National Review Panel

Review of the death of a young person who was in aftercare: Yvonne

August 2013

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) 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 National Review Panel. 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, and action plan. When the HIQA guidance was developed, it was envisaged that the NRP would need to review up to two deaths per annum and three to five serious conclusions, recommendations and an 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:

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 includes 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.

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.

Concise review: to be held **w**here 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.

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.

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. Yvonne

At the time of her death, Yvonne was in an after care setting where she had been placed by the HSE. This was a private residential setting for adults with intellectual disabilities and behaviour problems. She had been in care from the time she was five years old. She was initially placed in care on a voluntary basis and became subject to a full care order when she was eleven years of age and that situation continued up to her 18th birthday. Yvonne was described by those who knew her as funny and an excellent mimic, likeable, warm, good company and very attached to her family

She was nineteen years of age when she died. An inquest into her death recorded a verdict of 'misadventure'. The medical evidence produced at the inquest indicated that she died from an accidental drugs overdose. It was also noted that there were no suspicious circumstances surrounding her death.

5. Level and process of review

This was a major review where the Health Board and HSE had been involved with Yvonne from early childhood until the time of her death. The review team consisted of Deirdre Mc Teigue and Suzanne Phelan (chair of team) with input from Helen Buckley, Chair of the NRP. All of the team members are independent of the HSE and had no previous knowledge or involvement with Yvonne.

The review consisted of an analysis of fifty Health Board and HSE files relating to Yvonne and her family, written submissions and face to face interviews with staff and managers from a range of agencies, including the HSE and a number of voluntary organisations. A total of eighteen people were interviewed. There were also two site visits to the Special Care Unit where Yvonne had been placed on three separate occasions and the After Care Unit which was Yvonne's final placement. The HSE personnel interviewed included seven members of the social work team whose posts included those of principal social worker, team leader, social worker and fostering link workers, child care leader, aftercare worker, and childcare manager. Several of the people interviewed had held more than one position in relation to their work on the case. One of the social workers (Social Worker 5), declined the invitation to attend for interview with the review panel or to make a submission.

The Guardian Ad Litem appointed to the case was interviewed as well as the director and support worker from the private foster care agency who had acted as social worker and child care leader to the placement. Three members of staff were interviewed from Yvonne's aftercare service. A senior HSE manager was also interviewed.

Members of Yvonne's family were invited to meet with the review team or send submissions. Two family members, including one who provided foster care to Yvonne over a number of years, met the review team. The other invited family members declined.

6. Terms of reference

- To examine the services provided to Yvonne by the HSE and HSE funded services prior to her death
- To identify opportunities for learning arising from the findings of the review
- To provide a report to the HSE with conclusions and recommendations

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

Yvonne was one of a number of children born to her mother, here called Kay, some of whom had different fathers. Kay had been known to the Social Work Department (after this referred to as SWD) prior to Yvonne's birth; she and Yvonne's father were problem drug users. When Yvonne was five years old, she and all her siblings were received into the care of the then health board because of neglect. During the previous few years, it had been observed and documented by a number of professionals visiting the family that the children at times presented as pale, undernourished, poorly dressed, cold, dirty and often hungry. Their play and language at crèche was considered to be inappropriately sexualised. There was a delay of two years in admitting the children to care due to a shortage of placements. The parents had requested care on previous occasions but had subsequently changed their minds.

8. Services involved with Yvonne

- Two Health Board Social Work Departments (later the HSE).
- Public health nursing in early years.
- Gardaí at various points
- Child and Adolescent Mental Health Services (CAMHS)
- Special School
- Residential Units managed by both the HSE and private sector.
- HSE foster placements
- Private foster care agencies
- Special Care residential unit
- High Support residential unit
- Adult Mental Health Services
- Out of Hours Crisis Intervention Service
- Private Aftercare services funded by HSE
- Juvenile Detention Centre

9. Summary of Yvonne's needs during her contact with health board and HSE Children and Family Services

Prior to her reception into care, Yvonne suffered from neglect, and had unmet basic care needs including supervision, nutrition, warmth, hygiene, and clothing. She also needed to be in a safe environment, as evidenced by her sexualised behaviour, as well as stable parenting as evidenced by her difficult and disruptive behaviour.

Once in care, Yvonne needed a placement that could cope with her challenging behaviour. Her need for stability remained unmet until she was a young adult and she had more than thirty two care placements over her lifetime, as well as a number of respite placements. Her behavioural problems, which later included chaotic drug use, continued to cause difficulties.

Yvonne had an intellectual disability and required special educational provision. She had problems with comprehension; this meant that staff or carers interacting with her had to communicate in a way that she could understand. She also had mental health needs, and required mental health services all of her life.

Yvonne's final placement in an aftercare facility for adults with intellectual disabilities and behaviour problems appeared to meet her needs. She achieved goals and was working towards independent living while undergoing counselling.

10. Chronology of contact between Yvonne and her family and HSE Children and Family Services

Early childhood

Yvonne's mother was known to the then Health Board prior to her birth, due to her parenting difficulties with an older child. When Yvonne was two, the SWD closed the case on the grounds that the family were considered 'stable and secure'. A short time later, when they had moved to another area, concerns arose again with regard to drug abuse by both Yvonne's parents and its effect on the children. The parents presented repeatedly as being unable to stabilise their drug habit and there were on-going child welfare concerns. Professionals who visited the family observed that the children at times presented as pale, undernourished, poorly dressed, cold, dirty and often hungry.

Records showed that significant supports were put in place for the family, including a place in a crèche where staff remarked on their inappropriately sexualised play and language. However, further concerns were reported about the children's sexualised behaviour when Yvonne was between three and five years, this time by the school who also noted poor attendance and supervisory neglect, for example unattended injuries and inappropriate imposition of responsibility on young children. The social work record indicates that when the children's sexualised behaviour was discussed with their parents, they gave plausible explanations. There is evidence on file that the services involved with the family were very concerned about the children. For example the Child and Adolescent Mental Health Service (CAMHS) urged the health board to remove the children from their vulnerable situation, stating that they could not offer a service to the children unless this happened.

Records indicate that Yvonne's family lost their accommodation when she was four years old because of problems associated with their drug use, and social work records indicate that the SWD had decided to remove the children into the care of the health board around this time but were unable to place them despite numerous attempts to access foster homes. Yvonne was received into care on a voluntary basis when she was five, at which point she was suffering from scabies, head lice, impetigo, and nocturnal enuresis and displaying very challenging behaviour. A health board area medical officer who examined the children on entry to care commented that their condition was the worst she had ever seen.

