on a regular basis for a couple of weeks. Some days later he was found dead, and the subsequent inquest concluded that death was by misadventure. The review team has noted the profound sense of loss expressed by the staff members who knew Tom.

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[1] The **Nightbus** Service provides assistance to rough sleepers at night time. Services include finding accommodation.

12. Analysis of involvement of Health Board/HSE Children and Family and Aftercare Services with Tom

12.1 Initial response: Appropriateness of Health Board Intervention

Having considered the file record going back to when Tom was a very young child, the review team has noted that the SWD was at first reluctant to become involved with Tom and his family and did so only after repeated requests from other agencies such as the Gardai and public health nursing and, indeed, his extended family. Intervention was on a voluntary basis and included the use of relatives as the primary carers. The advice given by the SWD that the Gardai would be a more appropriate agency to address the domestic violence Tom's mother was experiencing portrays a very narrow perspective on child welfare on the part of the department. The level of support and therapeutic intervention provided at the time was inadequate to meet Tom's needs. In the opinion of the review team, intensive therapeutic support should have been put in place at an early stage to address the level of trauma that Tom and his siblings were likely to have experienced.

12.2 Assessment

When Tom reached adolescence the normal issues of the teenage years became apparent; but these were compounded by his early life experiences and traumas. However, the social work assessment of his needs and those of his foster carers in dealing with his behaviour appear to have been inadequate given the extent of trauma and unwanted change Tom had experienced throughout his young life. Social work team leaders responded to allegations that Tom was being physically chastised by his foster carers by speaking to them about it, but did not take it any further. It is difficult not to conclude that the SWD was more concerned about the continuation of the foster care arrangement for the other children than any physical and emotional harm that might have been experienced by Tom in his placement. If this is the case it represents a failing in professional practice and judgment on the part of the SWD.

It is the view of the team that that the SWD should have launched a more formal investigation of the allegations about excessive chastisement, including an assessment of the risks of allowing the fostering placement to continue for the other siblings. Instead, the anonymous allegations which Tom concurred with, while apparently believed, may have appeared to him to have been ignored. The failure to hold a formal investigation also denied the foster carers their rights and may have helped protect them against what might have been unfounded allegations. While the review team recognises that it would have been challenging for the SWD to find an alternative foster placement for Tom and his

siblings, these are the sort of professional judgements and tasks which social workers and social work managers are called on to make.

12.3 Compliance with regulations

12.3.1 Early protective action

As noted earlier in this review, the X Health Board seemed slow to intervene when Tom's family first came to their attention in spite of clear evidence of domestic violence and parental alcohol/drug abuse. Failure to respond by providing therapeutic input to the children and restoring a sense of safety and stability demonstrates a lack of compliance with national child protection guidance. Section 3 (1) of the Child Care Act 1991 states that: *"It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection;"* further section 3(3) of the same act states: *"A health board shall, in addition to any other function assigned to it under this Act or any other enactment, provide child care and family support services..."*. This did not occur.

12.3.2 Child care reviews

Under the 1995 Child Care Regulations, children in foster care should have regular Child in Care Reviews. This is a statutory requirement. There is no record in the files of reviews having taken place with the necessary frequency. Had reviews been conducted regularly, some of the problems in the foster placement may have been identified earlier and preventative action put in place. This was a serious failing and impacted on care planning. Evidence of regular reviews started to appear on the file after Tom left foster care and entered residential care. There is evidence that Tom was consulted and had input into these reviews.

12.3.3. Response to allegations of abuse in respect of Tom

Under the Child Abuse Guidelines issued by the Department of Health (1987) a health board is expected to notify the Gardai of any alleged case of child abuse where it is expected that a crime has been committed. In the case of alleged physical abuse the Gardai must be formally notified immediately. There is no evidence on the files of this happening when anonymous allegations of physical abuse were made against his foster carers. This was a serious regulatory failing.

12. 4 Quality of practice

12.4.1 Interaction with child and family

There can be little doubt that the SWD, when they became involved, did attempt to act in Tom's best interests and devoted substantial financial resources in doing so. The social worker who was assigned to Tom during the time he was in care, here called Social Worker A, clearly built a strong relationship with Tom and had many positive things to say about him. Yet, as noted above, there were fundamental failings in the service provided. Central to these issues were the lack of regular statutory reviews and the failure to follow through on the allegations of emotional and physical abuse.

During Tom's early years in care, the death of a family member who was caring for him, and to whom he was very close, together with several changes of placement must have impacted on Tom's emotional wellbeing and would have necessitated very careful therapeutic advice and support. There is no evidence of this having been considered or sourced.

