TF
A Case Review
1983 to 2002

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Terms of Reference

The terms of reference for this review are as follows:-

1. To review the care provided to TF from the time she came into contact of the HSE and its predecessor
2. Review how the case was handled in the different parts of the health system such as community services, addiction services, out of hours service, including the period of time after Ms F achieved her majority
3. To make recommendations from the findings
4. To submit a report to Mr Pat Dunne, Local Health Manager, Dublin North, of the review findings and recommendations

This review was established on a non statutory basis. The review was conducted entirely on the basis of the documentation provided covering the Health Services involvement with T from 1983 to 2002. In addition, the relevant statutory provisions concerning child care as well as the publications of the Dept of Health and Children, Dept of Education and Science, the Social Services Inspectorate, the Residential Services Board, the EHB, NAHB, ERHA and the HSE were reviewed. A wide range of investigations into childcare and specific child abuse cases that were conducted in Ireland were also incorporated into the review process. A similar process was undertaken in relation to the publications and statutory provisions from the UK and the Isle of Man. It is noted that the Eastern Health Board was replaced on 1st March 2000 by the Northern Area Health Board.

In attempting to understand the totality of the interaction between T and the range of services she engaged with a chronology of all such interactions was tabulated for each day for which there were written records. Thus information from the social workers, OOH service, her residential placements, the Gardai, the UK social services, community welfare services with whom there was contact, the Guardians Ad Litem involved with T and each of her children, the legal teams representing T and the then Health Board, the staff supervising access visits between T and her children together will any further contact with any other person or organisation was chronicled. From this, emerged a series of themes and focal points for detailed review. In conjunction with this analytical framework, an episodic overview of T's interactions with the then health board was undertaken from a case management perspective. The information and insights were then integrated into a composite overview. There is thus some overlap in the content which is unavoidable for the completeness.

Executive Summary

This case review concerns a girl TF born on 26th May 1983 and who died on 24th January 2002. T was placed by mother in the voluntary care of the then Eastern Health Board in May 1998. In her eighteen years T, lived chiefly in Ireland but moved backwards and forwards to Wiltshire in England principally between the ages of eight and fourteen years. T grew up as a young child living with her mother in her grandparent's house and went to the local school in Coolock. During this time concerns regarding her mother's relationship with T were raised with the then Health Board that were not addressed in accordance with the prevailing child protection protocols of the time. T's mother, when T was three years old, gave birth to another child, by a man who was not the father of T. This child was placed for adoption. Nothing of the concerns or issues relating to T were incorporated into the adoption reports or caused any review of the current care for T to be ascertained. T's mother became involved with yet another man who became her long term partner and by whom she had two further children. In total there were five instances between 1983 and 1987 where concerns that properly should have been considered in a formal child protection framework as provided for in the Guidelines on procedures for the identification, investigation and management of non accidental injury to children which was published in February 1983. There is no documentation to show this occurred.

Upon moving to England in 1991 T aged eight, was placed on the Wiltshire Child Protection Register because of two instances of physical assault on her by her mother's partner. T's name was removed when she returned to Ireland later that year. T, when she was again back in Wiltshire in 1997, was placed on the Child Protection Register at age fourteen for reasons of physical abuse and emotional abuse by her mother's partner. Her name was again removed on her return to Ireland in December 1997. Both of T's half siblings were also placed on the Wiltshire Child Protection Register for emotional abuse.

In December 1997, T returned with her mother and siblings to Ireland, fleeing from a domestically violent relationship. They all stayed with her grandparents initially. However, due to arguments, T, her mother and siblings left, moving into women's refuges and subsequently into B and B accommodation. Within five months the relationship between T and her mother had broken down so completely that her mother placed T in the care of the then Health Board when T was two weeks short of her 15th birthday.

Over the course of the rest of her life in care T was accommodated in a very significant range of accommodation including B and B accommodation on thirty one occasions in at least twenty different residences; in three separate apartments; in two emergency accommodation settings, in supported lodgings with five different families; in two mother and baby homes; with her grandparents and uncles; in two services designed to focus on multi-issue children and in two dedicated services specific and solely for her. In addition, T also was admitted on a number of occasions as a social admission to whichever of the Dublin maternity hospitals that had an available bed, on another occasion she slept on a bench in the A&E department of the Mater Hospital, in a tent on at least one occasion, overnight in other houses on several occasions and slept rough on one occasion.

