

**Review undertaken in respect of the death of Nicholas,
a young person known to the child protection system.**

March 2014

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 eighteenth 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 and began its work in August 2010. The NRP consists of an independent Chairperson, a Deputy Chair, and approximately twenty independent members with relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and receives administrative support from the HSE. When a death or serious incident fitting the above criteria occurs, it is notified through the HSE to the office of the National Director of Children and Family Services 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 will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. Depending on the nature of the case, one of the following types of review will be conducted.

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 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.

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.

Internal review: Under *Children First: National Guidance for the Protection and Welfare of Children*, all areas should conduct a review where a child in receipt of services has died. Internal reviews should be sent to the Chair of the National Review Panel. In certain circumstances, e.g. where the death has been from natural causes, or where the death or serious incident has more local than national implications, the internal review, once quality assured by the National Review Panel, may suffice and the NRP will not conduct one.

4. Child Death or Serious Incident

This report concerns the service provided by HSE Children and Family Services to a young person, here known as Nicholas, who died suddenly and unexpectedly aged 17. The Coroner's Court determined that his death was due to misadventure. The cause was respiratory failure brought on by the consumption of what proved to be a toxic combination of drugs.

5. Nicholas

Nicholas lived with his father, here called Philip, with whom he had a strong friendship, and saw his mother, here called Denise, regularly. He was described by persons who knew him in a professional capacity as, "charming, pleasant and agreeable", "charismatic", "sensitive and caring", and "a lovely boy". He was fondly remembered by the social workers and teachers who had engaged with him and who were shocked and saddened by his death. While he had not applied himself academically he was said to have shown an interest in, and an obvious aptitude for, art. Nicholas became a father, a

role that he appeared to welcome and tried hard to fulfil, despite his immaturity. His partner and child lived nearby and he had frequent contact with them.

6. Level and Process

This is a comprehensive review. It was carried out by Dr Bill Lockhart, Deputy Chair of the NRP, and Professor Ian O'Donnell, member of the NRP with editorial input from Dr. Helen Buckley, Chair of the NRP. The timeline upon which the review principally focuses is the five years prior to Nicholas's death. While contact with the Social Work Department (SWD) was more longstanding it was during this time that the breakdown in his parents' relationship became permanent, that he disengaged from school and became involved in crime and anti-social behaviour, that he was taken into care, that he became a father, and that his substance misuse began to cause serious concern. Given the impact of his early life experiences on him, the review inevitably has to comment in passing on the earlier response of the child protection services.

The evidence for the review was obtained from written HSE records (including social work intake forms and a summary report, case notes, minutes of child protection conferences and review meetings, applications for residential care, and correspondence between the SWD and other services); interviews with HSE staff and written submissions from same; interviews with care staff at the supported housing project where Nicholas lived; interviews with a manager and key worker at the high support unit where he spent several months; an interview with Nicholas's father and a member of his extended family; and a report of the coroner's inquest. Nicholas's mother and one of his siblings were invited to interview but did not attend. Transparency and equality of treatment was given to all HSE employees involved in this case. All interviews were audio-recorded and transcripts were made and retained by the NRP.

7. Terms of Reference

The review team adopted the following Terms of Reference:

- To examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice.
- To provide an objective report to the HSE.

8. Background and Reason for Contact with Child Protection Services

The original reasons for contact between Nicholas and the child protection services were neglect due to parental conflict, Denise's alcohol misuse, and family homelessness. When these issues were successfully addressed through the separation of his parents and the provision of supported accommodation to his father, himself and his siblings, Nicholas remained at risk on account of poor school attendance, a caring but disorganised home environment, deepening involvement in anti-social behaviour, and drug misuse. While the risk factors may have changed over time what remained constant was the identification of Nicholas as a child who required a high level of intervention.

9. List of Services Involved

- HSE Children and Family Services. A social worker was allocated to the case from 2002, when Nicholas was eight years of age and continuously thereafter. Prior to this he was dealt with on a duty basis.
- Housing charity. Supported temporary accommodation and long-term housing for a short period when Nicholas was 10 and continuously from when he was 11 until his death aged 17.
- An Garda Síochána. Juvenile Liaison Officer. Intermittent involvement from age of 12.
- National Educational Psychology Service (NEPS). Assessment carried out when Nicholas was 13.
- Voluntary child care charity. Referrals for family therapy when Nicholas was 13 and again when he 14.
- Local counselling service 1. Contact established with a view to family therapy when Nicholas was 13 but discontinued on account of non-attendance.
- Intensive youth programme run by voluntary agency. Placed on priority waiting list when he was 14 but this came to naught.

