National Review Panel

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

December 2012

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Review undertaken in respect of the death

of Robert, a young person known to the child protection system

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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 and recommendations. 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 Robert, who had been in the care of the HSE and living with relatives for the previous seven and a half years. Robert committed suicide when a young adult. A coroner's inquest linked his suicide with 'recent use of multiple drugs'. Robert was described by people who knew him as likeable, funny and popular and 'a little charmer'. It was also noted, however, that he was not easy to know and found it hard to trust people. The review team was told that he appeared to have something troubling him during the weeks prior to his death although no specific issues were identified.

5. Level and Process

This is a comprehensive review. It was led by Dr. Helen Buckley, Chair of the NRP, assisted by Professor Ian O'Donnell, member of the NRP. The timeline upon which the review focuses is divided into different phases, from early childhood until Robert's admission to care, and the period from admission to care until his death. The evidence for the review was obtained from written HSE records (including case notes, legal orders, fostering contracts, referral forms, placement reports, correspondence and a care plan); a report, which was requested by the review team from a child sexual abuse assessment service; interviews with HSE staff; and interviews with members of the deceased young person's family. Some written submissions were also received. Transparency and equality of treatment were given to all HSE employees involved in this case. All received documentation informing them of the fair procedures being adopted.

It must be pointed out that the review was conducted within some limitations. Much of the earlier contact between the Social Work Department (SWD), Robert and his family, which took place over twelve years ago, was conducted by different duty social workers, none of whom had any involvement beyond single meetings. The first allocation of a social worker to the case was when Robert was ten years old, and that worker, known in this report as Social Worker 1, subsequently left the HSE and the country. Apart from one letter from a social worker telling Robert's foster carer that she was leaving, there are no records to show which social workers, if any, were allocated between then and the time Robert was sixteen, and there is no evidence at all on file of their involvement. As a consequence there is no information about Robert or his placement for a five year period during which he was in the care of the HSE. The review panel contacted the two social workers who were allocated to Robert when he was sixteen and seventeen years old respectively. They are known in the report as Social Worker 2 and Social Worker 3. They worked on the case for approximately one year each. Social Worker 2 came to meet the review team, but there are very few records of her work on file and a dearth of information regarding events during that year. Social Worker 3 came to meet the review team. The social work team leader who had supervised Social Workers 2 and 3 also came to meet the review team. Two further social workers were allocated to Robert when Social Worker 3 left the HSE but they never met him; the worker who took over the case four months before Robert's death came to meet the review team, but she had never met Robert. Social Worker 4, who was the fostering link worker allocated to Robert's last foster family had left the HSE before the review started. He heard about the review and came to meet the team on his own initiative.

The review team invited two managers who had been involved at different times for interview. One manager, who had been involved when Robert was eleven years old and had chaired the only child protection conference held on the case, attended for interview but had no memory of the case and had been unable to locate any records kept at the time. The other staff member, who had been a social work line manager from the time the case was first referred twelve years ago until a short while before Robert's death, responded to the review team's invitation by saying that the young person was known to them in name only and had not been considered to be at risk, and that they felt they had had nothing to offer to the review. This manager was subsequently invited to make a submission about the organisational context which prevailed during this period but did not do so.

There are no records whatsoever about Robert's first foster placement which lasted five years. The review team was unable to ascertain much information about the foster carer or any events during the period between Robert's late childhood and early teenage years when this person was caring for Robert. This foster carer was invited to meet the review team but did not respond to our letters.

Other relatives who later fostered Robert were invited and attended for interview. Robert's mother was invited to meet the review team. Her social worker arranged to pick her up at the appointed time but she changed her mind on the day and did not attend.

The records delivered to the review team were incomplete. There are no notes from Social Worker 2 on file apart from some letters and a transfer summary which was unsigned though apparently written by her. Social Worker 2 acknowledged to the review team that her records were incomplete, but she believed that she had placed more notes on file than those received by the review team, and would have referred to them in writing her transfer summary. The last social worker who was actively involved with the case, here called Social Worker 3, has since left the HSE. She viewed her social work files on the case prior to meeting the review team. She told us that she believed that case notes that she had written were omitted from the files. The social work team leader who supervised Social Worker 3 told us that in her view, material was missing from a number of the files in the area, and she also recalled that Social Worker 3 had been 'fastidious' about her paper work and expressed surprise that there was so little evidence of that in the files. We raised this matter with the SWD in the relevant area and received further case notes, however, these were duplicates of the material already in the files. We were informed by some of the staff we interviewed that many files in the area were missing.

6. Terms of Reference

The review adopted the following Terms of Reference:

- To examine the service provided to Robert prior to and following his admission to care, and after his formal period in the care of the HSE had ended.
- To identify any deficits in the provision of services to Robert, as well as examples of good practice.
- To provide a report to the HSE National Director of Children and Family Services.

7. Background

Robert was the eldest of his siblings. His father died before he was born, and for his first eleven years, his main carer was his mother, here known by the pseudonym of Maureen. Maureen had a partner who lived with her and her children for several years. While he was in his mother's care, Robert spent periods of time with her extended family and also stayed for weeks at a time with another family living in their neighbourhood.

Robert first came to the attention of the HSE when he was five years old because of an allegation that he had been sexually abused by a person known to his mother. The allegation was not confirmed. Robert again came to the attention of the Social Work Department (SWD) two years later in the area where he was residing with his mother, Maureen and her partner, because of alleged neglect and physical abuse. Three years later Robert was admitted to the voluntary care of the HSE along with his siblings. He was just over eleven years old at this point and according to notes on the social work file, he disclosed serious neglect and physical abuse and witnessed severe domestic violence. Maureen gave her consent for Robert and his siblings to remain in the care of the health board. No further access was facilitated between him and his mother until he was eighteen years old. He was placed with two separate family members, the first for a period of five years and the second for two years. At around sixteen years of age his behaviour, which included the use of alcohol and drugs, became very challenging. His placement with his first foster carer eventually broke down and he moved to live with another family member before his seventeenth birthday. During the following two years, his social worker (Social Worker 3) attempted to engage him with different services; he attended Youthreach and met regularly with a Probation & Welfare Officer. He was also offered treatment for his drug use but declined it and continued to use drugs. Robert was offered an aftercare service by the HSE when he reached his eighteenth birthday and was said to have declined it on the basis that he would remain living with his extended family. The review team was told that he made contact with a counselling service prior to taking his own life in late 2010. His suicide appears to have been pre-meditated. He rang a number of family members on the morning that he took his life; he told one that it was 'time to go to sleep for good' and asked another to look after his grave.

8. List of Services Involved

- HSE Children and Family Services. There were three separate areas involved, here called Area A, Area B and Area C. Robert's mother, Maureen, grew up in Area A, and her extended family remained in the area. Maureen, had lived for a period in Area B and had some contact with the SWD there when Robert was six years old. She subsequently moved to homeless accommodation in Area C with her children, and it was while they were in this area that the children were taken into HSE care and placed in Area A. Responsibility for the case remained with Area C.
- The public health nurse in Area C was involved with the family while they lived there.

- A social work team dealing with homeless families was involved when the family lived in Area C. Their main purpose was to assess and prepare the family for permanent accommodation.

While Robert was in foster care in Area A, he had contact with the following services:

  - Extern: Robert had a four-day respite placement at age sixteen years prior to the breakdown of his first placement.
  - Drug treatment service for young people (YODA); the start of Robert's engagement with a youth drug treatment service is not documented, but he was discharged from the service when he was sixteen years old, having stated that his drug use was under control. His file there was closed six months later.
  - Probation & Welfare Service: Robert was involved with this service for the seven months prior to his eighteenth birthday.
  - Youthreach: Robert attended Youthreach for the eighteen months prior to his death.
  - HSE Psychology/counselling service: Robert was in contact with this service a few months prior to his death. There are no records of whether or how often he attended. He was over eighteen at the time.