In the first six months of being in care, T was accommodated in a minimum of nine different accommodation arrangements. In that time T became seriously encultured in the out of home scene becoming highly sexualised, becoming involved in prostitution, being pimped, using heavy drugs, drinking, fighting with residents, assaulting and being verbally abusive to staff.

While in the care of the Health Board T became pregnant twice, the first time when she was 16 years old and secondly when she was just over 17 years old. Upon the birth of her first child the Health Board sought to enable T to parent her baby but serious concerns as to her ability to do so resulted in

the Board securing an Interim Care Order and placing the baby boy in foster care. Initially this was with the father of the baby's parents and subsequently with another foster family. Significant access to her son and support were provided to T. In her second pregnancy T who by now had had a Guardian Ad Litem appointed to represent her interests, secured the opportunity to care for her second child a daughter for a negotiated period of six weeks. Substantial supports were provided by the Health Board in the house in which T lived with her daughter including an intensely monitored environment aimed at providing T with very high level of advice on and practical education on being a parent. However, within six weeks the Heath Board had to take emergency action taking T's daughter into care due to their concerns about the manner of her interaction with her daughter.

The response of the psychiatric and psychological services in providing care, diagnosis and advice was clear and sensitive. Five psychiatric assessments and one psychological assessment of T were undertaken in her lifetime. In addition there are seven documented instances of recommendations for T to be assessed by a psychiatrist that did not lead to any such action. There is no evidence from the files that the insights provided by the psychiatric assessment of T were brought to the knowledge of the residential care staff and appropriate advice as to the ways in which they might adapt or redefine their care roles in the light of those important insights. There was a delay of over two years in actually getting a psychological assessment of T and this undoubtedly led to delays in ensuring T's needs, abilities and competencies fully informed the care provision process in all settings.

During 1999, for which period T was pregnant for the latter part of the year during which time her effective accommodation was various B and B's. During the time that T was accommodated in B and B accommodation there appeared to be no care plan or programme for therapeutic engagement by her direct carers with her.

When T was first admitted to Sherrard House it was clearly done to ensure her personal safety. It was a good service to immediately provide a child care support worker for T over the first weekend in Sherrard House. Overall the supportive and facilitative role of these workers emerges strongly as a positive feature of the services made available to T. In all the documented interactions, twenty one in total, there is only one reference to T not keeping an appointment with a child worker. There are no documented incidents of abusive behaviour towards any of these workers.

Supported lodgings also provided an important service to T when she was 15 years old. The most important role, in addition to safe care, was the opportunity it gave T to speak of difficult issues in her past and current life. A pragmatic and safe care decision was made to extend the financial terms of the scheme to enable T's granny care for her without financial difficulty although there are no records of the appropriate statutory assessment being undertaken.

The service in Parkview initially proved supportive of T enabling her to be safe from the street scene and its attendant dangers. T found it a service in which she was able to disclose her involvement in prostitution and received a lot of support to enable her break loose from being pimped. This was a most important outcome and the staff concerned are to be deservedly commended.

The dilemma that originally presented in T's residential placement in Sherrard House again presented in her placement in Parkview. The dilemma as to at what stage did the needs of other residents as a group take precedence over T's individual needs. Ultimately the staff of Parkview concluded that they could no longer cope with T's highly sexualised and provocative behaviours and that she must leave the service. Regrettably, the immediacy of both making the decision and implementing it on the same day, resulted in T being placed in a B and B service. It does not demonstrate a cogent interlinking of corporate Health Board responsibilities towards a child in care by exposing that child to possibly greater risks than were presenting in Parkview.

The period of residence by T in Lefroy was an eventful period in her life encompassing a range of events including psychiatric symptoms, allegations of physical assault, allegations of rape that were subsequently withdrawn, exposure to a drug culture, highly sexualised behaviours and the death of

her grandmother. There was a good degree of planning for her first admission to the service. The end of T's initial period of residence in Lefroy was so unplanned as to appear chaotic. In the second period of her episodic referrals to Lefroy House, T was in late pregnancy with her first child and these admissions were opportunistic rather than part of any planned process of care.

The brief stay by T in An Grianan was one of four residential placements T experienced in her first year of being in care. The efforts at planned admission and ensuring a clear and well thought out process of integrating T into the service went somewhat askew when the admission date was deferred through delays that arose in recruiting an additional staff member for the service.