- Family Support Service. For one year when Nicholas was 14.
- Special education project. For one academic year (September to May) when Nicholas was 14.
- Child and Adolescent Mental Health Service (CAMHS). Appointment made when Nicolas was 14 but he refused to attend.
- Teen parents support programme. Referral when Nicholas was 14 and his child was due, but he was not interested.
- Community-based programme. Nicholas dropped out after one week, aged 14.
- Youth Action Project. Two appointments made when Nicholas was 14 but neither kept.
- High support unit. Nicholas attended for five months when he was 15.
- Youthreach. Nicholas was enrolled for almost one full academic year (September to April) when he was 16.
- Local counselling service 2. Appointment made for counselling for anger management when Nicholas was 16. He did not attend and follow-up letters elicited no response. He had attended two years previously for a single session.
- Residential training centre. A referral was made when he was 17 but he did not attend.

10. Brief Summary of Nicholas's Needs throughout his Contact with HSE Children and Family Services

Domestic environment

SWD records show that throughout his life Nicholas experienced a great deal of domestic upheaval. His mother was an alcoholic and his father a chronic opiate user, later stabilised on methadone. Evidence provided to the review team indicated that their capacity to provide effective parenting, individually and as a couple, was severely limited. This meant that Nicholas grew up without consistent boundaries or adequate supervision in an environment which was often unhygienic and

where his diet was poor. For several years the family was of no fixed abode and this added to the sense of turbulence. There was conflict between his parents with Denise behaving violently towards Philip on several occasions in the presence of Nicholas. He was regularly exposed to parental substance misuse and intoxication and sometimes to direct physical abuse. This was an uncertain, hazardous and sometimes threatening environment for a young child who needed stable accommodation, a good diet and a safe home.

Education

While punctuality and attendance were perennial problems given his chaotic home circumstances, family members reported that Nicholas fared well in primary school. His experiences at second level were not happy, either for himself or the teaching staff with whom he came into contact. He was prone to outbursts of aggression and tearfulness, was regularly suspended, and eventually exited mainstream education aged 13. He attended specialist services for early school leavers sporadically for a time but left before he attained the legal school leaving age and without any formal qualifications. Nicholas needed to attend school regularly and to receive learning support and psychological assistance there.

Drug treatment

Given that exposure to drug and alcohol misuse was a constant background feature in his life the professionals who worked with him were not surprised that Nicholas began to drink and to experiment with drugs at an early age. He was known to smoke cannabis regularly, sometimes in the presence of his father and, on several occasions, had become dangerously affected by the products of so-called Head Shops. Living in an environment where drug taking and addiction are normalised makes abstinence extremely difficult, regardless of the supports available outside the home. Nicholas needed drug prevention work which took account of his own developing problem and of the family context in which he was growing up.

Coping with being a father in his mid-teens

The challenges associated with successful parenting are significant, even for the most emotionally stable, financially secure and thoroughly prepared adults. For children who find themselves in this

situation the challenges are multiplied and intensified. The situation for the teenage mother is well understood and there is a range of support services available. But the child father can find himself somewhat adrift, especially if he is keen to play a role in the life of his son or daughter. Social workers and family members shared the view that Nicholas wished to be a good father, but his circumstances – financial, emotional and domestic – made this very difficult to achieve. As one of them put it during interview, “he didn't really have a chance in life from day one.” Nicholas needed support to enable him to develop effective relationships with his girlfriend and child.

11. Chronology of Service Involvement with Nicholas and his Family

Early years

According to social work records, Nicholas was referred to the SWD when he was five years old because his mother, with whom he and his siblings resided, and who at that time was temporarily separated from his father, was not providing adequate care or supervision. Reports were received from concerned neighbours that he was being left at home without adult supervision and that he was missing school. His personal hygiene was being neglected and his clothes were dirty. These reports were dealt with by the duty social work service for two and a half years. This meant that once an immediate response was made to each referral, no further action was taken until the next referral came in. Nicholas had allocated social workers thereafter, from when he was eight years old, until his death.

Denise was drinking heavily at that point and was receiving treatment for depression. Nicholas had witnessed intravenous drug use and an act of serious violence in his mother's flat. The family lived in Bed and Breakfast accommodation at a variety of locations before being offered supported temporary accommodation when Nicholas was 10 years old. Difficulties arose with neighbours and, as a result, the family was given notice to quit and returned to the Bed and Breakfast sector. The family moved back to the supported housing project the following year but Denise's alcohol consumption continued to be problematic and after an allegation that she had physically abused Nicholas she left the family home on a permanent basis. Social workers were visiting the family regularly at this time.

When he was older Nicholas told a social worker he had come to trust that he had been locked into a room for long periods during his early childhood without access to food or toilet facilities and that he had been beaten by his mother. Philip was hospitalised at one point following a psychotic

breakdown that was believed to have been induced by substance abuse. He was also medically unfit having undergone a major surgical procedure.

These were very difficult times and there were serious concerns for the child's safety given his parents' substance misuse and residential instability. The Gardaí were on notice to remove Nicholas from his mother if she was discovered drunk in charge and to notify the SWD immediately. Denise spent some time in prison during this period for fraud. Nicholas's older sibling drifted away from the family home and was sleeping rough. He became involved in crime and later ended up in custody.