9. Brief Summary of Robert's Needs Throughout his Contact with HSE Children and Family Services

It has been difficult for the review team to document Robert's needs, as there is nothing in the case records to suggest that they were canvassed at regular intervals or taken into account when planning his care. In fact, it was difficult, from the records, to get any sense of Robert as a person particularly, when he was younger.

From the evidence in the file and interviews conducted as part of the review process, it can be inferred that from an early age, Robert's basic physical, emotional and psychological needs were not adequately met. An allegation that he had been sexually abused at the age of five was investigated by health board social workers and referred to a child sexual abuse assessment service, but was never fully resolved. Between that time and his entry into foster care, Robert suffered regular physical abuse in the form of beatings from his mother's then partner who also verbally abused him. The disclosure of this abuse, made by both Robert and his mother to a child protection social

worker, was corroborated in this review by interviews with a neighbour of Robert's extended family who had befriended him as a young child, as well as by Robert's own extended family. According to social work records, both Robert and his mother disclosed that all the children witnessed her being beaten. She acknowledged that the children were aware that she and her partner injected drugs and had seen drug-related paraphernalia around their flat. It appears that Robert suffered significant trauma during this time and lived in a very unsafe situation. In addition his school attendance was erratic.

The social work files show that at the age of nine, Robert was reported by a member of the public to have been malnourished looking, with dirty clothes. His school attendance was intermittent. It was reported by his grandmother that between the ages of nine and eleven he used to travel on his own from his home out to the area where his mother's relatives lived, and around the same period a medical social worker reported an allegation that he sometimes slept rough. From this it can be surmised that his needs for supervision and safety as well as education were not met.

From the above evidence which came from social work records, corroborated by information received in interviews, it can be concluded that by the time Robert was received into care, he had considerable physical, emotional and psychological needs. He suffered serious trauma, had lacked stability and security, and his education had been disrupted. The only formal attempt to identify his needs as a young child was recorded in the one Care Plan in his file, developed when he was eleven years old after he had been received into care. This noted his need for stability and security in the long term, and it also noted a need for counselling, and remedial teaching. There is no information on how or if Robert's needs were met during this time, but when he reached the age of sixteen, problems with drug and alcohol abuse became evident along with anti-social behaviour. As the review will show, his foster carers' capacity to meet his needs was never assessed, and they were not given any guidance or support during the first five and a half years of his placement.

10. Chronology of contact between HSE Children and Family Services and Robert

This chronology is divided into a number of phases, starting with the years prior to Robert's birth and his early life.

Family Background and Early Childhood

Although this review is focused on Robert's life, it is necessary to consider some earlier background information on his mother, Maureen, and her family in order to provide a context for some of the issues that have been of concern to the review team. Briefly, Robert's maternal family, i.e. his mother (Maureen), aunts and uncles, were known to the SWD in Community Care Area A as children over a number of years from the late 1980s in respect of different reported concerns, including suspected physical and sexual abuse, mental health and behaviour problems and school attendance. These matters were discussed at different times with their parents (i.e. Robert's grandparents) who denied that their children were at any risk, and indicated that they did not want any services from the SWD.

Prior to Robert's birth, Maureen alleged to a public health nurse in Area A that she had been sexually abused by her father over a number of years. However, there is no record that any investigation followed this allegation. When Robert was around four years of age, his mother repeated the allegation to staff in both maternity and mental health services, stating that she was concerned about the safety of those of her siblings who still lived with her parents. At this time, she had just given birth to a child and had been admitted as an inpatient to a psychiatric hospital. This allegation was the subject of a case conference in Area A. The conference concluded that 'there is a child protection issue here for other children in the household' and recommended that the matter should be pursued with An Garda Síochána. However, there is no indication that the matter was further explored and Area A closed the case within a few months, terminating their involvement. The case conference noted that there were no concerns about Maureen's parenting. Although the review team was told by Robert's grandmother that she was aware that Maureen was making these allegations, there is no evidence that she or her husband were officially informed of them by the relevant SWD at the time. The allegations were common knowledge in the family, and were consistently denied by Maureen's father with her mother firmly supporting her husband's denials.

While some of the above events took place prior to Robert's birth, and prior to the first reports about him to the HSE, they are relevant to this review, as Robert was later placed in foster care with his mother's extended family.

When Robert was five, his mother Maureen self referred to the SWD in Area B, where she was residing at the time. She reported that Robert had told her that he had been sexually abused by a person known to them and living in Area A, which was where her extended family lived, and where

Robert spent some time and occasionally stayed overnight. It should be noted that she was not alleging that the perpetrator was her father, but someone else.

The available records indicate that Robert was referred to a child sexual abuse assessment service. There was no record of the assessment on the social work files received by the review team; we subsequently approached the assessment service directly and they obliged us by providing a report. Their report indicated that Maureen had described what seemed like a credible disclosure on Robert's part, but that when he attended his first appointment he was restless, and unclear as to why he was attending the service, so the interview was of an exploratory and introductory nature. Follow up appointments were offered but not kept, so the assessment was never completed. There is no evidence that the alleged perpetrator was informed of the allegation or investigation at the time, though the Area B social worker had apparently been told by Maureen that the alleged perpetrator had been challenged about his behaviour by a member of Robert's extended family. According to the report from the child sexual abuse assessment service, Maureen had made a statement to the Gardai about the allegation. However, there is no record on file that the matter was pursued by the Gardai. According to the report sent by the assessment service, the Area B social work team attempted to continue the investigation but were unable to locate Maureen and Robert. They would have been in possession of, or could easily have obtained the address from Maureen's extended family but did not appear to use this channel to find her or Robert. The assessment service report also notes that Maureen had told the SWD in Area B of her own alleged sexual abuse by her father, but there is no evidence on file that this was followed up by the SWD even though there were young children still living in the family home.

According to a social report in the file, Robert and his sibling were left by their mother at the home of her extended family in Area A about two years later and stayed there for a few weeks. Robert became friendly with a boy of his own age in the neighbourhood, and that boy's mother, here known by the pseudonym of Mrs. K, later invited him to stay for weekends and other extended periods during the school holidays. The review team met with Mrs. K, who told us that when Robert stayed with her, Maureen rarely called her to ask about him. Mrs. K was aware that Robert appeared to be frightened of his mother's partner but she was initially reluctant to interfere with the family situation, and she was concerned that if she raised this matter, Maureen might stop Robert from staying with her, which she felt would be detrimental to his welfare.

Mid Childhood Years

The next contact between Robert's family and the child protection services was when Robert was aged nine years and an anonymous caller contacted Area B, reporting that Robert and his sibling were missing school and being neglected by Maureen and physically abused by her partner. The family were at this point residing in homeless accommodation and the adults were said to be misusing drugs. The caller also reported suspicions that the children were being sexually abused though could not provide any evidence to support these suspicions. As the address of the homeless accommodation was in Area C, the report was passed to the social work duty system there. While transferring the report, the Area B duty social worker mentioned that there was already a file on the family in Area B; however, the fact that allegations of child sexual abuse had been made in respect of Robert was not specified in the onward referral letter.

In Area C, numerous efforts were made by different duty workers to visit Maureen and Robert's home; there was confusion about the address but the correct one was eventually traced through the Community Welfare Officer. Letters of appointment were also sent to Maureen but she failed to appear. Area B was re-contacted by Area C in an effort to get more detail about the referral and was unable to obtain any, but at this point the Area B team leader informed the Area C SWD about the child sexual abuse allegation from three years earlier. Duty social workers in Area C persisted in efforts to meet with the Robert's mother and partner over a period of four months without success and the case was closed some months later with a case note stating 'There has been no further referrals since last year all efforts were made to contact the family but they moved around very quickly'. An anonymous referral later that year, raising similar concerns, elicited no response.