The unit at 490 North Circular Road provided a period of stability for over five months to T when she was aged 16 years. It proved a relatively successful placement in that T was able to access on a weekly basis some nine hours of personal tuition, which in the opinion of her tutor was very positive. Whilst there was approval for continuation of the tuition service while T was resident in Eglington House in September/October 1999 it is not clear why the tutor service was not reactivated.

The service of Eglington House provided an opportunistic period of care at a time when T was pregnant and homeless. The second placement had worthwhile objectives from a parenting perspective but did not succeed in meeting them.

T's placement in the Cork adoption residential unit was quite opportunistic and unrelated to any structured care pathway identified at any time between herself and the social work services. There were no stated expectations as to the desired outcomes from this placement or the requirements as to the supports to be provided while T lived there. It was not a successful placement and the manner of her discharge from Cork was completely unprofessional and cannot be regarded as acceptable.

By year end the Health Board had established a dedicated unit at Orchard View When T was accommodated there, the vision held for its operation was that T would be encouraged to develop household and budgeting skills and the unit adapted its support to T in accordance to her changing circumstances. T was to be assisted in developing independent living skills and the ethos of the house was to build on T's strengths. Initially it was quite a good service led by a coordinator on site who interacted and managed the presenting care issues in a thoughtful and purposeful manner. However, when he left and was not replaced the reality of care became based principally on rules that were devised in an ad hoc manner responding to the most recent crisis. The range and availability of professional supports to be provided both for T and the staff who cared for her were insufficient. What resulted in Orchard View was a building in which T was accommodated in a highly supervised, constantly observed and regulated environment with all her activities with her children minutely observed, detailed and recorded. When volatile moments arose, when T expressed anger, when arguments ensued between T and staff as to how loudly she could play music, about how she could not have her boyfriend in the house or about how she could not cook for her boyfriend these issues were not managed in any therapeutic manner or according to any sourced therapeutic plan.

There is no evidence on file that any of the staff in any of the services had been trained in Therapeutic Crisis Intervention or if they had there is no evidence of its use in addressing the violence that did present in T's behaviours while living in Orchard View or any other service.

Maintenance was a source of fairly continuous concern over the period T resided in both No 2 and No 5 Orchard View. In the case of No 2 Orchard View, where T lived for almost eight months there were issues regarding frozen pipes, blocked toilets, missing locks, a defective shower, a blocked drain, a leaking ceiling and eventually a ceiling that fell in. When the ceiling fell in No 2 Orchard View, alternative accommodation in an adjacent house No 5 was arranged. T lived in this house from August 2001 until her death in January 2002. During that time there were problems with the drains, the windows would not close, the back yard was unhygienic with raw sewage overflowing on occasion and full of rubble such that the children could not safely play there.

The Green Door into which T was linked into by her assigned child care worker provided a practical daily support service to T including washing her clothes when Sherrard House was not available to her when she was barred from that service during the latter part of 1998.

Placing T in an educational programme in St Vincent's Trust was a very important action. Strong support was provided by the social worker working alongside T to encourage her attendance. The fact that T while initially enjoying the programme, later sought to move away from it is indicative of the difficulty she had in participating in formal educational processes. The placement was terminated by the service due to T's behaviour and was not to be reoffered until 1:1 staffing was made available. The then Health Board agreed to fund the 1:1 service but T never availed of it.

The services of Claidhe Mor were sought during two separate periods of T's life, initially when she was 15 years of age when the service was proposed in the context of her then family relationships. The service request did not progress. The second referral related to the period when T was 17 and 18 years of age. The purpose of this referral was to acquire from Claidhe Mor individual counselling and parenting skills for T as well as couple counselling and appropriate psychological and psychiatric assessment. This did not happen and the only counselling T and her partner actually got was that which they themselves secured. Some eight months elapsed between referral and the decision being taken by Claidhe Mor management not to provide a service.

Intermittent contact arose between Focus Ireland services and T when she was aged 15 and 16 years. There is no evidence on file to demonstrate what was learned of T's needs and how better they might be met from the interaction between T and Focus Ireland services that arose over a two and a half year period.

T's involvement with drugs appears to be limited to two time frames, the first occurring in 1998, being the year in which her mother placed her in voluntary care. When it became known that she was taking drugs she was advised of the dangers of so doing. T's use of drugs identified eight times that year must also be viewed in the context of her very unsafe sexual behaviour during that same period. In the second period of drug use, which occurred in the last few months of T's life when she was living in Orchard View there is no evidence available that any of the nurses had professional expertise in addiction care nor was any referral made to the addiction services notwithstanding the growing concerns of the network of professionals. There is no recorded incident of drug misuse when T was ever pregnant.