There is evidence from both the files and interviews with HSE staff that the social work department devoted considerable time and resources to Tom and his siblings at a later stage. Efforts made to respond to Tom's complex needs included the referral of himself and his foster carers to a counsellor in a family therapy centre. Unfortunately the review team was unable to interview this counsellor to ascertain the nature and extent of this therapeutic intervention. But it is known from files that Tom valued the relationship with the counsellor and engaged with this person on a sporadic basis over an extended period in his adolescence. After the eventual breakdown of the fostering relationship the HSE social workers put a great deal of work into trying to support Tom and his other siblings in their various settings.

The breakdown in the fostering arrangement was to prove a major negative turning point in Tom's life. At interview Social Worker A was asked to describe what would have been the best placement for Tom after the relative foster placement broke down. An immediate response was *"fostering with other members of his family"*. This aspiration reflected the social worker's belief that Tom badly wanted to be with his extended family. Indeed Social Worker A tried to convene a family welfare conference to encourage family members to become actively involved, but this did not materialise. The next alternative would have been to secure a foster placement through the HSE but no suitable families were available.

The review team is of the belief that by this stage Tom's needs were so complex that a specialised therapeutic foster placement would have been required. Various attempts were made to assess his needs and to find a suitable arrangement, but these all failed. It is estimated that Tom went through seventeen care settings, although some were repeat placements.

The review team believe that Tom had an acute sense of abandonment and of rejection and these feelings almost certainly contributed to his deteriorating behaviour, which in turn led to his being discharged from one hostel after another. Residential units in which he was placed were not suited to the volatile behaviour he progressively exhibited, including continual absconding and other serious breaches of house rules, verbal and other threats to staff and other residents and anti-social behaviour generally, that degenerated into conflict with the law. These incidents inevitably resulted in discharge from each placement.

During Tom's teen years, various supports were offered to him. Therapeutic support appeared to benefit him and he built up a good therapeutic relationship with his counsellor. The social work team supported him in this regard but Tom's motivation was not sustained. He was offered an intensive assessment by psychologists and social workers from the Risk Assessment and Consultation Service in order to identify his educational, emotional and psychological needs but did not engage with the service and refused to attend. A planned Family Welfare Conference did not proceed due to the absence of engagement with the process by extended family members. Addiction counselling was also offered on numerous occasions but again Tom did not engage. Key working sessions were offered to Tom to support him in his residential placements. The support focused on areas such as behaviour, criminality and emotional wellbeing. Tom did not respond and when his behaviour deteriorated into criminality he did not engage with the probation service. He did link sporadically with a voluntary youth mentoring/support scheme which aimed to support him in education, peer relationships and positive life choices.

12.4.2 Quality of record keeping

The review team received ten files from the HSE and a further three files from other agencies. Generally, record keeping was of a good standard, particularly in the latter years. There were substantial case notes that were appropriately dated and signed.

12.5 Management

12.5.1 Allocation

The review team interviewed a manager in the LHO that provided social work services to Tom and his family. The review team gained the impression of a very busy office in an area with high social needs. The sense was of a properly managed service, albeit one under considerable pressure. At the time of the review, all children in care had an allocated social worker. In Tom's case there was a good level of continuity in service. His social workers had good relationships with him, particularly in the latter years of his life.

12.5.2 Inter-agency meetings or cases conferences

Inter-agency meetings and case conferences appear to have been convened as and when appropriate after the breakdown in the foster placement. The manager who was interviewed, expressed the view that the social work teams could have benefited from augmentation from other specialist professions – particularly psychologists.

12.5.3 Supervision

Files records and interviews with staff provide ample evidence of supervision of staff. Team leaders, in particular, had a high level of involvement in Tom's case. Supervision notes were counter-signed by both the social workers and team leaders, usually on a monthly basis following the breakdown with the long-term relative foster family.

12.5.4 Policy

HIQA have now published inspections of fostering services in a number of local areas. Inspectors found evidence of good practice in many aspects of the foster care service provided. However, they made some negative findings in respect of procedures for the management of allegations against foster carers, the process by which complaints with child protection concerns were assessed, internal monitoring of child protection procedures, the frequency of social work visits and the role of the local monitoring officer.

The following specific weaknesses were found:

- Lengthy periods when children were not visited by a social worker.
- Inconsistent social work practice.
- Significant deficiencies in the vetting, assessment and approval of carers.
- Concern in relation to child protection locally.
- Evidence of poor record keeping practice.
- Poor governance and management of foster care services in the Area.

The review team believes there was ample evidence of such shortcomings in Tom's case. The manager who was interviewed by the review team accepted that some of the services which could have benefitted Tom were not then in place. This was with particular reference to the need for a specialist fostering service for adolescents with complex needs. Such a service is now in place. The manager also accepted that there was an increasing need for specialist addiction services for younger adolescents.