During this period, and unknown to the SWD, Robert's mother and partner were receiving services from a team known as the Multidisciplinary Homeless Team (MHT). A summary report, later provided by the MHT outlines that they had been asked by the Community Welfare Officer to become involved with Robert's mother and partner around that time, primarily because 'it was not clear how they were negotiating their way out of the homeless trap' but also because of concerns about the children's non attendance at school and a suspicion that the parents were spending all their money on drugs. Eleven professionals were involved over the course of the next few months, including a public health nurse, school attendance officer, school principals and various housing staff. The MHT social worker and the Public Health Nurse (PHN) did a number of home visits and attempted unsuccessfully to motivate Maureen and her partner to complete the formalities required to get housing. None of the professionals involved appeared to regard this as a child protection case

despite the circumstances of the children and there is no record of any communication at the time between them and the SWD for Children and Family Services.

Late Childhood

The social work records show that fifteen months after the case was closed in Area C, a report was made to the SWDs in both Areas A and C by a medical social worker at a hospital where Robert had been admitted following what he described as a row with other children; he had told a nurse that his mother's partner hit him. This was followed by some other reports initiated by a concerned local resident (Mrs K) which ultimately reached the SWD in Area C, to the effect Robert stayed with her frequently to his mother's apparent indifference; she added that he was 'skeletally thin', dirty and frightened to go home. This person also informed the review team that at ten years of age, Robert was smoking cannabis and drinking alcohol and sometimes slept rough. The response of the SWD to these concerns was delayed; the PHN and school were contacted and both provided information of a worrying nature, but a home visit was not achieved for a further six weeks. It is not clear what attempts had been made to contact the family between the time the reports were made and the meeting took place, though the records generally imply that it was hard to find anyone at home. Social work records show that at this meeting, Maureen was absent, but her partner was present and denied abusing Robert, describing him as difficult to manage. He acknowledged that he had a poor relationship with him. The social worker recorded her assessment in the case note, which consisted of four bullet points outlining that 'Robert is at risk if he has no stability', noting that he required structure, safety and security, and commenting that 'the family are dealing with mental health problems which have a huge bearing on the children's welfare'. There is evidence on the file that at some point around that time, Mrs. K had contacted the SWD to say that Robert was missing and the duty social worker had contacted the Gardai but there is no further information about this on record. There is no record that the social worker discussed any of these events during her discussions with Maureen's partner.

The records indicate that another home visit was carried out five weeks later by a different duty social worker. Again, Maureen was absent but her partner was there. Robert was also there 'for a few minutes'. This appears to be the first time that a social worker actually saw Robert, but it does not appear from the file as if she engaged with him in any meaningful way. School issues were discussed and undertakings were made by Maureen's partner on behalf of both himself and Maureen, Robert's mother. A further home visit was conducted one month later, and again, Robert's mother was not at home.

There is a brief note on the file indicating that a home visit was made by a duty social worker a few days later at which Maureen was present; it says that she gave some undertakings about getting the children to school and progressing her housing application, but showed reluctance to allow the treatment service that she was attending to share information with the SWD about her progress. There is a copy of a 'consent to share information' form in the social work file, but it is blank. A further appointment was made but there is no note on the file indicating that it was kept. A few days later, the SWD was informed that Mrs. K was no longer prepared to look after Robert as she had found him smoking cannabis in her house. Given the amount of compensatory caring she had provided for Robert, this would have been a significant loss. The social work team leader in Area A wrote to the SWD in Area C urging them to support Mrs. K in her care of Robert. However, there is no record on the file to confirm that the SWD in Area C ever made direct contact with Mrs. K

The next contact with Maureen does not appear to have been made by Area C until two months later. The social worker who was assigned to the case, here called Social Worker 1, contacted the addiction service that was being attended by Maureen, and managed to meet her there in the company of the social worker from that service. At the time, Maureen was reported to be doing well in treatment, and at this meeting, she told Social Worker 1 that she had been reluctant to meet him, or to allow the treatment service to share information about her progress with him, in case the housing department would subsequently find out she had a drug problem. Social Worker 1 reassured her of confidentiality, and a home visit was arranged for two days later to discuss school for the children as well as a 'safety plan' however, Maureen and her partner did not answer the door when the social worker called.

During the same period, the PHN contacted the SWD to say that she was concerned that the children may not be enrolled in school for the coming September. She reported that she had assessed the children's development and they were all 'well'. A school attendance officer (SAO) became involved regarding the children's schooling, and is recorded as giving advice about a change of school. Later it became clear that this advice went unheeded but there is no further record of the involvement of the SAO. The social work file shows that Robert did not attend school at all from then until he was received into care five months later.

There is a record to show that both a duty social worker who carried out a home visit and Social Worker 1 requested a case conference when Robert was eleven years of age and also suggested that the case be allocated to the Long Term Team in the area. However, the case appears to have remained with Social Worker 1 and the conference did not occur for a further eight months. In a later transfer summary in the case file, Social Worker 1 noted that from August of that year until the

end of the year the SWD was unable to make contact with the family. Although it was known that Maureen was regularly attending the drug treatment service to get her methadone, there is no evidence that the social worker tried to contact her there; or is there any evidence that the social worker contacted either Maureen's extended family or Mrs. K in order to ascertain Robert's whereabouts so that they could see him.

Early Adolescence

At the beginning of the following year, Robert's grandmother approached the Area A SWD to report her worries about Robert, then aged just over eleven years old; she told them that he came out to her house late at night to sleep and that nobody was aware of his whereabouts during the day, and that he travelled on the bus from the city on his own, stayed on the streets and had regularly come to her house under the influence of drugs or alcohol. The Area A social worker passed this information on to Area C with some difficulty; the file records four attempts by the Area A social worker to telephone Area C with no reply, and one message left with no response before she ultimately reached the duty service the following day.

Approximately three weeks after this report, the children were found abandoned at their mother's address, and were brought to Area A to a member of the extended family. A case conference was subsequently held in Area C, which concluded that 'it would not be in the children's best interests if returned to the care of [mother and partner]', and that they should be placed with their extended family. A week later, Social Worker 1 met with the children to conduct a needs assessment. This appears to have been the first time that a social worker talked to Robert or his siblings. Robert told the social worker that he had been beaten by his mother's partner and had witnessed him beating their mother five times in his and his siblings' presence. Robert went on to disclose that he had witnessed his mother's partner using drugs and had seen needles in the toilet. He told how they had also been physically abused by their mother's former boyfriends. According to the record, both Robert, who was then aged eleven, and his sibling said they 'would want to go for counselling for the trauma they went through'. He was due to receive a counselling service from Barnardos the following September but there is no record that either that or any extra educational service was provided. The records do not detail how decisions about the placement of the children were reached; Robert and his sibling were placed with one family member while the youngest child was placed with another. The review team were told by family members that the decision was made within the family, largely on the basis of which family member had the room to take which children.

Maureen subsequently signed a consent form allowing the children to remain in voluntary care, acknowledging that her partner used to beat the children and that they had been exposed to drug use. After the children were placed there are some notes on the file recording telephone calls in respect of getting financial assistance for the two families, whose allowances had not yet been approved.

There are records of two attempts made by Social Worker 1 to transfer the case to Area A two months later, at the suggestion of the Area C fostering team leader, who asserted that it was the norm for Section 36 assessments[1] to be conducted and supported in the areas in which the children are in care. Two letters requesting transfer, not actually specifying what aspects of case management should be transferred were sent. One was sent erroneously to Area B and one to Area C. Social workers from both of the teams wrote back refusing the transfer, one pointing out that the children's family address was not in their area and the other one implying that the children's mother's address was the one which determined which area had responsibility for the case. It later transpired that the foster care team leader was unaware that the transfer had *not* occurred and consequently, no fostering link worker was allocated to either Robert's foster carers or to his siblings' foster carers, and no assessment of either placement was conducted. This situation persisted for five years.