Five to seven years; placement in foster care

Yvonne's first placement proved challenging for her foster carers due to the sexualised behaviour, knowledge and language that she displayed at home and at school. A formal child sexual abuse assessment was conducted shortly after her admission to care and concluded that she had probably been exposed to sexual behaviour, but that there was no evidence that she had been a victim of sexual abuse herself. Around this time, her parents separated. Regular access visits were arranged, but not always availed of by her parents, particularly her mother. School reports from that period described Yvonne as popular with her peers, but showing difficulty in concentrating, and constantly demanding attention and 'craving affection'. She was referred to CAMHS around this time. Her placement disrupted after eighteen months due her carers' inability to cope with her sexualised behaviour.

Seven to nine years; relative foster care

After her first placement broke down Yvonne, then seven years old, was placed in foster care with a

relative. From the beginning, there were concerns about her relative's ability to care for her. Within the first few weeks, a child care worker was assigned to assist her with parenting. Records indicate that the child care worker found it hard to enlist the support of Yvonne's relative carer in implementing any parenting regimes in the placement. Yvonne's behaviour was quite extreme, and her foster carer tended to respond by disciplining her physically as well as threatening her. The situation eased somewhat when Yvonne started in the local national school. Almost two years after Yvonne was placed with her relatives, it was decided to postpone the foster care assessment because of concerns about the relative carer's lack of suitability to foster. The review team were told at interview that despite reservations, Yvonne was left in this placement as there was no available alternative. Yvonne was referred to her local CAMHS, and referred from there to a school for children with behaviour problems. She was described at the time as very insecure, of low academic ability and very attention seeking.

Problems occurred in the placement around this time, when Yvonne's father moved into the household. There were conflicts between him and the relative foster carer over parenting, and some domestic violence. Yvonne began absconding to see her mother, becoming exposed to all sorts of dangers alone on the streets late at night. Although her father eventually left the house, Yvonne's relative foster carer allowed her to stay with him on occasions without informing her social worker. Around this time, Yvonne was seen in town begging with her father, who still had a significant drug problem. The file records that Yvonne told a relative about seeing her father naked on his bed. Her behaviour at school became even more disruptive at this time. A meeting in the foster home decided to continue the placement with monitoring. The review team were unable to establish the rationale for this decision, as there is no evidence for it on file and the social worker involved declined to meet the review team.

A series of events raised concern over the following year. Yvonne's father alerted the SWD that Yvonne was making sexual abuse allegations against him, which he denied. He claimed that these accusations had been orchestrated by Yvonne's mother in an effort to claim custody of her. Around the same time, Yvonne physically assaulted an elderly person residing in the house and threatened violence to her foster carer. Other worrying indicators included the fact that Yvonne was becoming unhappy in her father's presence at access, and anonymous complaints were being frequently made to the SWD indicating that she was at risk of sexual abuse by her father. Concerns were also expressed about the quality of care she was receiving from her relative carer. It was later revealed that those reports were made by extended family members. Other reports were made by the school about Yvonne's aggressive and sexualised behaviour. The allegations of child sexual abuse were not

addressed by the social worker at the time. It was decided at a Child in Care review to seek another placement. A memo on the social work file conveys an urgent message from Yvonne's social worker to the SWTL requesting an alternative placement.

Yvonne had a number of respite placements over the following weeks. She then disclosed for the first time to another relative that her father had sexually abused her. She was referred to a child sexual abuse assessment unit, and the outcome of their investigation confirmed that the alleged abuse had occurred. The review team have noted that the referral made to the unit contained only details of her recent disclosure and omitted to include her previous history of sexualised behaviour and concerns from family members which would have been of relevance to their assessment. At this point, Yvonne was finally removed from her relative's care.

Ten to thirteen years: Residential Care Voluntary Service and Special Care

Yvonne moved to a residential unit near one of her siblings when she was ten and remained there until she was twelve. She settled in very well initially and reported that she felt safe there being away from her father. Contact with her former relative carer was supervised. She continued to attend the Special School and was reported to be doing well. When Yvonne was eleven, her mother Kay renewed contact with her after a number of years' absence. Yvonne was very happy with her renewed contact. An incident subsequently arose where Kay removed Yvonne from the unit during an access visit. Up to this time, Yvonne had been in care on a voluntary basis, however following this incident, the SWD initiated legal proceedings and a full care order was granted.

After the positive start in the residential unit, Yvonne became very unsettled and frequently absconded, sometimes bringing other residents with her. She usually went to her former relative foster carer, who did not discourage her behaviour. Placement in a High Support Unit was considered. It is not clear to the review team why the proposed move to High Support was not followed through, according to those interviewed their recollection was that it was decided it was better for Yvonne to remain in the community based residential unit close to her sibling. After a brief improvement, her behaviour deteriorated once again. She had contact with siblings but at her own wish, did not see her father. She began self-harming around this time.

When Yvonne was twelve, Yvonne was placed in Special Care following an application to the High Court. The objective was to stabilise her behaviour, after which she would return to the same residential unit. In the referral letter to the director of the Special Care Unit from the SWTL stated

that; “This 12 year old girl has a history of absconding every night from 8.00/10.00pm and returning or being returned by the Gardaí every morning at 6.00/8.00 am. [Yvonne] is spending every night in the company of people who are involved in prostitution.”

Although her absconding and self-harming continued while in Special Care, Yvonne also engaged in some of the unit activities. She continued to attend her previous Special School where she managed satisfactorily. In the Special Care Unit, she found it difficult to interact and mix with her peer group. It was intended for her to ‘step down’ to her previous unit, but trial overnight stays were not successful, as she continued to abscond. She complained that no one liked her there apart from her sibling. It was decided not to return Yvonne to her previous residential unit but instead to seek an appropriate foster placement. Shortly afterwards, having spent six months in Special Care, she was placed with a foster family through a private agency.

Her case was reviewed by the High Court two months later, and her former relative carer told the court of her own belief that Yvonne’s father had never abused her. The Judge was critical of what he perceived as the lack of direction in the case and the fragmented approach adopted, and the lack of analysis of Yvonne’s needs, as well as the lack of effort to prioritise her treatment. He described a psychiatrist’s report as ‘sparse’ and ‘reluctant’ and claimed that none of the reports provided to him had allowed him to deal with the case as he would like to. The Judge went on note that Yvonne had now been placed with a family and expressed his hope that it would work out.

Twelve to thirteen years - Foster Family 3

For the first year of her new foster placement, Yvonne settled well. The location of the placement reduced opportunities for her to abscond as before and her carers went to considerable lengths to facilitate her continued attendance at the same school. She had contact with some of her siblings and her maternal grandparents and brief contact with her mother. She initially had no contact with her former relative foster carer, at her own request. In the meantime, the SWD was concerned at the lack of progress in the Garda investigation into the earlier allegations of abuse against her father. Four months after she was placed, a Child in Care review noted the improvement in her behaviour and commented that she had become calmer and happier. It was agreed that a local school placement could be sought for her for the following school year.