The risk level was high at this stage of Nicholas's life and his domestic circumstances were deemed to be inappropriate but the question of placing him in care did not appear to have been considered. It was suggested to the review team by a close relative that this may have been because of the support he was receiving from members of his extended family who were concerned for his welfare. This relative said that she lived nearby and "was like a second mammy to the boys ... I helped [Philip] to feed them and dress them, everything, you know."

Entering adolescence

The family was still living in supported accommodation when Nicholas entered his teens. Social work records show that he came to the attention of An Garda Síochána in his early teenage years when he was found carrying a knife which he claimed was for self-protection. This did not lead to criminal proceedings. Social Worker 1, who was allocated to Nicholas for three and a half years, described to the review team how this was an upsetting time in his life on account of his mother being required to leave the family home after assaulting him. This assault was reported to An Garda Síochána but did not lead to a prosecution. While Denise and Philip had been separated before, this time the split was final and several interviewees told the review team that Nicholas felt responsible because he had reported the incident which led to his mother's forced departure. There was also upheaval caused by a change of address, albeit within the confines of the sheltered housing project where they resided. These factors combined to ensure that the transition to secondary school was not a happy or successful one. Having done well in primary school there was a marked deterioration in his commitment and performance when he entered the senior cycle. Nicholas was referred by his school to the National Educational Psychology Service for a comprehensive assessment because of his "defiant and aggressive behaviour" towards pupils and teachers. His conduct was variable and a report written at the time noted that on occasions he "arrived in school and wept uncontrollably".

The social work file contains reports from school staff who felt that Nicholas had reached “bursting point” and he was suspended on numerous occasions.

The detailed report prepared by NEPS, which was shared with the SWD, concluded that the extremes of behaviour exhibited by Nicholas could be attributed to his domestic circumstances rather than any underlying learning difficulty, although his reading ability and verbal comprehension were very poor. The report recommended a reduced timetable so that Nicholas’s difficulties with reading could be addressed; exemption from Irish; access to a special needs assistant; and the drawing up of a behavioural contract and plan which stipulated what would be deemed to constitute acceptable conduct. The social work file indicates that the school did not have an opportunity to implement these recommendations because Nicholas’s attendance had become even more intermittent.

When Nicholas left mainstream school, aged 13, he attended a special education project. Initially he engaged quite well but after a few months he refused to participate, arrived late or not at all, and was angry and aggressive, leading to his suspension. According to social work records, he stopped attending completely after an allegation of theft.

A social work report for a case conference held during this phase of his life described Nicholas as “very much at risk ... confused, vulnerable and emotionally fragile”, and in imminent danger of spiralling out of control in the absence of effective intervention. A referral letter written by Social Worker 1 to a local counselling service stated that he required “urgent therapeutic intervention”. The fact that he was living with his father in supported accommodation with a range of services available on site, some aimed at children (such as a breakfast club and afterschool activities) and others at an older age group (addressing drug and alcohol addiction, relationship difficulties, physical and mental health problems) offered some hope that the level of risk could be monitored and perhaps reduced. Every family living in the project had an allocated support worker. The SWD arranged supervised access for Denise but on occasions Nicholas would skip school in order to spend time with his mother, including some overnight stays. These encounters were believed to contribute to his emotional instability and volatile behaviour. Social Worker 1 recounted at interview that, while she felt she had won Nicholas’s trust initially, “it was hard to build a relationship with him because the mum was very anti-social work and ... she was anti-me as well ... [Nicholas] didn’t want to upset his mum by having a relationship with me.”

Parenthood

Allegations of theft were made against Nicholas, then aged 14, around the time that he found out he was to become a father and it was suggested in the social work records that he may have been attempting to acquire some of the resources that would be required to support his child. As he lacked both a job and any realistic prospects of attaining one, his ability to save money was extremely limited. Despite these practical concerns he was very pleased at becoming a father.

Social workers attempted to identify appropriate services and to connect him with them. He was referred for psychiatric assessment at his local CAMHS but did not attend. He was enrolled on a programme for teen parents but did not take up his place. He was on the priority waiting list for an intensive youth programme run by a voluntary agency but was resistant to the idea of becoming involved. He was referred to a community-based programme but dropped out within a week. Social Worker 1 tried to overcome his resistance to availing of these options, but without success. Social Worker 3 experienced the same problem, describing to the review team, how “When I spoke to him about linking him in with services, he just went blank, he said he’d talk to me but that would be it.”

This was another challenging period. Aged 15, Nicholas was found in possession of a gun and drugs. Gardaí accepted that these items did not belong to him and that he was storing them for someone else. As a result criminal proceedings were not instigated. He was arrested twice in the months following this seizure; neither incident resulted in a court appearance. There was a clear escalation of risk. Social work files revealed that there were reservations about Philip’s ability to provide appropriate parenting for Nicholas given his own long-term drug dependence. Social workers and the housing charity which provided accommodation for the family expressed concerns that Philip was smoking cannabis heavily and openly in the home, which further impeded his ability to support and supervise his son as well as exposing him to regular drug use. The extent to which Philip’s drug use went unchallenged by the staff involved in the case was striking. An interviewee who was involved with the supported housing project where he had lived for many years commented that, “He was using an inordinate amount of cannabis, I would imagine...and tablets.” He also kept his prescribed methadone at home for daily consumption.