Notably, a communication from Area B to Area C in the course of the attempted transfer raised the matter of the sexual abuse allegation made in respect of Robert against a person with whom he was now likely to have contact. No response appears to have been made to this information.

Teenage Years

Apart from the aforementioned records of telephone calls and one Care Plan completed shortly after placement, there is no further record of contact between the SWD and the children or their carers from the time Robert was twelve until he was sixteen. Although the Care Plan specified that that his physical and mental health needs required to be 'constantly monitored and assessed' and that he be given 'positive images of his mum' there are no records to indicate that any of this occurred at all during his first five-year placement. This was confirmed to the review team by Robert's extended family.

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[1] Pursuant to Section 36 of the Child Care Act, 1991 which deals with placements made with relatives.

A letter in the file, in the middle of this period, from a social worker who signed herself 'allocated social worker' informed Robert's foster carer that she was leaving the area and stated that it had been a pleasure working with the family. However, there are no notes in the file indicating that this social worker had any contact with the family.

The records indicate that the case was re-allocated to a social worker (Social Worker 2) when Robert was aged sixteen years old. The trigger for this was a request from Robert's carer for a passport, which ultimately alerted the SWD to the fact that the case was unallocated. The review team was told by a social work team leader, who started working in Area C that year, that no register of children in care existed in the local area when she arrived, and that Robert and his siblings were on a waiting list for allocation. In a note in the file at the time of allocating the case, the social work team leader stated 'Care Plan needed as none since [Robert aged eleven years]'. However, the files do not contain a copy of a new Care Plan, and the social work team leader told the review team that she could not recall whether or not one had been prepared (a later transfer summary indicates that it had been difficult to set up reviews with Robert's foster carer). The team leader's note also recommended that access between the children and Maureen was to be 'explored' on condition that their mother was stable, presumably referring to her drug use. There is no evidence that this occurred. Social Worker 2 told the review panel that she had been unaware that Robert's placement with his relative had not been assessed and had assumed that as the children had been there for a number of years when she was allocated the case that all the necessary formalities had been completed. She described the files as having been in 'disarray' when she arrived which meant that she was unclear about past events. When asked if she had not noted the absence of a fostering link worker, she told the review that even when fostering link workers were assigned, the fostering team were somewhat isolated from the rest of the social workers. She claimed that the main responsibility tended to remain with the child's worker so it had not occurred to her that none had been assigned.

The only activity in the case during this year appears to be an application to court to dispense with parental consent to obtain passports for the children after failed attempts to get Maureen to sign the necessary forms. Social Worker 2 completed the necessary reports for the court.

There is evidence in the records that Maureen sought access to the children at this time, via the social worker in the addiction service that she was attending but this does not appear to have been arranged. The social work team leader from this time told the review team that given Maureen's drug use and previous failed appointments, access was to be arranged under certain conditions but Maureen had not attended the meetings required to agree them. The file also showed that the social worker at her treatment centre had sent letters from Maureen to her children via Social

Worker 2, and that there was a considerable delay in forwarding these letters. Social Worker 2 told the review that this was because she felt that the children needed preparation before receiving them.

There are copies of letters in the file from Social Worker 2 to Robert's foster carer arranging a home visit, and a letter inviting her to a review three months later. However, there are no case notes in the file to show if these events occurred and if so, what transpired. The content of the letter implied that the foster carer was reluctant to attend reviews. Social Worker 2 told the review team that she couldn't recall whether or not a review had occurred, but did recall that the foster carer was reluctant to attend reviews partly because she would have needed to take time off work but also because she had been managing Robert's care on her own for several years. Social worker 2 described the irony of a situation where a foster family is 'left to their own devices' over a number of years and 'you're coming in placing demands on them and talking about statutory obligations'.

Robert, who was sixteen years old at this point, was referred by Social Worker 2 to Extern for a four-day respite period, and a post-placement report from Extern indicates that this was because his placement was under strain due to his challenging behaviour. The report also records that Robert got on well during the respite period. This is in fact the only written report in the social work record that gives any real sense of Robert's personality, describing him as likeable and sociable, though indicating that his self esteem was low. Robert is recorded as acknowledging that his foster carer was losing patience with him because of his behaviour.

At that time, a series of faxes from the Out of Hours service, together with a number of 'Significant Event' reports from an emergency accommodation unit show that Robert spent a number of nights out of his foster home, and on at least one occasion was brought to the service by his foster carer on the advice of the HSE social worker as she felt she was no longer able to cope with his behaviour, which involved misuse of alcohol and drugs and staying out late or all night.

An undated transfer summary written by Social Worker 2, reports that Robert's placement broke down during the summer of that year and he moved to another family member. The reason given for the placement breakdown was 'risk taking behaviour including criminal activity, taking drugs and binge drinking'. Social Worker 2 told the review panel that she had been surprised at how quickly the placement disrupted as it had appeared to be going well. She further explained that the foster carer, having had no allocated worker for five years, had probably got used to dealing with difficulties without alerting the SWD, and had come to a decision on her own. Social worker 2 felt

that her own attempts to save the placement over the summer came too late as the foster carer's mind was already made up.

There is no evidence on the file that Social Worker 2 ever met with Robert but she told the review team that she had met with him six or seven times. The social work team leader who had been supervising Social Worker 2 at that time told the review team that Social Worker 2 had a particular problem with recording her work because she was under a lot of pressure, and indicated that more contact actually took place than might have been evidenced. From documents on the file, it seems that Social Worker 2 referred Robert to a treatment service for his alcohol and drug use but that he chose not to attend after the first session. An application to a local counselling service was also made by her but was rejected on the basis of an incomplete form.

Later that year, when Robert was aged seventeen years, Social Worker 2 left the area and the case was allocated to Social Worker 3 who started by reading through the complete file. She immediately became aware of the allegation made by Robert's mother that Robert had been sexually abused by a person known to them eleven years earlier. This appeared to be the first time that any social worker had comprehensively read the file since Robert had been admitted to care five and a half years earlier and the information was in fact of considerable significance as Robert's placement had potentially brought him into proximity with the alleged perpetrator who lived in Area A. A meeting was arranged between Social Worker 3, another social worker and the team leader to discuss the allegation with the alleged perpetrator. At the meeting, this person vehemently denied any knowledge of either the alleged incident or any subsequent investigation. Robert also denied any memory of it. The Gardai were contacted with regard to their investigation of it but no record came to light.

The review team asked Social Worker 2, who had been the previous allocated worker, if she had been aware of the child sexual abuse allegation when she was working with Robert. She responded that she had been, but had assumed that as the children had been placed back in the area several years earlier it had been dealt with at the time; therefore she did not see the need to address it.

it came to light at this time that the fostering team had assumed that the case had been transferred three years earlier and that no link worker had been provided to either assess or support any of the family members who were fostering Robert and his siblings. A fostering link worker was then appointed, here called Social Worker 4 who met with Robert shortly afterwards and ascertained that the sleeping arrangements in his new foster home were inadequate.

There is evidence on file that Social Workers 3 and 4 kept in regular and frequent touch with Robert's new foster carer during that year. Social Worker 3 told the review team that she had frequent telephone contact with Robert's new foster carer and that she visited the foster home at least once a month and took Robert out on his own on two occasions. She found him pleasant and polite but difficult to engage. She liaised with his school and coordinated a meeting between Robert, his foster carer and the school. Concerns were expressed by the school about Robert's behaviour and the fact that he often appeared to be under the influence of drugs. Social Worker 3 subsequently initiated an application on Robert's behalf for Youthreach. The Youthreach application was further supported by Robert's foster carer, who spoke to staff on his behalf. Maureen, Robert's mother, got in touch with Social Worker 3 wanting an update on the children and was offered a meeting but failed to attend.