Likewise there was an acceptance by the manager that the "out of hours" accommodation service did not meet the needs of many adolescents, who need much more settled accommodation. There were at least two incidences in Tom's case where specialist providers funded by the HSE appeared to reject Tom against the wishes of HSE social workers, displaying a limited tolerance level and understanding the needs of troubled young people and reinforcing Tom's sense of abandonment.

12.5.5 Inter-professional and inter-agency cooperation

There was evidence in the files and at interview of adequate inter-agency working and communication. There were appropriate meetings and case conferences. The only exception to this was when two residential providers discharged Tom in spite of written and verbal protests from social workers.

Otherwise there was good evidence of inter-agency co-operation. This applied particularly during Tom's period of aftercare involvement. The review team was impressed by the desire of some of the voluntary/independent sector providers to meet Tom's needs and engage him in services.

13. Conclusions

On the basis of its analysis, the review team has reached the following conclusions:

13.1 Tom suffered from an acute sense of loss, abandonment and rejection. It is a matter of conjecture the extent to which these contributed towards the downward spiral in his behaviour. There is enough evidence to suggest that the various traumas in his life affected his behaviour and the lifestyle that led to his death.

It is highly probable that the breakdown in his relationship with his relative foster carers was a seminal period in Tom's life and a crucial consequence may well have been the beginning of his substance abuse. Tom craved stability and had an alternative suitable foster placement been available, either with a relative or stranger, matters may have turned out differently. However, given the circumstances of the breakdown in his relative foster placement, it is likely that any alternative foster carers would have had to have been given a level of support and training that was not available at that time. It is also likely that had alternative interventions been used or been available the outcome could have been different

13.2 The apparent failure to hold regular statutory Child in Care Reviews that may have included input from other agencies such as schools was a significant failing on the part of the HSE/X Health Board.

13.3 The constant moving from one residential unit to another was detrimental to Tom's wellbeing and played a major part in contributing towards his deteriorating behaviour. An earlier psychological assessment provided to the SWD had been influential in their decisions to place Tom in open units, and in hindsight, his needs would probably have been better met in high support or special care. His constant absconding, drug taking and unacceptable behaviour generally inevitably resulted in discharge from one unit after another. Discharge from one residential centre in particular may have been premature and ended any hope of stability in Tom's life. In particular when the supported lodgings element broke down, greater consideration could have been given to seeking the making of a referral to a high support or secure unit.

13.4 Overall, the review team is satisfied that, in the context of the available resources and with the challenges presented by Tom's behaviour, the social work department (SWD) achieved most of the tasks that could have been expected of it in the latter years of Tom's life. We identify several serious shortcomings by the HSE/X Health Board in his early childhood and during the period of the breakdown with his relative foster carers.

14. Key learning points

The review identified a number of key learning points which should be considered by the Children and Family Service.

14.1 There is now substantial evidence that early childhood trauma can have a devastating impact on childhood, adolescence and adulthood[2]. Children with such backgrounds need high levels of therapeutic support. The earlier this support is provided the better. It is clear that Tom and his siblings were exposed to considerable trauma in their early years and needed to gain a sense of safety, stability and therapeutic services as quickly as possible. Unfortunately in Tom's case this did not happen.

14.2 Placement with relative foster carers should be based on an assessment of a child's needs and a reasonable level of confidence that relatives have the capacity to meet them, rather than an assumption that relative placements are always the most appropriate.

14.3 The review provides further illustration that foster carers who are asked to care for children with complex needs require specialist support, training and monitoring for the very difficult task they are undertaking. This applies whether or not they are family members. Furthermore, evidence of difficulties within a fostering placement should be stringently investigated and, where shown to have validity, should elicit timely intervention.

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[2] See, for example, *Cook et al. 2003, Complex Trauma in Children and Adolescents: White paper from the National Child Traumatic Stress Network Complex Trauma Task Force*).

14.4 Allegations of excessive chastisement by foster carers should always be formally investigated, no matter what the source of the allegations. This helps protect all parties concerned. In the event that initial inquiries point to actual physical abuse, notification should be made to the Gardai where it is suspected that a crime may have been committed.

14.5 The breakdown in a foster placement in early to mid-adolescence can be particularly devastating. In Tom's case this led to a steep and ultimately irretrievable decline. Where an assessment indicates the benefits of a new (and specialist) foster placement being sourced this should be the main priority for action.

15. Recommendations

15.1 Children coming from a background of complex trauma in their lives should be a priority for the provision of specialist assessment and therapeutic services.

15.2 Social work departments should consider augmenting their child protection teams with psychologists who are readily available for assessment and case management advice.

15.3 Specially tailored services for younger adolescents with alcohol and drug addiction problems need to be sourced and proactively provided in a user friendly manner.

Signed: Bill Lockhart Date: 23/1/13

Dr. Bill Lockhart

Chair of the Review Team

Signed: Helen Buckley Date: 17-12-2012

Dr. Helen Buckley

Chair, National Review Panel