After a child protection case conference when Nicholas was 15, Social Worker 1, who was in regular contact with the family, recommended that Philip should no longer have sole responsibility for Nicholas’s care. The conference was attended by Philip and one of his siblings as well as by representatives of the charity which provided housing to the family, the Youth Action Project, and the SWD. As a result, a decision was made that he should be placed in care.

The Emergency Local Placement Committee deemed him to be unsuitable for mainstream care. An application for special care was made by Social Worker 1. This acknowledged that a family member had come forward to offer to care for Nicholas but concluded that the view of the SWD was that he could not be managed in the community at that time. The family member in question felt that her views had not been taken seriously enough because her domestic circumstances were such that Nicholas would not have had his own bedroom. The application also reported that a family placement would be considered as part of a discharge plan and that Philip, but not Denise, agreed with the need to apply for special care.

The National Special Care Admissions and Discharge Committee, which deals with applications for special care from across the country, determined that Nicholas did not meet the criteria for placement in a special care unit. In the letter outlining this decision it pointed out that “this is the first residential placement being considered for [Nicholas] ... and all other non-special care options should be attempted before a special care placement is considered.”

The only remaining option was considered to be a high support unit (HSU). One of the two possible HSUs had no space and a long waiting list and when contacted by Social Worker 1 it stated that even if a space had been available it would not have been offered. The letter which conveyed this news explained its decision in the following terms: “... there was unfortunately little indication from the referral to support the view that [Nicholas] would be likely to engage with the service to the level needed to support an admission ... it would not have been appropriate to offer [him] a place in [HSU] at this time.” The other HSU was prepared to consider the application.

The stated reasons for the HSU referral were the same as those outlined in the unsuccessful application for special care, namely:

1. Nicholas was outside of adult control. He left the house at will and was sometimes absent for a number of days.
2. There were ongoing concerns regarding his emotional and mental health.
3. He was a risk to himself due to his inability to control his anger.
4. He was a risk to others due to his anger and his involvement in crime.
5. He would not accept support or help.

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Furthermore, and adding to the level of risk, the files show that Nicholas had exited the educational system at this point. He frequently smoked cannabis. He had a young child and his home circumstances remained chaotic. His father had disengaged from the SWD, his drug use was escalating and he had been given notice to quit his tenancy with the effect that the family was facing homelessness again. At this stage the options for Nicholas were extremely limited. It was too risky to leave him at home, especially given the likelihood that he would soon be of no fixed abode. He was not considered suitable for mainstream residential care or special care. It was not clear if there was a space at a HSU that would be made available to him. Social Worker 1 went to great lengths to address Nicholas's needs, and to reduce the level of risk he posed, by securing a successful HSU referral for him.

High support

When Nicholas visited the HSU to be assessed for admission, he was reported to be a "very enthusiastic young person" who "impressed the staff" with his determination to change his ways. He settled in well initially and made steady progress. Staff at the unit described him as "helpful", "extremely likeable", "courteous and polite" and his application was accepted.

HSU staff recounted during interviews with the review team that the strain of being apart from his infant child, and his inability to communicate effectively with his child's mother on the telephone, led to a deterioration in his behaviour. As one staff member put it: "Being away from them [partner and child] was very difficult for him. And equally we were trying to balance that with allowing him to be a child as well ... that was his constant struggle throughout the placement ... being here, being a young lad and having fun and craic and equally the responsibilities of being a parent." He absconded in the second week of his placement but returned. He settled in for a while thereafter and his father made regular visits to the unit, staying the night so that they could spend time together. Nicholas wavered between wanting to stay on the unit to speaking negatively of what was on offer, damaging property, and displaying an aggressive and dismissive attitude towards staff. There were concerns that he was using cannabis, and sharing it with other children, as well as drinking alcohol. Staff contacted Gardaí and Nicholas was discovered to be in possession of cannabis. This impacted adversely on his relationships with staff on the unit and led to the initiation of court proceedings which were not concluded. Nevertheless, there was a view that he was benefiting from the service and during his time at the HSU he completed several Further Education and Training Awards Council (FETAC) modules. After five months he failed to return from a visit home and neither Nicholas nor

his father attended a closure meeting when it was arranged. The SWD files show that several attempts were made to hold a Child in Care review but that it was cancelled initially and then postponed. There is nothing on file to confirm whether such a review which, according to the regulations must be carried out within two months of the placement taking effect, eventually took place.