Problems arose a few months later when Yvonne contacted her former relative foster carer following an altercation with her current carers and complained about her placement. Following this, the former relative foster carer complained to the SWD about their decision to prevent contact between herself and Yvonne. It was noted by her psychiatrist shortly afterwards that while Yvonne

was as settled as she had ever been, the influence of her former relative foster carer was not helpful. In the psychiatrist's view, Yvonne was not suffering from a psychiatric disorder.

A Child in Care Review held two months later recorded positive feedback about Yvonne's progress in her placement, including her relationship with her foster mother and her change of school. However, she absconded shortly after the review whilst on an outing with her child care worker. It was suspected that Yvonne had spent the night with her former relative carer in her home. When the agency social worker went to collect her she was told by the relative carer that Yvonne was not there but she refused the worker access to the house. On the following Monday it was discovered that Yvonne had, in fact, spent the entire weekend with her former relative carer. At a meeting with social workers on the same day, Yvonne stated that she did not wish to return to the foster family and alleged that the foster father had touched her inappropriately on a number of occasions. She was subsequently interviewed by the Gardaí in respect of this allegation but refused to elaborate on her earlier statement. Yvonne was later assessed by the same child sexual abuse assessment unit as previously, but refused to engage with them. A year later the HSE reached the conclusion that her allegation against the foster father had been unfounded and the foster family were informed.

Thirteen to fourteen years:

Despite protests from her former relative carer, who wanted Yvonne placed back with her, the SWD placed her with another private foster family. During the following nine months she had thirteen placements, all of short duration. They included three placements through private foster care agencies, all of which terminated because the carers were not able to cope with Yvonne's behaviour which included self-harm, animal cruelty and sexualised behaviour. She had two HSE foster placements which both disrupted because of absconding and an allegation made by Yvonne against a male carer; two placements in emergency and out-of-hours services and a placement in a private residential unit which ended because of her absconding and attacking staff and residents. During this time, she was hospitalised three times due to alcohol consumption. A re- referral was made to Special Care at this point by an area based HSE senior management panel that had oversight of high risks cases. The application was not accepted as no onward placement had been identified.

Yvonne was placed at one point back with her former relative carer, on the basis that it would provide her with stability in the absence of any other placement, but similar behaviours caused it to terminate. Alcohol became a feature of Yvonne's behaviour at this point and she was hospitalised on three occasions for alcohol consumption. She made a statement to Gardaí that she had been

sexually abused by a friend of her father. She spent a number of nights on the street with homeless people and was attacked on one occasion. The extended family were again concerned as they felt Yvonne's relative could not cope and was concealing the reality of what was happening from the professionals involved. The placement with her relative carer was interspersed with further placements in emergency accommodation and further absconding. Ultimately, following a second application to the High Court Yvonne was again placed in Special Care with a private residential unit identified as her onward placement. Yvonne's perception of her family at this point was that her relative carer was the only one who cared about her.

Fourteen to fifteen years

Yvonne remained in Special Care for four months and then moved to a private residential centre. Initially she appeared positive about the move and spent a lot of time preparing for it in advance. Within a month, her behaviour deteriorated rapidly resulting in incidents of absconding and volatile and aggressive behaviours. This resulted in injuries to staff. The Gardaí were called on three occasions and had to remove her. On two occasions she absconded from school and was returned by the Gardaí. On another she went looking for her mother and found her, but was returned by the Gardaí following an altercation between herself and her mother. A number of supports were put in place including continued work with the community child care leader and referral to the local CAMHS. This placement broke down after two months and, in the absence of an alternative placement Yvonne was again discharged to her relative carer. There was significant concern on the part of social workers about her safety and protection from her father in this placement. However, it was considered that because of her limited intellectual capacity, she was actually safer in this placement than in the out-of-hours services. Over the following six weeks, Yvonne had at least twelve out-of-hours placements and for some nights her whereabouts were unknown. There is evidence that social workers made numerous attempts to find placements for her and linked in with her every day. She was then admitted to Special Care for a third time following an application to the High Court.

Sixteen to seventeen

Yvonne, now sixteen, spent the next fifteen months in Special Care. The file contains many incident reports, some relating to interaction with other residents or staff member, others to self-harming. Yvonne made some attempts to phone her mother and got no response; she described her life as "shit" at this time. Onward referrals were made to seven residential units, four of which were in the UK. None of these were able to offer a placement. A High Support Unit was also considered as an option.

However, at the same time, staff reported that Yvonne was making positive progress during her placement and was able to have regular off site access with her relative carer while supervised by staff. She attended a psychiatrist in CAMHS who stressed that she was not "presenting with a psychiatric disorder". A Family Welfare conference was held a few weeks after her admission, which concluded that her family were 'unable to offer a safe placement at this present time".

After nine months in Special Care an attempt was made to move Yvonne to a step down placement in a High Support Unit (HSU). However, this was unsuccessful. She was unwilling to engage with new staff and could not settle, her behaviour became dangerous and unmanageable and her discharge from Special Care was postponed. Records show that in a subsequent key work session Yvonne described "her time there as being a disaster". She described how she "had gone out every night and drank alcohol and took drugs". Around this time, a psychotherapist was assigned to work with Yvonne's relative foster carer in respect of the allegation that Yvonne had been abused by her father; her relative had serious difficulty accepting this possibility, eventually acknowledging that abuse may have occurred and linking this with his drug abuse but feeling unable to share that view with Yvonne.

Yvonne remained in Special Care for a further seven months. Ultimately, a decision was made to place her in a private residential facility where she would initially be the sole resident to be joined later by some other young people. An intensive series of introductions was followed and Yvonne was happy to move there at the end of her fifteen month placement.

Seventeen to seventeen and a half years

Soon after her admission to the private residential unit, Yvonne exhibited some very challenging behaviour which the staff found difficult to manage. Yvonne allegedly assaulted staff, was verbally abusive and threatening, self- harmed and refused medical attention. She also threatened other residents. Staff were able to use techniques to de-escalate the situation at times, but on many occasions they appeared to lack the skills to respond appropriately and Gardaí had to be called. Yvonne's feelings about her mother continued to act as a trigger for her difficult behaviour. Contact with her former relative carer continued but this was not always supportive, as the relative carer continued to apply pressure for Yvonne to live with her.

During this period, Yvonne had several admissions to a psychiatric unit, following suicide threats. The psychiatrist advised the unit that Yvonne should be brought to hospital when she was in a heightened state or threatening to harm staff. Records show that care staff were not properly briefed in terms of supervising medication, or on intervening with her suicide attempts.

Yvonne frequently absconded from the unit. In general, the Gardaí were cooperative with the unit when these instances arose. Staff had to continuously search for her at night, putting themselves at risk. Yvonne often ran to her relative carer, who was inconsistent in informing the unit when this occurred.