The physical attacks by T on staff and members of the public led in a number of cases to the Gardai being called and statements taken. While T had many instances of disruptive behaviour there is only one instance of her actually damaging or defacing property. There does not appear to have been any systemic overview of the background factors that surrounded these attacks. Neither was there any systemic oversight as to what effective harm reduction, behaviour modification or other forms of anger management was required. It does not appear there was any seeking or sharing of the coping strategies used in other high support or secure units with any of the units in which T lived over her time in care.

There appears to have been a reliance on the fact that the staff in the main had psychiatric nursing backgrounds and that of itself this would be a suitable to ensure appropriate care for T.

The personal safety of staff was a significant health and safety issue that does not appear to have been addressed nor evaluated from a risk perspective at the time. No debriefing or support processes were identified where a carer was subjected to threats or assault.

The emotional impact on T's children of her outbursts created strong concerns for their safety. The then Health Board properly and promptly sought to have the children taken into care. The staff

concerned acted promptly, professionally and correctly in undertaking this unfortunately necessary role on two occasions.

The highly sexualised behaviours exhibited by T were never looked at systemically with a clear plan to manage the sexualised behaviours or how T might be stopped from being sexually exploited. The issue of T's sexualised behaviours were considered principally in the context of the impact these behaviours had on the wider group when she was living in a group situation rather than a focus on the needs of T as an individual. Available highly specialised professional advice and professional services expertise in Ireland and the UK was not sought to address the individual needs of T as regards her sexual behaviour.

The appointment of a Guardian Ad Litem enabled T's needs and views to be clearly articulated. There are no records of any difficulties in T's behaviour towards her Guardian Ad Litem. The provision of information to the Guardian Ad Litem was slow and fragmented and was the subject of discussion in the court hearings. There appears to have been some difficulty in accepting the views of the Guardian Ad Litem as presented, rather than a positive welcoming of the clarity and objectivity with which T's views and an objective assessment of her needs by her Guardian Ad Litem were being expressed. For the care staff in Orchard View, there undoubtedly must have been some confusing moments with three separate Guardians Ad Litem coming to the house and interacting with the staff at different times.

T went missing from care placements on at least twenty three occasions while she was under 18 years of age and in the care of the Health Board and a total of six occasions when she was aged over 18 years of age and living in a house provided by the Health Board. Gardai were infrequently notified. In the majority of instances it was not known where T spent her time when missing or what she was doing during this time. No overview the incidents of T going missing took place.

A total of 227 recorded contacts between or on behalf of T and the OOH were identified over the period 1998 to 2002 with the most significant number occurring during her first year of being in care. There was regular and good communication between the OOH service and the area based social work team regarding all contact with T. Good recommendations for T's future care were made by OOH staff who became very concerned about the increasing problematic behaviours of T that made her very unsafe. Being pimped was very well tackled by OOH staff who are to be commended for the alacrity with which they dealt with the matter. An appropriate referral was made to the Gardai by the service regarding the matter of her having sex with an older man. When T was living in Orchard View, the OOH service on at least three occasions, was incorrectly cast by the staff working there in the role of care manager. T presented on at least four occasions when OOH did not offer her accommodation but instead offered food, bus ticket or a service she had previously rejected. This cannot be construed as an appropriate response to an extremely vulnerable girl while in the care of the then Health Board.

T had five social workers who were principally involved with her care whilst she was in the care of the Health Board. In addition, there were thirty nine other social workers - principally at basic grade – involved to some degree or other with T when in care. In the initial year of T being homeless there was a structured and continuous process of social work involvement that had purpose, context and direction. There was generally good social work communication between the Irish and English social work departments. A complaint made by a relative of T was properly reported by the social worker to her supervisor and so recorded. The documentation does not show the subsequent process for managing the complaint nor its outcome.

Social work management properly brought the range and extent of T's care needs to senior health board management for their attention. Ensuing discussions did result in some developments including dedicated nursing staff accompanying her whenever she was placed in B and B. These were in themselves ad hoc responses to T's needs rather than a structured long term service as envisaged. The lack of actual secure care was a major deficit arising at this time not alone for T but

also for a wider cohort estimated by Health Board management at the time of some 20 children. There were significant difficulties in relation to the recruitment of residential child care staff with hugely expensive and extensive recruitment campaigns undertaken but with little success insofar as the needs of the then Health Board were concerned.