Eighteen Years

Robert was subject to a probation order because of a public order offence he had committed during the previous year. His Probation & Welfare Officer told the review team that Robert had not taken his misdemeanour very seriously, but that he was quite compliant with the conditions of his probation order, part of which obliged him to attend Youthreach. He attended all his meetings, and participated in some activities organised by the probation service. His attendance at Youthreach was sporadic initially. However it improved following a further contact with An Garda Síochána, after which his foster carer threatened that he would have to leave if his behaviour did not settle. He seems to have settled fairly well by the middle of the year; the manager of his Youthreach project described his attendance as very good in terms of turning up each day, but noted that he found it hard to stay for a full day. Both the Youthreach manager and the Probation & Welfare Officer told the review team that they believed Robert to be a habitual cannabis user, who also enjoyed partying and drinking alcohol and wasn't really interested in any other activity. They described him as likeable, warm, funny and affectionate. They both described his extended family as warm and caring. Social Workers 3 and 4 remained in regular contact.

As Robert was due to turn eighteen he was offered an aftercare service; however he never met the after care worker. The records indicate that after a discussion between Robert, Social Worker 3 and Robert's foster carer, it was decided that Robert would remain living with his foster carer and that 'no supports were needed'. The after care worker closed the case and offered the opportunity for a re-referral should Robert require after care in the future. Social Worker 3 left the service later that year.

An unsigned case note records a conversation between Social Worker 4 (the fostering link worker) and Robert, in which the social worker explained that a condition of Robert's remaining in the placement was that he would stay out of trouble, i.e. avoid crime or drugs. There is a further record of a similar conversation between Social Worker 4 and Robert in the middle of the following year. There are no further records of any contact with him at this point. Two social workers were subsequently allocated to the case, the first one left within six months, having made no contact, despite being advised by the fostering link worker that Robert required intervention. Robert died four months after the final social worker was allocated but she had not made contact with him in the meantime.

11. Analysis

11.1 Initial response of HSE to this case

While the child sexual abuse allegations and early referrals detailed in the chronology took place so many years ago that it was impossible for the review to examine them in detail, we consider it relevant to comment on these because of the impact they directly or potentially had on the course of the case.

The review team considers that the lack of follow up by either Areas A or B to the allegations of child sexual abuse in respect of both Maureen and Robert was unsatisfactory. Both disclosures had serious implications and required urgent follow up from the HSE and the Gardai. From a child protection perspective, the lack of action meant that appropriate responses were not provided to the alleged victims, and that other children could have been endangered. In addition, the failure to properly investigate these allegations was a disservice to those accused. One of the alleged perpetrators died a number of years ago and by the time the matter was raised with the other alleged perpetrator when Robert was aged seventeen years, it was inevitable that the ability of the social workers involved to take the matter further was going to be constrained and these efforts came to nought. At this remove it is not possible to say whether there is any truth in the allegations. The primary reason that the review team chooses to highlight this issue is because it was inappropriate on the part of the then Health Board to place children in a setting where such unresolved matters had prevailed.

When later reports of alleged child abuse in respect of Robert and his siblings were made when Robert was aged nine years, it took a long time for the SWD in Area C, where Robert was residing, to make contact with him and his family. There was some difficulty in accessing the family due to confusion over the actual address, but mainly because of broken office appointments and failed

attempts to find the family at home. The review team acknowledges the dogged attempts that were made by different duty social workers in the early part of that year to contact the family by calling to their address. However, the rationale for closing the case after a year on the basis of no contact was not logical and the assumption that the family moved around quickly is also spurious, given that there was no evidence of this. Other services that were undoubtedly in contact with the family could have been used to mediate contact or at least provide up to date information.

When the second series of referrals about the family were received two years later, it appears from the files that six weeks elapsed before face to face contact was achieved with family members. The referrals involved allegations of physical abuse, malnourishment, and physical neglect of the children. They also mentioned Robert's absence from school and suspicions that he was sleeping rough as well as spending long periods away from home to the alleged indifference of his mother and her partner. It is possible that attempts to contact the family were made in the meantime, but there are no records to that effect.

It appears to the review team that the referral was not acted upon with the urgency that it warranted. Having heard repeated allegations that Robert was being physically abused and neglected, the social worker's acceptance of the denials and excuses made by Maureen's partner and later by Maureen, without speaking to Robert, having him medically examined or carrying out at least an initial assessment can only be described as inadequate. No other investigation into the allegations of abuse appears to have been conducted either at this time, or at any other time prior to Robert's admission to care. The file records a series of broken appointments and unfilled commitments made by Maureen and her partner, but there is no evidence that these were reflected upon in any meaningful way, or that any adverse inference was taken from them.

A consequence of the delayed response and failure to adequately address the reported allegations from the first instance onwards was that Robert and his siblings were subjected to three further years of neglect and abuse, the extent of which was never really known, prior to their being received into care. A notification to the Gardai about the alleged abuse was made for the first time two months after the children were received into care, three years after the initial allegations were made. This seems to confirm that the concerns were not taken seriously at the outset, despite being made many times by different persons.

11.2 Assessment

Given the worrying state of affairs portrayed in the reports, it would be reasonable to expect that an assessment of Robert's physical, psychological and emotional wellbeing would be conducted as a

matter of urgency following referral. The first time that a duty social worker met Robert was at a home visit two and a half months following the later referrals. She noted that he came into the room for about five minutes and then went out to play. No opportunity appears to have been taken to engage with him and he was not seen by a social worker again until his reception into care some eight months later. A summary report in the file records that what is described as the 'risk assessment' that took place at this time revealed that the family's housing situation had 'a huge bearing on the welfare of the children'. In the opinion of the review team, this implied that resolution of the housing situation would have an ameliorative effect, even though the same report showed that Maureen and her partner had little or no motivation to improve their situation. The community welfare officer had told the SWD that Maureen and her partner never seemed to undertake any task required of them and had a history of non compliance. It also noted that Maureen's partner's mental health problem had a 'huge bearing on the children's welfare' but that he was reluctant to avail of treatment. The review team concludes that the risk assessment was superficial and failed to take full account of the couple's lack of insight into their neglect of Robert and his siblings, or their lack of willingness or capacity to change sufficiently or quickly enough to meet the children's needs. According to the records, a PHN had 'assessed' the children in the summer of the later referral and reported them to be well, but there is no record of the nature of her assessment. This assessment was carried out at a time when Robert was reported by others to be malnourished and dirty, so the conclusion that the children were 'well' seems anomalous. It is notable that the decision to place the children in care was not taken as a protective measure on the basis of documented concerns or the outcome of any discussion; it was actually a reaction to the fact that they had been abandoned.

The records contain a document dated some weeks after Robert was admitted to foster care. It is entitled 'needs assessment' and consists of ten bullet points on one page, which basically summarise events prior to the children's entry to care and is based on conversations with Robert, his next sibling and a relative. It records Robert's disclosure of the abuse that he and his sibling suffered, including physical abuse over a long period, exposure to at least five serious beatings inflicted on his mother by her partner, and witnessing injecting of drugs. The document records no attempt to analyse the impact of the abuse, any further assessment of the children's needs or any plan to address the needs that were identified. Social Worker 1 was alerted in writing by Area B to the aforementioned allegation of sexual abuse in respect of Robert two months after Robert was admitted to care. The letter from Area B invited Social Worker 1 to consult the closed file but there is no evidence that this happened. This alert came on foot of the fact that Robert was now living in the same neighbourhood as the person who had allegedly abused him as a young child. It could

reasonably have been expected that this would have been a key concern from the perspective of the child's welfare and any assessment of the suitability of the placement, however, the alert went unheeded.

A Care Plan, completed seven months later identifies Robert's need for 'his emotional, physical and mental needs to be constantly monitored and assessed' and for him to have access with his mother, counselling and remedial teaching in school. There no evidence anywhere in the file that he received counselling or remedial help at school, and no further assessment is included in the records. It would appear that the next time Robert spoke to a social worker was six years later.

The review team finds the absence of robust assessment to be a significant deficit.