Yvonne had several positive contacts with her mother, Kay, during the first six months of her placement. However, Kay ultimately told her that she was going to terminate the visits because of her behaviour and the allegation she had made against her father. Yvonne found this difficult to handle and made continued attempts to contact her mother by phone, often resulting in further attempts at self-harm. After a further assault on staff, Yvonne was remanded by the Court first to a female prison and later to a Youth Justice Remand Centre for assessment. The review team were unable to access any information about this, despite requests to the remand centre.

Yvonne was held on remand for a six week assessment period after which she was discharged back to the residential unit. She resumed her absconding, including overnight absences. The required protocols were consistently followed by the unit when she went missing. At one point, the Gardaí contacted the unit to discuss Yvonne's frequent absconding and suggested that reports to the Gardaí might be restricted to occasions where she remained missing overnight.

There appears to have been little oversight by HSE management of what was happening for Yvonne at this time; staff were unable to intervene to prevent her from leaving the unit. On one occasion Yvonne claimed that she had been simply sitting in a park because she couldn't sleep. After two months of frequent absences without leave the residential unit decided to move Yvonne to a different location and secured a house in another county, where Yvonne had a single staff member caring for her. The move was successful and Yvonne was compliant and calm throughout. The HSE residential care inspectors were concerned by this move and sought the opinion of the Social Worker (11) who advised them of the SWD's view that the move had been in Yvonne's best interest. The unit manager subsequently sourced additional support from the HSE to help with Yvonne.

Yvonne's father died shortly afterwards. She spoke openly to staff about the sadness she felt about his death, despite their difficult relationship. The SWD considered that, as abuse of Yvonne by her father was no longer a threat, she may be able to stay with her relative foster carer with minimal supervision.

The residential placement was terminated very shortly afterwards because of an alleged serious assault by Yvonne on two staff which caused them to require medical treatment. Yvonne was

moved to her relative carer, who was advised about the risks of self-harm and overdoses of medication. Supports were put in place, including financial assistance and medical and psychiatric care.

Seventeen and a half to eighteen

Shortly after Yvonne's move back to her relative carer, a member of her extended family reported an incident where Yvonne had been intimidating and abusive to her carer; the reporter indicated that they had threatened to physically punish her if it occurred again. The social worker explained that threats of physical violence could not be condoned and advised them of Yvonne's need for reassurance about her safety in the house. This was acknowledged by her extended family member who retracted the threat.

The social work team had developed a wraparound service for Yvonne following her discharge from the private residential unit. A Child Care Leader continued to work with Yvonne and an After Care Worker (1) was also appointed to work with her with a view to engaging her in plans for education and training. This plan was being supported by her social worker, who was also seeking an appropriate after care programme for her.

The placement continued, but with a number of difficulties. Yvonne continued to abscond, a fact which was not always reported to her social worker by Yvonne's relative carer. Yvonne often missed the visits of the community psychiatric staff who called to give her medication. She did, however, attend the adult mental health services who reported that she was doing quite well. On one occasion, she alleged a kidnapping and rape, but Gardaí were unable to find corroborating evidence and judged her to be very drunk. The same pattern continued over the following weeks, and the SWD made an application on her behalf to a privately run facility for people with intellectual disabilities and complex behavioural difficulties such as aggression and impulse control. The service, which was expensive, appeared to be able to meet Yvonne's needs. She was accepted for the facility but could not be admitted until she reached majority, five months hence.

Yvonne's disturbed behaviour pattern continued over the next few weeks. After one particular episode, she was detained in a psychiatric unit for a week under the Mental Health Act 2001. She was discharged to another private residential unit, where she continued to engage in high risk behaviours and required intensive supervision. Her mother, Kay, renewed contact with her. Yvonne was quite excited by this and her social worker cautioned her to temper her expectations in respect of Kay, reassuring her that the previous breakdown in their relationship had not been her fault. She

was also assured of plenty of support from different staff in the unit and in the community. Despite these supports, Yvonne felt that she was not understood.

There is evidence that Yvonne's social worker went to considerable lengths to coordinate mental health services for her, as her move to a different residential facility had disrupted her connection with previous services. One of the psychiatrists who had previously seen Yvonne made a strong recommendation for on-going supportive care, pointing out that Yvonne was unable to manage her own moods and was reliant on the support of staff to move her from 'a low and hopeless mood to a more positive one'.

Eighteen years to eighteen and half years

When Yvonne turned eighteen, she was at last placed in the privately run facility for people with intellectual disabilities and complex behavioural difficulties. There was an initial delay because of difficulties in accessing funding for an aftercare placement. She was placed under special one to one twenty four hour observation for the first six weeks; this arrangement was repeated for a second six week period at the request of her social worker as Yvonne was finding the transition difficult and it was hard to complete the necessary required assessments. She went on a number of unauthorised absences but as she was over eighteen at this point and not detained legally, staff could not prevent her. They used a number of measures to discourage her from leaving the unit, which had limited success. On her return from some of these outings, she was tested for drugs and found to be using a mixture of illicit substances. Yvonne had also engaged in a number of incidents of self-harm, attempted self-harm and alleged assaults on staff. As a result the HSE made a significant financial outlay in order to provide the one to one observation to keep her safer, promote stability and allow for drugs testing at regular intervals. It was also believed that it would facilitate consistency and stability and help her to take part in the activities that were provided. Importantly it allowed staff to use different strategies to modify her behaviour.

Although a gradual improvement was noted, a review of probation conditions held six months after her admission found that Yvonne's behaviour had deteriorated, she was testing positive for drugs, breaking all probation conditions and presenting as 'not caring about anything'. A plan was developed whereby targets for behaviour were set over shorter periods. She was to attain more freedom if she adhered to the plan.

By the end of the summer, Yvonne had neither absconded nor self-harmed in three months, and for the first time engaged in the therapeutic process. She had only tested positive for illicit drugs once

over a four month period. All the staff noticed a difference in Yvonne; she had engaged in all the interventions, assessments and programmes. However, while she had been doing well overall, the placement was not without its difficulties and Yvonne continued to struggle with a number of issues including her feelings about her mother and the rest of her family which often made her sad. She continued to have urges to self-harm and use drugs. She was charged with assault and due to appear in court. Sadly, she was found dead a few weeks later. A coroner's inquest found that she had died through misadventure from an overdose of prescribed medication and opiates.

11. Analysis of involvement of Health Board/HSE Children and Family Services and Aftercare Services with Yvonne

In their analysis of the evidence obtained through interviews and written material, the review team has adopted an ecological framework which places the needs of the child in the centre and then works outwards to the child's extended family, the management of the case by professionals and any organisational issues that have national implications for practice and policy. This approach is based on the concept that the outcome in any system is influenced by the interaction of all these systems.