One relative expressed the strong view to the review team that Nicholas had been sent to the HSU against the wishes of his parents and despite the extended family's desire to provide accommodation for him and to share the burden of care with his father. In the opinion of this interviewee the time spent away from home was the cause of a significant and sustained downward spiral in behaviour. As she put it: "Down there [HSU] he got involved in a lot of drinking and drugs ... When Nicholas was took off his father he completely changed." This view was not shared by other interviewees and the written records indicate that the father agreed with the decision to admit his son to care.

A written staff review of Nicholas's time at the HSU raised concerns about his alcohol consumption, poor appetite, mental health, reluctance to participate in meetings, anti-authority attitude, and incidents when he deliberately damaged property. On the plus side, the review team was told by care staff and teachers at the unit that he got on well with the other children and took pride in his personal appearance. Another positive development occurred during this period, namely that the notice to quit that had been served on Philip was overturned. The housing charity that provided his supported accommodation permitted him to continue residing there and the threat of a return to homelessness was lifted. This removed a potential source of major instability from Nicholas's life. Social Worker 1 told the review team that his time at the HSU, especially the initial phase, had been good for Nicholas, "they seemed to get him ... they recognised that this was a vulnerable young person ... there was a change in him ... there was a motivation for him to change his life, to do something with his life".

Later teens

Not long after quitting the HSU Nicholas enrolled in Youthreach with the support of his social worker. Initially he did well but then became disruptive in class, non-cooperative with teachers and arrived late or not at all. He was believed to be smoking cannabis before coming to school and, following an incident with another young person, he was asked to leave. He continued to see his child frequently and their relationship was very positive.

Due to growing concerns about drug consumption and at-risk behaviour a residential placement was sought by the SWD with the agreement of both parents. Attempts to deal with what Nicholas acknowledged to be a growing cannabis dependency through the services offered by a local project, which provides a community-based response to drug misuse, did not progress because he failed to attend appointments. His drug use became increasingly problematic. He had begun to indulge heavily in a range of substances, especially the so-called 'legal highs' that were available from Head Shops, and there were concerns that he was becoming a danger to himself. Gardaí came upon him staggering near traffic along the side of a road and removed him for his own safety. When searched he was found to be in possession of drugs (a sizeable number of bags of 'Snow Blow'). Two weeks later he was found on a dual carriageway, again under the influence, disorientated and stepping in front of oncoming vehicles. He collapsed and was assisted home. There was more evidence of criminality with SWD records revealing court appearances for shoplifting, theft of a motor cycle and possession of drugs. He was smoking cannabis on a daily basis. He was subjected to a court-ordered curfew and was smoking cannabis on a daily basis.

A child protection case conference was convened around the time of Nicholas's seventeenth birthday at the instigation of Social Worker 2, who had been allocated his case eight months earlier. The purpose of the conference was to consider the needs of Nicholas and his younger sibling. It was attended by both parents, several members of An Garda Síochána, the National Education Welfare Board, SWD, housing charity which provided accommodation to Nicholas, and the school principal. The only invitee who did not attend was a representative from an intensive youth programme run by a voluntary agency. The minutes of the conference show that the main concerns were around criminal activity and drug use, inadequate parental supervision, overnight absences at unknown locations, and that when the SWD put plans in place with Nicholas's parents these soon broke down. The conference concluded that another high support placement was required.

The Children's Resource Panel which considered the application agreed that his needs could not be met within mainstream residential care but was unable to offer any high support facility. The Children's Resource Panel recommended that an application be made for special care and that, in the interim, staff would seek to work with him on an outreach basis.

Social Worker 2 told the review team that she was not clear whether this decision was due to the unavailability of a place or Nicholas's unsuitability for such a placement: "They just said that they didn't have a high support unit that would meet their needs and suggested I apply for secure care. And when I mentioned that to my team leader he put his hands in the air and said 'How can you go straight from home to secure care? What High Court is going to, you know, allow that?'"

There was considerable variation between the view taken by the child protection case conference (that high support was urgently needed) and the opinion of the resource panel (a special care order should be sought) and the eventual outcome (the continuation of community outreach). This was dispiriting for those who were working closely with Nicholas and desired a proportionate response to what they perceived as an increasingly risky situation. As Social Worker 2 expressed it during interview: "They said they didn't have a [place in a] high support unit. I felt, rightly or wrongly at the time, that I was being fobbed off." There seemed to be a lack of transparency around an important decision-making process with the result that the social worker could not say why their application was rejected.

The case was reallocated shortly afterwards to Social Worker 3. After review by the SWD it was decided not to pursue the special care option for two reasons. First, Social Worker 3 expressed the view that Nicholas's behaviour "had improved dramatically ... and he had gotten a job with a paper round." Secondly, the same social worker observed that Nicholas had an infant in whose life he was involved and this was an important consideration when the question of a residential placement was reviewed: "That's number one. Obviously my main job is to try and keep family, especially with teenagers, together, especially when they have a child ... and he's wanting and is actively involved in that child's life." As a result it was decided to concentrate on identifying appropriate community supports so that Nicholas could remain at home and help raise his child. A report from the housing charity indicated that he was spending more time at home and had withdrawn from an antisocial peer group.