11.3 Compliance with Regulations

It can be definitively stated that compliance with guidelines and regulations in this case was seriously deficient. *Children First*, which had been published by the time that the case was referred when Robert was aged nine, was largely ignored in spirit and letter; the case was closed in 2001 with no direct contact having been made with the family to ascertain the children were safe. When it was re-opened, the pace of investigation was slow particularly given the level of concern that had been expressed. No attempts were made to see Robert, the allegations were not properly investigated, no child protection plan was developed and the first and only case conference was held ten months after the referrals.

The Child Care (Placement of Children with Relatives) Regulations, 1995 were almost totally ignored in this case. A Care Plan was completed and signed off over six months after Robert was placed in care, with a specified review date for six months later. There is no evidence to suggest that this review took place or that a subsequent Care Plan was ever prepared. Four years later, it was noted in a memorandum from the social work team leader that a new plan was long overdue but there is no evidence that this acted as a stimulus to action. In other words, during the eighty two months between this young person's admission to care and his eighteenth birthday, a single care plan was drawn up. This falls far short of the legally-defined minimum standard, as set out in s. 18 of the Child Care (Placement of Children with Relatives) Regulations 1995, which specifies that a care plan must be reviewed at least once every six months during the first two years of any placement and at least once a year thereafter. By law therefore at least eight reviews should have been completed. The absence of any review, revision or redrafting of Robert's care plan from the time he was twelve years until he turned eighteen is a cause of serious concern. Even more serious is the fact that no

contact was made by the social work department with the children or their carers for such a long period.

Apart from one meeting with the children, there is no evidence that a social worker visited Robert's placement between age twelve and age seventeen years. The foster carers, who were relatives that had been previously known to the child protection services, were not assessed. The absence of reviews meant that the failure of clumsy and unsuccessful attempts to transfer the case were not revealed and it was assumed by the fostering team leader and her team that it was no longer their responsibility. This meant that no link worker was assigned to the family, to support their care of a child that was acknowledged to have particular needs, including therapy for the trauma he had suffered.

Garda clearance forms were distributed to the two families of relatives caring for Robert and his siblings. It is stated on the file that these were completed and returned although copies are not on file. It is noted on the file that completed Garda clearance forms were not available for two family members, one of whom lived with one of the families, and for another who was an occasional resident at the same home. A contract to foster signed by the family member who fostered Robert from age seventeen years is on file. This is the only contract available, although Robert had already been fostered with another relative for over five years at this stage. At the time of Robert's death, a foster care assessment had not been completed.

When a young person reaches their eighteenth birthday, a social worker's report on their future plans is required. There is no indication that this was prepared. When an aftercare worker was allocated and attempted to make contact, the young person, through a third party, expressed no desire to engage. The case was closed without any meeting between the young person and the designated aftercare worker.

11.4 Quality of practice

11.4.1 Interaction with the child and family

As the chronology demonstrates, allegations of child sexual abuse made in respect of Robert by his mother were not followed through at the time. Later on, there was scant contact between child protection services and this family for three years until the children were received into care. As this review has shown, there was an unacceptable delay in acting to protect Robert when he was evidently being physically abused and neglected. Authoritative attempts to change Maureen and her partner's parental behaviour were not made, and inappropriate leniency seems to have been applied to their promises, never fulfilled, to provide stability for the children in terms of school and

housing. Significantly, no efforts were made to examine or assess the children's physical and emotional wellbeing or safety. Ultimately, the decision to place the children in care was in response to their abandonment, not to any pro-active intention on the part of the professionals involved. This represented inadequate practice.

The substandard practice persisted beyond the placement of Robert and his siblings. Apart from one meeting between Social Worker 1 and the children, there was no further recorded interaction until Robert was seventeen years of age. Social Worker 3 appears to have been the first professional to have taken seriously the role of the HSE in this case. She read the file, drew the attention of senior staff to the unresolved child sexual abuse allegation and its implications, and attempted to address the matter. She tried to engage Robert as an individual, kept in regular contact with his foster carer and with his newly allocated fostering link worker. She visited the placement regularly. The records of her contacts give the impression that she was committed and concerned about Robert's welfare and that of his siblings. However, at this stage Robert was well into what was quite a troubled adolescence. His previous placement had broken down and he was using drugs and alcohol, had been in trouble with the Gardai and was not doing well at school. It seems that he was not keen to engage with a social worker for the first time at that point. Social Worker 3 had a difficult relationship with Robert's extended family, who had been caring for the children for a number of years without contact from any services. The family members told the review panel that they would have preferred the social worker to 'back off', seeing their efforts to become involved as intrusive and unhelpful.

11.4.2 Child and family focus

Reviewing the social work records, it is not possible to get a picture of Robert as a young child, or any sense of his journey through adolescence, his strengths and needs, hopes or fears. The only document that gave any sense of his personality was the report provided by Extern following his respite placement when he was seventeen years of age. From the evidence, it appears that Social Worker 1 had only one conversation with Robert. Social Worker 2 acknowledged that while she got to know him better when his placement was disrupting, she did not know him well or have the sort of relationship that she had with other children in care. The review team met some of his family members and the adult who had befriended him as a young child in the community, as well as his Probation & Welfare Officer and the manager of the Youthreach project that he attended. At that point the review team became able to form a mental picture of him as a likeable, witty and caring person who was generally good humoured but also known to be restless and troubled. It is unacceptable that no staff member from the HSE had a relationship with him. We accept that Social

Workers 3 and 4 made efforts to engage with him and with his carers but at that point the prospects of a successful outcome were low.

Whilst the review team are aware that the members of Robert's extended family who fostered him loved and wanted to have him living with them, we found no evidence that the placement was made with Robert's best interests in mind. A combination of circumstances meant that the decision to place him within his extended family should have been given careful consideration. There were unresolved child protection concerns in respect of the earlier child sexual abuse allegations made by Robert's mother in respect of herself and in respect of Robert as a young child. Related to these allegations, there were tensions between the extended family and Robert's mother which impacted on any future contact he might have had with her. In addition, Robert and his siblings had experienced chronic neglect and trauma, both of which are predictors of later difficulties and there was no assessment of the extended families' capacity to deal with these. While there is no information about his first five-year placement, there is some evidence that he was drinking alcohol and had been using cannabis before he was placed in care. By his mid teens and possibly earlier, he had become involved in drug and alcohol use which neither his first nor his second foster family was able to address.

It would not appear that much sustained effort was made to bring Robert's mother back into his life and the lives of his siblings. Accepting that she was disorganised and unreliable when it came to keeping appointments, on the few occasions when she made an effort to re-engage with her children in care the notes do not indicate that this was supported or encouraged. When Robert was fifteen it was noted on the social work file that there had been no contact between him and his mother for around three years. That year, Maureen wrote to request access via a social worker at the centre where she was being treated for drug misuse. Some months later that year, according to the file, it was 'envisaged that this will occur in the future'. The Social Work Department expressed a commitment to encourage access and re-engagement. However, there is nothing in the files to suggest that this was facilitated and as noted above, placing the children within the family from whom their mother was estranged was unlikely to promote contact. When Maureen re-established telephone contact two years later, and expressed a desire to see her children, she was told that this would have to be arranged via the social work department. There is no record that any such contact was made and if it was, what actions were taken as a result.

The available documentation is silent on the question of self-harm although the importance of psychological support is a recurrent theme. The desirability of seeing a child psychologist was raised in the Care Plan made when Robert was eleven years old and this was to be facilitated by Barnardos.

Five years later, there was a referral to Teen Counselling but the documentation submitted by the HSE was incomplete and a fresh referral form was requested. It is not known whether this was submitted. It is noted on several occasions that Robert was in contact with a psychologist or a counsellor but no indication is given of the reason for this, nor any detail. A family member told us that he had been in contact with a HSE counsellor for a few months prior to his death.