11.1 Yvonne

11.1.1 Initial response of services to early concerns

Yvonne's family were already known to the then Health Board at the time of her birth. When she was less than two years old, her parents' drug misuse and chaotic lifestyle gave rise to a lot of concern about their capacity to meet their children's need. As the chronology has shown, Yvonne's parents showed little motivation to change and the supports provided were evidently insufficient to prevent the circumstances of the children from deteriorating. Yvonne's parents requested care for the children at one stage, admitting that they could not cope. Despite the worsening circumstances of the children and the concern expressed by all the services involved, it took more than two years and four case conferences for the SWD to reach a decision to place them in care and the move was then further delayed by the lack of suitable placements. The physical condition of the children at the time was described by the Area Medical Officer as being the worst she had ever seen.

In the opinion of the review team, there was sufficient evidence to place the children in care at a much earlier stage, and the delay in doing so was excessive. The failure to source placements once a decision was made was also unacceptable. The review team inquired if any special efforts had been made to find a placement, for example, a specific campaign, but were told that nothing of that nature had been tried. The consequence of a failure to find placements was that children were exposed to neglect and abuse over an even longer period.

11.1.2 Assessment

There is little evidence of a full assessment of Yvonne's needs prior to, or after, her reception into care. Despite the input of numerous services, there was no evidence that her needs were identified, nor any documentation of the expected outcome of the interventions or any time frame in which improvement should have taken place. Consequently, the case was allowed to drift, even when her parents offered to relinquish the care of the children. When Yvonne's first foster placement disrupted, the relative with whom she was then placed was never assessed in respect of her suitability as a foster parent, or her capacity to manage Yvonne's already very disturbed behaviour. It is the opinion of the review team that failure to adequately assess Yvonne's needs when she was a small child undermined the prospects of compensating for the earlier serious deficits in her care, and contributed to her on going behavioural problems.

Yvonne's intellectual difficulties were not formally diagnosed until she was fourteen years old despite her significant engagement with CAMHS. This meant that she was often placed in situations where she could neither comprehend the restrictions imposed on her nor respond to the guidance that was provided to her and staff were unaware of her needs and the appropriate responses required. In the opinion of the review team, the lack of a comprehensive assessment of her abilities compromised the likely success of the various placements in which Yvonne resided during her late childhood and early teens.

11.1.3 SWD response to allegations of abuse made in respect of Yvonne

The review team is not satisfied with the responses made over the years by the SWD to allegations that Yvonne had been sexually abused by her father. Early signs indicative of sexual abuse were investigated by a child sexual abuse assessment service shortly after she was admitted to care. The investigation concluded that she had probably not been directly subject to abuse but had witnessed sexual behaviour. However, other worrying signs displayed by her at different times, after she had been placed in the care of the health board, were not addressed by the SWD. The review team has

found that numerous allegations that she was being abused by her father were conveyed to the SWD by extended family members. Others were made by a worker in a community based service and by her school. These continuous and frequent reports, which were made on an almost weekly basis at one point, were made more urgent by the fact that Yvonne had a lot of contact with her father whilst living with her relative. Despite this, the SWD did not actively consider the need to move Yvonne until she made a more explicit disclosure of abuse by her father two months before her tenth birthday. The review team were unable to discover either at interview or in reviewing the file why all the reported concerns of abuse were not taken more seriously at the time. The referral report to the specialist child sexual abuse unit did not reference any information regarding the concerns of sexual abuse made by family members

The response to an allegation made by Yvonne against the foster parent with whom she was living when she was thirteen was prompt and decisive. She was interviewed by the Gardaí where she gave very little information and was subsequently referred to a specialist child sexual abuse assessment unit, but refused to engage with them. The SWD ultimately concluded a year after Yvonne's complaint that the allegation had been unfounded but in the meantime Yvonne had been moved to another foster placement. In the opinion of the review team, opportunities to clarify the source of the allegation and efforts to salvage the placement were missed at the time.

11.1.4 Care Planning

The review team found serious deficits in the care planning in respect of Yvonne's placements. Her first placement in foster care disrupted because of her carer's inability to deal with her sexualised behaviour. The review team were told at interview that this couple had specifically said that they could not cope with a child who had been sexually abused, which raises the question of why she was placed there. The review team understand that the couple were experienced foster carers and it was hoped they would cope with the children's sexualised behaviour and that there were no alternative carers available at that time. Yvonne spent the following four years in foster care with a relative who had not been assessed, and whose capacity to foster was in doubt because of her health, age and ability to manage a child with special needs and sexualised behaviour. Only two Child in Care Reviews were carried out during this time, one of which was conducted even though the carer was unable to be present. Evidence provided to the review demonstrates a number of problems with the placement, including the carer's inability to stop Yvonne absconding at eight years of age, her inappropriate methods of discipline and the disruptive presence of Yvonne's father who was using drugs at the time. Other family members believed that this carer's divided loyalties prevented her

from accepting that Yvonne was at risk of her father, which put Yvonne at even further risk. As the chronology has shown, the fears of the extended family were realised.

There is evidence from the files that social workers visited Yvonne regularly whilst in the care of her relative, and some of them were seriously concerned about the quality of care she was receiving and advocated strongly to their line managers that Yvonne be moved. Yet, she was allowed to remain there for four years and re-placed there on several occasions. In the opinion of the review team, the judgement exercised by the SWD in respect of that placement was flawed. Instead of compensating for the chronic neglect that Yvonne had suffered prior to entering care, it exposed her to some very adverse experiences and may have added considerably to her difficulties.

Following the termination of her placement with her relative and after a period in Special Care, one of her most stable placements was disrupted by an allegation made by her against her foster father which was ultimately discounted by the SWD. The allegation had been preceded by a chain of events. Yvonne had run away while on an outing on a Friday with a child care leader. She was subsequently concealed over a weekend by her former relative carer who then brought Yvonne to a local Garda Station on the following Sunday night despite having told a social worker who visited on the Saturday she was unaware of her whereabouts. Immediately after she was returned to her placement, Yvonne made the allegation of child sexual abuse. In the opinion of the review team, this placement was terminated precipitously and may have been saved if a comprehensive appraisal of the allegation had been carried out. Yvonne subsequently entered a cycle of disruptions; her behaviour worsened and her placements frequently ended because she had assaulted staff members or other residents. It appeared that staff lacked the capacity to manage her.

While the various social workers involved with Yvonne engaged with directly, developed warm relationships with her and made considerable efforts to find care settings to suit her needs, it appears to the review team that much of the time the care planning was reactive, responding to crises as they arose. Yvonne had particular needs because of her learning difficulties and it is not evident from reports and files that these needs were understood in many of her placements, or that staff had the appropriate professional knowledge and experience.

An exception to this was the preparation involved in planning for what was going to be her final placement, which catered for persons of her ability and appeared to meet her needs. The review team noted the high standard of aftercare service provided to Yvonne, which included an aftercare worker who was well known to her and with whom she could engage as needed. The review also acknowledges the positive comments of the High Court Judge dealing with the case in respect of the

aftercare plan, including his view that the SWD had demonstrated innovative thinking in seeking solutions in a 'hugely difficult case'.