Social Worker 3 continued to make efforts to link Nicholas with appropriate services. Like the previously allocated social workers he found it difficult to meet with Nicholas who would not answer his telephone or make himself available during home visits. He told the review team that, "[Nicholas] would jump over the back wall when I would call to the front door. So I think it was about six or seven home visits before I actually got him." Social Worker 3 visited the home on a fortnightly basis. In the months before he died he referred Nicholas to a residential training centre but despite his initial enthusiasm he declined to engage on the grounds that he was not prepared to avail of an opportunity that would make access to his child problematic. In the months leading up to his death Nicholas was speaking of a return to school so that he could prepare to take some state examinations. Given his previous experiences of formal education this was an ambitious and perhaps unrealistic plan.

Nicholas spent his final evening socialising with friends and he fell asleep in their company. When he could not be roused the next morning, assistance was summoned immediately and arrived swiftly but he could not be resuscitated.

12. Analysis

12.1 Initial response of the SWD to referrals concerning Nicholas

Despite concerns about Nicholas being neglected and abused (both emotionally and physically) and Philip's obvious inability to care for himself, let alone any dependents, the emphasis of social work intervention was on maintaining the family and attempting to build Philip's parenting capacity. Philip was assessed as being loving and kind but, given his poor health and chronic drug problem, he could not provide adequate care. The review team believes that it was ambitious to think that he might be able to do so in the face of much evidence to the contrary. One consequence of supplementing his prescribed medication with heavy cannabis use was that Philip slept a lot. When awake and alert he lacked a sense of proportion regarding his children's behaviour and enforced few meaningful boundaries. He was described during interviews as forgetful, routinely missing appointments and failing to honour prior agreements. While there is no suggestion of any malign intent, this lethargy and ineffectualness was to the detriment of Nicholas who, as a child, required a clear and consistent routine as well as his father's care. The review team would therefore question the strategy of maintaining Nicholas (and a younger sibling) with either or both parents given the complexity and long-standing nature of their needs and the clear evidence of neglect. The review team would also question why this situation was allowed to persist over many years.

Several interviewees expressed a strong view that Nicholas should have been taken into care much earlier. One commented that he "should never, ever, ever have been left with either one of the parents". The family did not share this view, believing that a strong bond existed between Nicholas, his younger sibling and father and that this was a solid foundation for good family life. As one of them put it, "he had discipline over them and they respected their father." There was no doubting Philip's love but nor was there evidence that he could cope. As someone who had worked with him extensively commented in interview, "His capacity to parent was very, very limited. While there was a lot of love, there wasn't the appropriate care that the boys needed." The chaotic and criminal lifestyle of Nicholas's older sibling, while not the subject of this review, should in the opinion of the review team have added significantly to the concern regarding the prospects for Nicholas.

12.2 Assessment

Children First specifies a number of key tasks that are involved in the assessment of a child about whom welfare concerns are believed to exist. These include establishing (in conjunction with the child and parents or carers) whether there are grounds for action, eliciting views from any professionals involved with the child and family, specifying the nature and severity of risks, and identifying strengths and protective factors that might lessen risk. If an initial assessment reveals a valid concern and unresolved child protection issues a child protection case conference should be requested. The purpose of the conference is to facilitate the sharing and evaluation of information and the formulation of a plan. The plan should identify risk factors and specify strategies for their reduction. It must be reviewed periodically. The review team believes that the requirements of *Children First* were complied with and that Nicholas's case was regularly assessed during the period under examination. However, when the plans that emerged from these assessments did not have the intended effect matters were allowed to drift, with a piecemeal rather than strategic approach being taken to issues as they arose and became pressing.

12.3 Compliance with Regulations

The HSE Social Work Department and other agencies are bound by legislation such as the Child Care Act 1991, the Children Act 2001 and the Child care (Amendment) Act 2011. These are implemented through a range of regulations (such as the Child Care Regulations, 1995), policies and practices.

In reviewing Nicholas's case in its entirety there was good evidence of the SWD complying with the requirements of *Children First*. Unfortunately this did not always lead to the best outcomes. This was often not the direct fault of the SWD but was due to some underlying problems. As outlined in section 11 above ('Later Teens') it was clear that there were differences in the views of a child protection conference and the opinions of the children's resource panel. It is not clear how these differences – which are frustrating for the social workers involved – could be resolved.

One result of a child protection conference should be a clear and robust child protection plan. This includes the need for contingency planning. It appears that in Nicholas's case a number of decisions of the child protection plan were allowed to drift.

The Child Care (Placement of Children in Residential Care) Regulations, 1995 require that cases of children in care are regularly reviewed by the SWD. The first such review must be carried out within

two months of a child being placed in a residential centre (s. 25 (1) a). Thereafter, reviews are required at intervals of no more than six months for the first two years. The views of the child are a necessary part of this review process (s. 25 (5) a) and a note of every review that is undertaken and any associated actions, must be included on the child's case file (s. 25 (7)). It was not clear from the files available to the review team if a Child in Care review was ever conducted after Nicholas was admitted to the HSU.