11.4.3 Quality of recording

As the foregoing sections have demonstrated, the quality of recording in respect of Robert was extremely poor during the first five years of his placement. Records prior to his placement were reasonable and those completed by Social Workers 3 and 4, particularly by the latter, were comprehensive. However, there is no particular logic to the way that case notes were compiled; they were often unsigned and sometimes undated and there are evidently a lot of missing documents. Overall, the management of records in the SWD was of a very low standard. The review team finds it extraordinary that there is not even one item of information on file about the placement where Robert resided between age twelve and age sixteen, despite the fact that the HSE was paying a fostering allowance to the carer throughout this period.

The Social Work Team Leader informed the review team that the computer programme in use at the time (SWIS) was awkward and unreliable as it kept crashing due to excessive demand, and that it was demanding of a lot of time because of the measures that had to be taken to save work on it. This criticism was reiterated by Social Worker 2.

Apart from the actual recording, the communication and utilisation of records in this case was very deficient. Robert and his mother moved when he was a young child, from Area B to Area C. Robert spent a lot of time in Area A. These moves and locations were known to the HSE services at the time, but no effort seems to have been made to collate records in one file. It seems that Social Worker 3 was the first person to read the entire file.

11.5 Management

11.5.1 Management oversight

There was a total lack of management oversight in this case. In the earlier phases, there was no sense of concern about a young child who was being physically neglected and beaten, was out of school, using alcohol and was very often out of home without his mother being aware of his whereabouts. There is no evidence that the concerns recorded by two social workers, including recommendations for a child protection conference and for the case to be allocated to the long term

team, were either seen or acknowledged by anyone in management. Later, when Robert was placed in care, there were clumsy efforts to transfer the case on the basis of an alleged policy that was clearly not shared by other local health areas. Robert had an allocated social worker when he was aged twelve but at sixteen he was on a waiting list for allocation and the foster care team leader was under the illusion that the case was being managed by another area even though no formal transfer had occurred. These facts appear to have been unknown to any managers in the area until Robert's then foster carer alerted the SWD that he required a passport. It was only when he had reached seventeen years that the foster care team became aware that the case had not been transferred some years previously. The team leader who attended the review told us that there was no list of children in care in the area while she worked there.

11.5.2 Standard of child protection practice

Social Worker 2, reflecting on her involvement in the case, told the review panel that in hindsight, she had been a relatively inexperienced social worker when she went to Area C and had been under 'massive pressure'. She felt that the combination of that, with her lack of experience, had led to her acceptance of the low standards operating in the area as 'how things are done'. She described a 'level of chaos' in the area which meant that there was no time for reflection while trying to prioritise work. She believes that this only became clear to her when she went to work elsewhere. Social Worker 3 left the HSE fourteen months after she joined the team in Area C. Social Worker 4 left six months later. Both told the review team that they could no longer cope with working in such pressurised circumstances where they felt that children were not getting the standard of care to which they were entitled. Social Worker 3 told us that she was worried that Robert's placement was not up to standard but that a culture existed in the SWD whereby her concerns were not taken seriously. She said there was a norm whereby a worker could only discuss their concerns with their immediate line manager and no higher.

Although the review team invited the person who had acted as a social work manager during period when Robert was both known to the service and in foster care to submit a statement on the organisational factors that may have influenced practice at that time, they did not do so. The review team are aware from other reviews that there were staffing problems in the area over a number of years with a high staff turnover, unfilled posts, and a very high rate of referral to the duty system.

11.5.3 Allocation

The continuity of social work service in this case can best be described as patchy. A total of nine social workers were allocated to Robert between age eleven and age eighteen years and there were several periods, including one of twenty months when no social worker was allocated to him or his siblings. The social work team leader who met with the panel told us that Robert was on a waiting list for allocation when she came to the area. From the files, it appears that of all the social workers that were allocated, only two actively worked with the case, i.e. Social Workers 1 and 3. Social Worker 2 evidently had some involvement, as there are copies of letters from her in the file, but there are no recorded case notes from that time. Social Worker 4 was the fostering link worker with Robert's foster carer, and was also very actively involved. Neither of the two social workers allocated following Social Worker 3's resignation had any contact with Robert. He was over eighteen at the time, but still a cause of concern.

11.5.4 Inter-agency meetings or conferences

The records suggest that only one child protection conference was held to discuss Robert's welfare and protection, when he was eleven years old. A child protection conference had been requested by two different duty workers during the previous six months and by the time the meeting actually occurred, Robert and his siblings were already in care, having been abandoned. While the files indicate a good deal of inter-agency discussion in the latter years of Robert's life, there does not appear to have been a meeting of the professionals involved, which included Youthreach, Extern and the Probation and Welfare service.

11.5.5 Supervision

There is no evidence on the file that staff working on this case were supervised regularly. There is a memo on the file from Social Worker 1 requesting a case conference and suggesting that the case should be allocated to the long term team, but there is no record of a response. There is a short note from the Social Work Team Leader who allocated the case when Robert was fifteen years, outlining tasks to be completed but no evidence that her instructions were fulfilled. The Social Work Team Leader told the review team that she supervised her team regularly and this was corroborated by Social Worker 3. Both claimed that supervision notes were kept. Social Worker 2 recalled that it was not standard practice for supervision notes to be kept on file at the time.

However, the team leader acknowledged that her supervision did not extend to looking at case files and that she had not read Robert's file while supervising Social Worker 2, therefore was unaware of

the earlier child sexual abuse allegation concerning Robert as a small child and its implications for his placement.

11.5.6 Inter-agency collaboration

There were a number of communication deficits within and between the SWDs in the various areas in the early stages of this case. These principally concerned important information which was not routinely exchanged, though it sometimes emerged as a result of one query or another. At one point, Area A became briefly involved not knowing that the case was open to Area C. The review team were told that within Area C there was a degree of separation between the social work team dealing with fostering and the teams working in child protection. One of the consequences of this was that Social Worker 2 was unaware that no fostering link worker had been allocated, and the team leader of the fostering team was unaware that the case had not been transferred.

There were also gaps in inter-agency communication. At the early stages, Robert's school, the PHN and the multi-disciplinary homeless team all had concerns about Robert but communicated them only when asked and did not appear to feel any responsibility for his safety and welfare. For example, when the PHN was asked at one point if she had any concerns about Robert and his sibling she said no, and then mentioned that she didn't think they were currently attending school, clearly indicating that she didn't consider this as worthy of intervention. There is a record of the involvement of a school attendance officer but no evidence of his or her actions in respect of the children. These professionals were aware of the involvement of the SWD with the family and appeared to assume that no more intervention was required which, in the opinion of the review team, meant that opportunities to try and get Robert to school, or to address the fact that he and his siblings were being neglected, were lost.

Collaboration between the different SWDs and An Garda Síochána regarding the child sexual abuse allegations seems to have been non-existent. There is no record on the file of any conversations or meetings between the two services to discuss them.

At one point, the social worker in the drug treatment service asked Maureen for her consent to share information with the SWD which would have been very relevant to the safety and welfare of the children. Maureen was initially reluctant to give consent, and it appeared that this social worker was allowing her to decide whether the information was to be shared, despite the obligation imposed by *Children First* on all professionals to prioritise children's welfare over the rights and needs of parents.

The lack of information on file between the times Robert was between age eleven and age seventeen years has prevented the review team from forming any judgment about the level of collaborative work during this period. Between age seventeen and eighteen years, Social Worker 3 evidently worked hard to stay in touch with all the services involved in Robert's life and recorded the outcomes of her discussions.

12. Conclusions

- This review was limited by a number of factors: the fact that it spanned a long period meant that the review team had access to only a limited number of the professionals who had worked on the case. The records were deficient for two apparent reasons, the first one being that nobody worked on the case for a number of years and the recording practices of some workers were poor; the second reason, as the review team were given to understand, is that some of the records allegedly went missing. Of great concern is the fact that the review team were unable to glean any sense of Robert as a person from the HSE records, indicating a lack of child centeredness in the social work practice in this case.