11.1.5. Yvonne's education

The most stable element of Yvonne's early years in the care of the health board appears to have been the special school to which she was referred by CAMHS when she was eight. She was able to continue attendance there over a number of placement changes including those in special care, and the review team commends the considerable efforts made by different staff involved in her care in transporting her to school and the school staff and foster carers for their continued support of her attendance there over six years

11.1.6 Response to Yvonne's mental health needs

Yvonne had mental health problems all of her life, and needed intervention from Child and Adolescent Mental Health Services. Her experience with the different services was mixed; the first team to which she was referred actively encouraged the health board to remove her to a safe place before they could engage with her. As it turned out, her subsequent placement was outside their catchment area so she did not ultimately attend their service. The next team were active in their involvement with her, placing her in a special school and providing parenting courses for her carer and her father. Overall, however, the mental health services provided to her at this point in her life varied in their response to her. One psychiatrist was criticised by the Court for the quality of their report. This particular service later refused to resume treatment with her when she moved back into their area on the basis that her placement was temporary. This was at a time when she had experienced multiple placement breakdowns and was feeling very low and her behaviour with her relative was going out of control.

Later, when Yvonne was fourteen and in Special Care, the CAMHS service contracted by the unit conducted a comprehensive assessment of her needs which clearly identified her intellectual disability and its link to her behaviour. The psychiatrist made recommendations which took these factors into account. The report suggested that the practical and social demands of her living environment should be compatible with her ability to respond; that her behaviour should be seen as a maladaptive strategy and should be dealt with as such, and that all interventions should take account of her ability. It does not appear to the review team that her later care placements were able to facilitate the recommended response. As Yvonne had numerous placements, she experienced many changes of service provision in respect of her mental health. In the opinion of the review team, flexibility on the part of services in continuing to see her despite her changes of

address could have been applied in an exceptional case such as this. The stability and consistency thus provided could have been valuable and prevented disruptive treatment.

11.1.7 Child centeredness

While the review has made a number of serious criticisms of the service provision to Yvonne in her early years, including a lack of placement planning, it has noted the significant commitment shown to her by individual staff from different services over the years. There is a sense from the material provided to the review that Yvonne was always the focus of attention and that at times of crisis workers were willing to go the extra mile to try and secure her safety and get her what she needed. There were many examples of direct work being carried with Yvonne by social workers and child care leaders including life story work and outings. It was evident to the review team that Yvonne was reassured by the response of the SWD to her disclosure of sexual abuse by her father. The fact that she felt believed gave her confidence that she would be protected from him. There is also a sense that she was shown affection and warmth by staff in different services, and that practitioners developed good relationships with her. The review acknowledges the great distress that her death must have caused those who knew her and worked with her.

11.2 Yvonne's family

While Yvonne was badly let down by her parents when she was younger, her extended family were interested in offering her support, and were consistent in their concerns about her over the years. One of her relatives offered her a home for several years, and for a number of years afterwards remained in contact with her and provided support to her. Placements within the family can be very beneficial for children needing alternative care; however they carry particular challenges, particularly given the complex connections between the family members offering care and the parents of the children who require it. Yvonne's behaviour was very troubled and challenging from an early age, and in the opinion of the review panel, the SWD should not have placed her with foster carers without first establishing that they had the capacity to meet her needs. As this review has already pointed out, no comprehensive assessment of Yvonne's needs had been conducted when she required placement at the age of five, and no effort was made to ascertain whether or not the second placement with her relative was the most beneficial arrangement. No assessment of the relative's suitability was ever carried out. The review panel find the practice of the SWD in respect of this relative placement deficient in several respects including:

- Failure to comprehensively assess Yvonne's basic needs as well as the particular needs that she had repeatedly demonstrated over the previous several years
- Failure to establish her relative's general suitability to act as a foster carer, including her mental and physical health, experience, attitudes, and her knowledge and experience of parenting and her relationship with Yvonne's parents
- Failure to estimate the capacity of Yvonne's relative to meet Yvonne's particular needs including her challenging and sexualised behaviour and her ability to protect Yvonne from further risk.
- Failure to act when concerns about the foster carer's ability to manage Yvonne and keep her safe were repeatedly and frequently brought to the attention of the SWD.
- Failure to respond to reports alleging that Yvonne was being sexually abused by her father, in the knowledge that he resided for a time in her foster home.
- Re-placing Yvonne with the same relative foster carer when it had been clearly established that she had been at risk of absconding and sexual abuse whilst previously living there.

In the opinion of the review team, the incompatibility of the relative foster placement with Yvonne's needs, as well as the fact that her loyalty to Yvonne's father sometimes obstructed her ability to keep Yvonne safe were serious issues that were never openly addressed with her relative carer. As a result the relative carer was left feeling aggrieved when the placement terminated. The review panel was given to understand that other members of Yvonne's extended family were willing to offer support at various levels. It appears that the possibility of an alternative relative placement was never seriously investigated.

On the positive side, the review notes the efforts made over the years to keep Yvonne in contact with her siblings and extended family. It notes the difficult relationship between Yvonne and her mother, and the efforts of social workers to try and help her to manage it.

11.3 Case Management

11.3.1 Child Protection

In the opinion of the review team, there was a considerable delay on the part of the SWD in acting to protect Yvonne and her siblings when she was referred to them as a two year old child. There appears to have been little or no evaluation of the effectiveness of interventions in improving the situation for the children. Opportunities to work in partnership with her parents who were requesting care for the children were missed. The fact that the children had to wait a considerable time for placements once a decision had been made about care denotes a service that was not child

centred. The review queried whether a campaign was held to recruit foster carers for the children or whether any efforts were made to attract the attention of senior management to what was clearly an urgent situation. They were not given any evidence that these actions had been taken.

Evidence provided to the review team indicated that there were numerous occasions when Yvonne as at serious risk while living with her relative carer, and in some of her later placements where she absconded regularly. It is the opinion of the review that these child protection risks received an inadequate response.

11.3.2 Compliance with regulations

Overall the compliance with regulations by the SWD was inconsistent. The 1987 'Child Abuse Guidelines' were in operation when she first came to the attention of the child protection services; these do not specify actions to be taken in response to neglect, but do outline the duties and responsibilities of social workers to take action in respect of children who appear to be at risk. In the opinion of the panel, the guidelines were not followed.

It appears that Children First guidelines, which were published during the period when Yvonne was in foster care with her relative, were not invoked on the occasions where Yvonne was found to be at risk, nor were any child protection conferences convened to pool information and make child protection plans.