12.4 Quality of practice

12.4.1 Interaction with the young person and family

The interaction between Nicholas, his family and the SWD was good and multifaceted. There was frequent contact by telephone and through home visits. A particular strength was that the family lived in sheltered accommodation where there was a lot of support on hand and easily available. In the absence of this support Nicholas's safety would have been much more seriously compromised. Philip was met with regularly and supported by the SWD and the staff of the supported housing project where he lived. The evidence in the files suggests that Denise had a hostile attitude towards social workers but she was met with occasionally to arrange supervised access to Nicholas and to discuss whether he should be placed in care. While there was frequent contact, the files indicated that plans seldom came to fruition and when they broke down matters drifted until the next crisis arose.

12.4.2 Child and family focus

The social workers who had responsibility for Nicholas worked very hard on his behalf and when they perceived the level of risk to be escalating were prepared to seek his removal from the family home. However, it could be argued that too great an emphasis was placed on supporting Philip who was clearly incapable of coping. In this regard the practice was insufficiently child centred. It is also an example of over-optimism in spite of the prevailing evidence. Central to the way that this case was handled was an unwavering commitment to keeping father and son together, despite evidence that this might not have been in the latter's best interest. Contact with the children's mother continued although concerns about her alcohol consumption persisted.

Social Worker 3 articulated a view that was shared by others, observing in interview that, "You know dad, like he has a history of drug use, there would have been concerns that he would have been

smoking cannabis in the house and Nicholas would be smoking with him ... it was kind of like the two of them were friends more than a father and son relationship.” The potential harmfulness of such an arrangement for the child was not fully addressed.

12.4.3. Quality of recording

The notes were extensive and relevant. Upon examination they yielded a detailed overview of the challenges faced by Nicholas over his life course and the variety of steps taken to support and protect him. There were no major gaps or discrepancies in the coverage. Several of the summary reports were particularly helpful, including the local review document produced following Nicholas’s death.

12.5 Management

12.5.1 Allocation

There was continuity in allocation. Each of the allocated social workers seemed well briefed and committed and was suited to the task in hand. One interviewee emphasised the range of issues involved in social work with children and suggested that there might be a need to allocate specialist adolescent social workers who would have knowledge of local services suitable for teenagers: “We do need specialist teams that work specifically and have resources specifically for that age group ... that’s the missing link. It’s very difficult to work a case load of very young children or very young babies and then also work with the teenagers, who are exceptionally demanding.”

12.5.2. Supervision

The social workers who were interviewed generally seemed to have been supported and adequately supervised. Social Worker 1 commented, “We had a lovely team, like colleagues and everything, brilliant.” Social Worker 3 described receiving good support from an experienced team leader: “We do actually more than what’s standard in terms of supervision.” The review team did not have access to supervision notes so cannot say to what extent social work practices such as maintaining a child in with a parent who lacked the capacity to care for him and where drug use was the norm, were challenged and alternatives proposed.

12.5.3. Inter-agency collaboration

The collaboration between the housing charity and the SWD was excellent. The interests of the family were taken seriously and they were offered a wide range of services in a high quality and structured residential environment. Even when the family's conduct was such that eviction proceedings were initiated this was handled in a clear and supportive fashion with the various options clearly set out and the underlying rationale well articulated.

Some concerns were expressed by Social Worker 1 regarding communications with An Garda Síochána. Information exchange was problematic and there were practical difficulties eliciting a response to telephone calls and correspondence.

12.5.4 Case conferences and inter-agency meetings

Family welfare conferences and child protection case conferences were well attended. However, there were some concerns regarding the criteria underpinning decisions, especially those of the Children's Resource Panel, and there were significant delays between the identification of a problem, the formulation of a plan, and implementation. For example, when Nicholas was perceived to be presenting an excessively high risk, a child protection case conference was arranged, but it was postponed for more than five months. When it eventually met and a decision was made to seek a high support place another four months elapsed before the place was made available. The review team believe this to be an inordinately long time for all of the parties directly involved to have to wait for action. For a child in a crisis a measured and prompt response is essential.

When Social Worker 1 approached two high support units regarding the possible availability of a place for Nicholas one deemed him to be unsuitable and stated that it would not have offered a place even if one was available, while the other admitted him. The review team was puzzled by such a divergence of opinion, especially considering the range and seriousness of the risk factors that were present.