- In the context of the limitations to which this review was subject, no inference should be drawn that any of the actions described in the conclusions in this report either directly or indirectly contributed to Robert's death, albeit that they identify deficits in service provision.

- Robert suffered very serious trauma as a young child, including physical and emotional abuse and neglect, and unsubstantiated allegations of sexual abuse. There was no serious effort made to assess his safety and welfare on the rare occasions when social workers met him. There was an unacceptable delay in taking decisive action to protect him, and he was virtually ignored for the first four years of his placement by the HSE staff members who had responsibility for his safety and welfare.

- It would be difficult to reach any conclusion on the basis of the evidence available to the review team, other than that Robert received a very poor standard of service from the HSE Children and Family Services over a number of years, and for long periods received no service at all. This inadequacy extended beyond social work services. Many of the practitioners, including health and education staff, who met the family when Robert was younger did not appear to take the neglect of this child seriously, or to register the impact that his experiences were having on his physical, psychological or emotional welfare. When Robert was aged between seventeen and eighteen years, two of the social work staff

involved in the case actively tried to promote his welfare but at this stage, he was mistrustful of professionals and difficult to engage.

- The review team concludes that while the members of Robert's family who provided foster care to him in his last placement were warm and loving in their attitude to him and lavished clothes, gifts and pocket money on him, the decisions to place him with different family members over the years were not made by the SWD on the basis of a careful consideration of his best interests. The capacity of either set of foster carers, who were known to child protection services, to provide the level of care required by such a traumatised child were not assessed, nor were the families given any guidance or support until Robert was seventeen years old. The fact that there is no recorded information on the first placement is totally unacceptable and the failure to support the placement fell far short of what should have been expected.

- This was a poorly managed case at every level. The lack of oversight, in fact the complete lack of awareness or information on the part of management about any aspect of this case had a determining effect on the inadequate service provided to Robert. It appears from the evidence available to the review team that nobody in the HSE, apart from Social Worker 3 and for a short time, Social Worker 4, actually knew Robert.

- The evident lack of compliance by the SWD with regulations, and the gaps in the records are matters of serious concern. What is most troubling is that these inadequate practices were allowed to persist for so long. While the review team understands that the area was under serious pressure and had significant staffing issues during the first few years that Robert was in care, there is no evidence of any concern or awareness that the practices were sub-standard, and no evidence that any efforts were made to draw the attention of senior management to the deficits.

13. Key Learning Points

Robert was invisible to the services most of his life. The social work notes quote his foster carer as saying that he had telephoned her on the morning of his suicide, from the site where he killed himself, saying 'I need to go to sleep for good'. According to the notes, he had allegedly told a friend a few days earlier that he had a horrible childhood. While he was generally regarded as easy going and good humoured, Robert was also considered to have a darker, more troubled side to his personality which was becoming noticeable in the weeks leading up to his death. His Probation & Welfare officer and Youthreach manager told the review panel that in their view, he had been at

high risk of getting into trouble with the law through drinking and drug taking. However, they both commented that had the right set of circumstances prevailed, he might have done very well as he had numerous strengths. A number of key learning points arise in the case

- A compelling lesson arising from this review is that neglected children need individual attention at an early stage, and that professionals need to be creative in order to eliminate any obstacles to providing a service. Opportunities to intervene when Robert was a young child were missed and may, if acted upon, have changed the course of his life. The non-cooperation of his mother and her partner, who were known to be active and disorganised drug users, was allowed to dictate how the case was managed with little consideration being given to how Robert was faring when the door wasn't being answered and appointments were not kept. It appears to the review team that there was a network of family members and neighbours, as well as various service providers, who could have tracked both the mother and children at any given time.

- Any assessment or estimation of risk must take account of the willingness and capacity of carers to do what is necessary to promote their children's safety and welfare. There is a lot of evidence in this case that Robert's mother and partner displayed little or no motivation to undertake any of the tasks required of them, yet the situation was allowed to endure over a number of months after the SWD began to take it seriously.

- The next learning point has been made many times. Children can do very well when placed in relative care which protects their sense of identity and provides continuity. However, relative placements can be more complex than others given the shared experiences of family members. This reality must be borne in mind, and family placements must not be regarded as a convenient option unless all parties are convinced that such an arrangement will promote and maintain the child's safety and welfare.

- The review team is unable to comment on the course of Robert's adolescence as there is no information available but it is possible that interventions at that time may have made a positive difference at a time when he may have been more open to remedial assistance.

- In many respects, Robert was typical of a young person who was badly neglected and abused as a child; the unsupervised and unsettled lifestyle led by him aged nine or younger probably left him unable to settle easily into a more stable situation. His later educational difficulties and problems with substance misuse, as well as his challenging behaviours could almost have been predicted, given his circumstances, yet there were sparks of resilience in

his personality. The fact that he was totally ignored for the five years following his reception into the care of the state meant that any opportunity to provide compensatory or remedial intervention was missed.

- Completed suicides are often preceded by suicidal ideation and threats or episodes of self-harm. Robert was known to be misusing alcohol and different types of drugs. None of the professionals involved with Robert during the two years prior to his death who were interviewed by the review team had observed any warning signs. However, in hindsight, Robert's experiences demonstrate commonly known risks of suicide. The review does not claim that his suicide could have been prevented by those working with him at the time, but makes the point that some indicators should alert concern and should trigger preventive measures.

- Inter-agency and inter-departmental problems occurred throughout the course of this case. It appears that, apart from HSE social workers, few of the professionals involved with Robert at various times felt any compulsion to respond to what was obvious neglect. This review reiterates the message underpinning all child protection policies that while the statutory services carry ultimate responsibility for protection, all services for children have responsibility to promote safeguarding.

- The review has demonstrated the consequences of poor recording and communication between and within social work departments that delayed and obstructed responses to Robert in his earlier years and left his foster carer without support for several years of his placement. While new ICT mechanisms will undoubtedly improve the flow of information, there needs to be a commitment from staff to utilise communication resources to best effect if deficits such as those identified in the review are to be minimised

- The review has highlighted the potential for general acceptance of low standards by both management and frontline workers within an area that is under pressure. In some cases, it was only after workers left the area that the unacceptability of some of the deficits became clear to them. It is important that managers proactively resist the development of a culture which tolerates poor standards, and where deficits cannot be addressed for resource reasons, these need to be brought to the attention of the National Office.

- The need for in service training and induction of new workers into standard practices such as maintaining proper records and following basic policies, emerged strongly from this review. It cannot be assumed that newly qualified social workers, who have been generically

trained, will have knowledge of the micro aspects of practice in a specific area. The full roll out of Standardised Business Processes should assist in this regard, but workers will still need to be given guidance at the outset.

- The key learning point from this review is a simple one; that children are damaged by neglect and abuse, and even if they appear to cope and survive, early and sustained measures need to be taken to compensate for the damage.

14. Recommendations

This review is being concluded in a context of considerable change in the child protection and welfare sector, where new legislation and policy, including the implementation of standards, are likely to determine management and practice to a greater degree in the future. Nonetheless, it makes the following recommendations:

1. The review team is aware that some of the very serious deficiencies and inadequate practices in this case took place several years ago, and that two internal reviews on this case have already been completed with recommendations. Nonetheless, it recommends that Children and Family Services conduct an in-depth examination of child protection management and frontline practice in this particular area to ascertain whether any legacy of the very low standards exposed in this review remains.

2. The review recommends that any child protection policies that are developed along with any multi-disciplinary programmes delivered within the HSE/ new agency, emphasise the duty of every professional involved with any children's service to respond to child neglect by providing immediate and appropriate services.

3. It is of paramount importance to ensure that full effect is given to a child's legal entitlement to regular reviews, continuity of care, safe and secure accommodation, and the preservation of a meaningful relationship with their birth parents

Signed:

Dr. Helen Buckley

Chairperson, National Review Panel

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