As outlined above, Yvonne was placed with a relative foster carer who had not been assessed, was without references and had not been subject to Garda vetting at the time of placement. As a consequence, this placement was inconsistent with the Child Care (Placement of Children in Foster Care) Regulations 1995. She had no Care Plan for most of her time in care. When it became clear that her relative foster carer was unlikely to be approved, attempts at assessment were abandoned but Yvonne remained in her care for a further two years. Further non compliance with the regulations was evidenced by the fact that only two reviews were convened, one of which was held despite the fact that the carer was unable to be present. Later, when Yvonne was in Special Care, no statutory reviews were held. While internal reviews were held regularly in Yvonne's later placements, there is no evidence of Child Care plans up to the time she was seventeen years old. The lack of statutory Child in Care reviews meant that many opportunities to review Yvonne's child protection needs were missed. In the opinion of the review team, such non-compliance demonstrates lack of accountability on the part of the SWD.

11.3.3 Quality of Record Keeping

There are copious amounts of paperwork in relation to Yvonne on file. However, the records were poorly kept. Correspondence, reports, reviews and case notes were not separated but jumbled together in files. The files relating to the different children were not separated for almost ten years after Yvonne's admission to care and it is therefore difficult to identify the parts relevant to Yvonne. An improvement in record keeping is noted from the time that Yvonne was 16. Notes pertaining to her were kept in an individual file and the various papers were appropriately divided into sections.

11.3.4 Allocation of social workers

Yvonne was in care from the time she was five, and it was inevitable that she would have had a number of different social workers; she had ten overall. It must be acknowledged that changes of worker can impede continuity of planning. However, it must also be pointed out that she had an allocated social worker for almost all of her time in care with a reasonable amount of stability; she had two social workers for three years each, and three for two years each. The review team notes that any gaps between changes of worker were covered by social work team leaders. The review team also notes the huge commitment made by the social work department in general. Yvonne was never without a service and if a worker was on leave the case was always picked up by someone else with whom Yvonne was familiar. There is evidence of social workers going to significant lengths to find Yvonne on the occasions she went missing. Following her death the principal social worker and after care worker were very sensitive in ensuring Yvonne's siblings were supported in receiving the news.

11.3.5 Inter-agency meetings or cases conferences

Four case conferences were convened during the two years prior to Yvonne's reception into care. There were other critical points where inter agency meetings would have been provided opportunities for information sharing and planning that might have been constructive, but were not convened. The review notes that the allegation made by Yvonne which disrupted one of her most stable placements was not followed by a child protection conference, thereby possibly missing a crucial opportunity to recover the situation. There were many other instances where child protection issues arose in respect of Yvonne while she was in care. As pointed out earlier, the review team is of the opinion that when a child's safety appears to be at risk in a placement, a child protection conference is required. There is evidence of positive inter agency working throughout

Yvonne's life where social workers and child care leaders worked with staff from other agencies to try and secure a positive outcome for Yvonne.

11.3.6 Supervision

There is evidence of on-going supervision of the social work staff in the case. This was most evident latterly. The social workers, child care leader and after care worker who were interviewed all mentioned the support and direction given to them by their team leaders. However, no supervision notes were maintained on Yvonne's social work files.

11.4. Organisational factors

The review team has noted a number of organisational factors that influenced the course of this case which have relevance for HSE Children and Family Services at a national level.

- There was a lack of national guidance on the assessment of vulnerable children. As the review has pointed out, the needs of Yvonne and her sibling, and the impact on them of living with drug using parents in a chaotic environment was not ascertained when they were small children. As the children's needs were not identified in a structured way, there was no link between them and the numerous services that were put at the family's disposal. Nor was there any method of evaluating whether or not the children's situation was improving or deteriorating. Consequently, the children were left in a damaging and neglectful situation. The failure to assess Yvonne's needs and match them with an effective service contributed to the risk to which she was exposed in her second placement, where a specialist assessment concluded she was sexually abused and from where she regularly absconded. As the review has shown Yvonne's particular intellectual needs and comprehension were not comprehensively assessed until she was fourteen years of age and had considerable relevance for the choice of placement.

- Inconsistent compliance with child protection guidance and Child in Care regulations was allowed to continue without corporate oversight.

- There was an absence of corporate responsibility for responding to the needs of hard to place children. Looking back on the Yvonne's very unsettled care career, the lack of suitable placement options is very clear. This resulted at times in Yvonne being placed back into a

setting which had already been deemed unsuitable and a risk to her safety. The review team estimates that expenditure on a series of private foster placements and private residential facilities in respect of Yvonne was probably considerably more than on other children in care at the time. Yet, at no point was there any intervention from senior management in the HSE to investigate how care planning might be improved and value obtained from the substantial financial investment in placements.

- The review team has noted the absence of any system of corporate risk assessment for children in care

12. Conclusions

The review team has concluded that, whilst deficits have been identified in the service provided to Yvonne, no action or inaction by the health board or HSE Children and Family Services either directly or indirectly contributed to her death. In line with the ecological framework applied in the analysis, the conclusions are set out in relation to Yvonne, her family, case management and organisational and national issues.

12.1 Yvonne

Despite a considerable amount of investment, Yvonne's needs were not consistently met by the child protection services. There was too great a delay in bringing her into the care system when she was a small child. This meant that she was exposed to further episodes of serious neglect and attachment problems that undoubtedly influenced her behaviour difficulties in later life.

Failure to assess Yvonne's needs and the capacity of her relative foster carer to meet them resulted in an unsafe placement over a prolonged period, during which she was abused by her father. She was put at further risk by being re-placed with the same carer on subsequent occasions. Several of Yvonne's later placements did not meet her need for containment and stability. The fact that she had over thirty two placements is testament to this.

12.2 Yvonne's Family

Yvonne's own parents let her down, but members of her extended family showed commitment and concern for her. The child protection services missed opportunities to maximise the goodwill and protective actions of Yvonne's extended family, and mishandled the willingness of one particular relative to offer Yvonne a home.

12.3 Case management

There was a reasonable amount of consistency in social work provision, and many examples of commitment on the part of individual practitioners, However, the review has shown many other practice weaknesses, including delayed response to significant child neglect, failure to assess Yvonne's needs before and during her life in the care system, lack of compliance with guidelines and regulations; reactive decision making and failure over a number of years to respond to the serious risks to which Yvonne was subject while in the care of the HSE.

12.4 Organisational and national issues

The review concludes that there was a serious lack of oversight of this case from an organisational perspective. The HSE was willing to expend considerable resources on private placements for Yvonne, but paid little attention to the on going lack of a suitable facility for a child with such serious needs. The review also found a lack of national concern about children at risk in the care system.