13. Conclusions

On the basis of the evidence available to it, the review team has reached the following conclusions:

- Nicholas was allowed to remain for too long in an environment where drug misuse was the norm and where his father could not adequately meet his needs. These obvious hazards should have been addressed more directly by the SWD. Because his father was passive, well-liked, and relatively amenable this did not become as pressing an issue as it should have and despite the obvious inadequacy of the domestic environment matters were allowed to drift.
- Had a decision been made to admit Nicholas to foster care or residential care or to place him with a relative this would need to have occurred at a much earlier age than the period covered by the review. The services made available to him could not compensate for the neglect he experienced from parents who did not have the capacity to provide adequate care, and his childhood exposure to domestic violence and substance abuse.

14. Key Learning Points

No direct link has been found between practice in this case and Nicholas's very sad death. However the review team has noted a number of points that are worth reflecting upon. The team did not speak to the social workers who had involvement in the case during Nicholas's early childhood but several of those who worked with him in the years before his death felt that there was a strong argument for taking him into care much earlier. The lack of a thorough assessment at this stage proved problematic in the long run.

14.1 Child safety

Keeping methadone, and to a lesser extent other prescribed medication, in a home where there are children, especially when it is known that the children are beginning to use a range of drugs themselves is problematic. In supported accommodation there may be greater scope to address where medication is held and consumed than under different living arrangements. Alternatively, liaison with the GP with a view to methadone being taken where it is dispensed may be advisable

when there are children at home and parents are not taking advantage of the opportunity offered by maintenance to play a constructive role in their lives.

14.2 Child centeredness and the assessment of parental capacity and motivation to change

There comes a point beyond which it is futile to persist with attempts to create appropriate relationships with parents, with whom strong bonds of affection exist, but whose capacity to support their children is severely limited. The longer this unsatisfactory state of affairs is allowed to persist, the more detrimental it is to the child's welfare, and the more difficult it becomes to resolve. Too much energy was spent supporting Philip to exert control, which he was clearly incapable of exerting, rather than supporting Nicholas to remain in school, avoid exposure to drugs and crime, and develop into a responsible adult. Denise was abusive and posed an immediate and obvious threat to her husband and children. After an assault on Nicholas she was required to depart the family home. Philip was permanently drowsy, or asleep, and while not a threat was incapable of discharging important parental duties such as ensuring that Nicholas got to school on time, was adequately nourished, sheltered from drug use, and could learn what constituted the limits to acceptable conduct. In the opinion of several interviewees Nicholas would have been better off in care than having to live in this home environment. There were particular concerns about allowing a drug-dependent father to live in temporary bed and breakfast accommodation with two children for an extended period. The review team shares these concerns and believes that earlier intervention may have been more productive.

14.3 Fixed focus and undue optimism

The *Child Protection and Welfare Practice Handbook* (HSE, 2011). sets out quite detailed guidance to social workers and their managers. For example, it lists risk factors in child protection, such as domestic and sexual violence, parental mental health and parental substance misuse. All of these were pertinent in Nicholas's case. The *Handbook* highlights the importance of assessing parenting capacity, the importance of multiagency involvement in assessment and supervision and evaluating child and family progress. It warns against having fixed ideas and being overly optimistic, such as adhering to one hypothesis regarding a case irrespective of other information available that might refute that hypothesis (e.g. the idea that improving a family's accommodation would automatically lead to the resolution of other problems).

14.4 Working with children who are parents

There are difficulties creating effective relationships with adolescents who do not wish to reciprocate. These are exacerbated when the child has become a parent and feels that they deserve to be treated as an adult. There may also be a need for social workers to develop their skills when working with adolescents more generally especially when there is a history of self-harm or drug misuse.

14.5 Supporting bereaved families

A close relative of Nicholas told the review team that it was regrettable that neither Philip nor his surviving children had been offered counselling after their bereavement. In this light it might be considered helpful to offer counselling to bereaved families, especially younger siblings. If this is not accepted at the time it would be prudent to renew the offer when the anniversary of the death or the young person's birthday is approaching, whichever occurs first.

14.6 Tracking

A young person will almost certainly need additional supports when returning home from a highly structured environment to one that is highly unstructured. Any gains made during a period of high support can quickly dissipate in such circumstances and, to prevent this happening, a mechanism of short-term tracking / monitoring could be considered.

14.7 Speed.

A lengthy period between calling a child protection conference, obtaining a referral for high support and gaining a place is unacceptable. If a child is genuinely at risk of harm then appropriate services must be made available quickly. The same applies to the waiting period for the intensive youth programme run by a voluntary agency. If a young person is prioritised they should not have to wait for an excessive period before being offered a place. This is especially true for a child or young person who is ambivalent, or hostile, to the idea of accepting support where delay may serve to copper fasten resistance.

15. Recommendation

The review team recommends a review of the mechanisms by which applications for special care are processed. The decision to request special care is not taken lightly by the SWD and there is a great deal of work required preparing the documentation required for such an application and bringing the various parties together. If such a request is denied a clear rationale should be provided to the social worker who initiated the process. Indeed the whole interface between applications for high support and special care and the decision makers is in need of review to ensure that it is operating in the best interests of effective child protection.

Dr. Helen Buckley

Chair National Review Panel

March 31st 2014