13. Key learning points

The review has noted the following lessons arising from the findings

13.1 Yvonne

- **In her early years, when Yvonne was living with her parents, they were problem drug users, and the fact that they were neglecting her and her siblings was reported to the SWD.** It is now well established that parents who use drugs are less available to their children, particularly when other problems are present. A three to four year old left in such a situation is likely to be physically neglected, at risk of violence, suffer from delayed cognitive and language development, regressed behaviour, insecure attachment, inappropriate behavioural responses. They may be subject to abuse from being left in the care of unsuitable people. All of these factors prevailed in Yvonne's case. Protective factors may lessen the adverse effect but there were few in this case. Interventions were made by various services, but appear to have made little useful impact. Yvonne's very troubled journey through the care system shows that she was in

many respects a typical victim of the aforementioned adverse factors. The key learning from this is the necessity to make an informed assessment of a child's needs when presenting in such circumstances, to agree a very limited and well monitored time frame within which to measure the impact of interventions. The decision as to when a child's situation has reached an unacceptable level is critical and the threshold for action must not be dictated by the availability of a suitable placement.

- **Yvonne's placements were not always in settings where the carers had the capacity to deal with the child's needs and the measures that were intended to protect her actually put her at higher risk in some instances.** Yvonne's first placement broke down because her foster carers were unable to deal with her sexualised behaviour; yet this aspect of behaviour had been recognised before she was placed. This indicates that the placement was not matched to her needs at the time. As the review has shown, her placement with her relative was unsuitable in many respects. In later, private placements, staff did not appear to have the capacity to deliver the services for which they were contracted. Some of the difficulties Yvonne experienced on placement were related to her limited comprehension and intellectual disability and the fact that she could not always understand or respond to what was expected of her. This reiterates the importance of matching placements to a child's need.
- **Children may still be at risk even when in the care system.** An important learning point arising from this review is that the need for child protection vigilance does not cease when a child is placed in care. There were many instances where Yvonne was at significant risk while in different placements, from possible sexual abuse during her placement with her relative, and the risks inherent in absconding, to which she was subject on all of her placements. The same sort of child protection response is required when risks arise for a child whether they are in care or in the community.

13.2 Yvonne's family

- **Social workers should attempt to work in partnership with families.** Early opportunities to work in partnership with Yvonne's parents, when they requested care, were missed. Later opportunities to work with Yvonne's extended family who frequently expressed concern about her second placement were also missed.
- **Relative placements should not be viewed as a convenient option and the family's capacity to meet the child's needs must be ascertained.** Relative placements can be very beneficial for children in terms of providing stability and preserving a child's

identity. However, one of the key learning points from this review is that the complex history that extended family members share with a child's parents as well as the divided loyalties to which they may be subject can undermine the placement if not carefully assessed and managed. In this case, Yvonne was placed with a relative who had not been assessed or subject to Garda Clearance and reference checking. From the outset, it was obvious that she found it difficult to acknowledge that Yvonne's father posed a risk to her. She lacked parenting experience and was unable to manage Yvonne's very disturbed behaviour. The fact that the relative expressed concern and affection for Yvonne and showed willingness to take her into her home should not have precluded full consideration of her fitness to meet the challenges that the placement would involve.

- **Contact between family members and children in care needs to be carefully managed.**The benefits of contact can be diluted if family members are negative about a child's carers or have a tendency to undermine a placement in any way. Good practice dictates that if these risks are present, contact is carefully and consistently supervised.

13.3 Case management

- As the review has made very clear, the response to high levels of child neglect in this case was inadequate; it is known that neglect is the most harmful form of child abuse in terms of its longer term outcomes and its potential to impede a child's physical, psychological and emotional development including their ability to form healthy attachments. A key learning point for frontline practitioners and managers is the importance of appreciating all aspects of the impact of child neglect, and the urgency required to deal with it.
- Child neglect needs to be assessed in a holistic manner that takes account of a child's needs, the degree to which they are being met or otherwise, and the motivation and capacity of their parents to change to improve their parenting behaviours. It also needs to take full account of the impact of parental factors such as drug use. Importantly it needs to consider any special considerations in respect of a child such as a learning disability. Social work assessment should include information from all relevant professionals. When a specialist assessment is being conducted, such as in a child sexual abuse unit, social workers should provide a comprehensive range of information in order to assist them in their determination of whether or not abuse has occurred.
- Research on child protection practice has demonstrated a tendency for practitioners to adhere to fixed ideas about a child's situation and fail to challenge their original views.

The fact that Yvonne was being abused whilst under the surveillance of social workers, who were being regularly contacted by concerned relatives trying to draw their attention to it, is an example of how such practice can evolve. There is an important lesson in this case about the potential for children to remain at risk whilst in a care situation and the need to be vigilant. One of the purposes of supervision should be to regularly challenge the thinking of practitioners, particularly when there are any disconcerting indicators in the situation.

- **The function of business processes such as child protection conferences or Child in Care Reviews is not simply to fulfil bureaucratic requirements.** Such mechanisms are intended to make the system more efficient. Child protection practice is complex and unpredictable and requires a level of rationalisation in order to avoid drift and dangerous practice. The absence of formal processes and lack of compliance with regulations in this case contributed to the lack of direction in Yvonne's care planning and meant that the risks to which she was subject were not picked up or addressed. The relative success of Yvonne's aftercare reflects the amount of planning that went into its preparation.

13.4 Organisations at a national level

- The lack of suitable placement options in this case was a recurring theme. While there is evidence that workers tried very hard to accommodate Yvonne, there is no sense of corporate concern about a child that was so difficult to place and who had to resort to very unsuitable provision at times in the Out of Hours service. While Yvonne's needs remained unmet over many years, the HSE spent a great deal of money on emergency placements in private agencies but did not appear to command any accountability in return for the expenditure.
- The fact that some children can be put at further risk by the actions that are taken to protect them has not been recognised at a corporate level, and it seems to the review team that there is an onus on senior management to not only acknowledge it, but to put in place a protocol for escalating and addressing concerns that a child's safety may be threatened by the nature of their placement.

14. Recommendations

The review makes the following recommendations in line with the ecological framework adopted for the analysis of findings:

The child

- The HSE/CFA should implement an assessment framework that is sufficiently comprehensive to encompass a child's unique circumstances and special needs.

Extended families

- Relative foster carers need to be assessed to the same standard as non relative carers. In addition, they need to receive training and support in line with the unique demands that caring for the children of a relative can bring. HIQA inspections should demonstrate the degree to which this recommendation is implemented.

Case management

- Compliance with child protection procedures and statutory regulations should be enforced. The outcomes of future HIQA inspections will demonstrate the degree to which this recommendation has been implemented.

The HSE/CFA

- The HSE/CFA should establish a risk management system to respond to situations where children in care are found to be at risk
- The HSE/CFA should establish a system whereby responsibility for accommodating the needs of a hard to place child can be shared at a corporate level.
- Guidance should be developed in respect of child protection risks of children in the care system; a protocol to address such risks should be developed
- The HSE/CFA should establish a memorandum of understanding with CAMHS to ensure that children in care get continuity of service within reason if they have to move placement.

Signed: **Date:**

Suzanne Phelan

Chair Review Team

Signed: Date:

Dr Helen Buckley

Chair National Review Panel