There were many demands on social workers arising from the care proceedings in respect of each of the children together with the demands arising from the initiation of judicial proceedings on T's own behalf for appropriate care in April 2000. T secured a Court order that the Health Board should provide her with the most suitable accommodation and to draw up a care plan for her as soon as possible. Monthly court applications for extension of care orders required updated reports from the social workers and appearance at the hearings. There are some forty dates of court attendance recorded in the files.

Increasingly, decisions of the court significantly influenced the overall care provision for T as well as her daughter whom she was allowed by court order to care for a period of time in order to develop a bond and care for the baby. Unfortunately this did not work out due to concerns of the Health Board staff regarding the safety of this baby while T was caring for her. The baby was removed and placed in foster care within two months of being born.

When T reached 18 years of age, the judicially driven process was guiding her future care and the management of the access visits for both children. The logistics of managing two sets of access arrangements for each of the children; the regularity of attending at court to secure extensions of the respective care orders for each of the children, dealing with the issues raised by the respective Guardians ad Litem for the children allied to the requirements of managing the residential accommodation provided for T was a most difficult and problematic experience for the social workers allocated to the case.

Significant difficulties arose in the care of T particularly regarding her barring from the OOH services. Equally problematic was the question of entitlement by T to supplementary welfare services from the Homeless Persons unit. After an initial refusal to assist her, this service did reconsider its decision and ensured that T benefited from its support.

A key case conference was held in mid January 1999 at which a dozen decisions were reached on how the health board would proceed in caring for T. Following the birth a further case conference agreed to the request of the paternal grandparents that they be allowed care for the baby. The significant issues and concerns for T's own physical and emotional safety together with the knowledge that she appeared to be sexually involved with older men, concerns about her being pimped, about her beginning to take drugs and going missing on a number of occasions did not result in the calling of a case conference under the provisions of the extant Child Abuse Guidelines

There are no records that any discussions took place concerning the ante natal care requirements of T, either with her or as part of any review processes for either of her pregnancies and it was left to herself to organise all this care which she did.

While it was suspected that T had become had become involved in using drugs in December and January she consistently denied this was so. There is no record of any involvement, even on an advisory level, of any of the substance abuse services to address the presenting concerns.

Within seven months of T being taken into Health Board care the professionals involved in her care were of the view that secure accommodation was required. The rapid escalation of the intensity of care levels required for T moved from the initial assessment of providing T with accommodation that was emphasised as being a safe and secure home to accommodation that was both structured and a secure environment. The escalation of the required care levels was supported by the assessment of experienced care professionals and seasoned expert child psychiatrists who had worked closely with T over these initial months of homelessness.

Efforts to secure a place in existing high support accommodation entailed contact across services throughout Ireland, Northern Ireland and the UK. All these efforts proved unsuccessful. The Health Board itself over the period of T's care was in serious difficulties in the provision of high support care units which led to many costly appearances before the High Court defending cases brought against it under the various statutes to vindicate the rights of the child. The difficulties in recruitment of suitably qualified staff and the difficulties in building planned units were frustrating, problematic and strongly managed by Health Board management within the presenting limitations and the constraints of what was in fact achievable.

Significant legal actions were a regular feature of the then Health Board's management agenda as constitutional challenges and judicial reviews were increasingly used as vectors for securing care arrangements for children in care. Media interest was intense and the corresponding publicity was creating its own agenda of demand for more and better service with sophistication and expertise. The construction process for new units had a timeline dictated by the physical requirements of construction projects rather than the needs of T or any other child. Finance of itself was not a stumbling block nor was the willingness of managers to push very hard to deliver on projects.

T died on 24th January 2002. Following an inquest held on 7th February 2002 the death certificate recorded her cause of death as resulting from ingestion of gastric contents, heroin toxicity, death by misadventure MDMA (Ecstasy) ingestion.

Recommendations

1. All recommendations made in respect of a child in care should be documented clearly as to expected outcome with the prerequisite actions and responsibilities by the named responsible professionals accompanied by the action timeline appropriate to the circumstances of the case.

2. At all times while a child is in care there should be a personal care plan in place that is monitored, managed and adjusted as required by a designated responsible professional.

3. The availability of a multidisciplinary working team to support the transition of a child into care is integral to good care practice and should be a planned feature of the pre and post admission process.

4. It is vital that case conferences are managed by experienced case managers and achieve clarity in the decisions taken, clarity as to the actions required to give effect to the decisions; who is to give effect to decisions and ensuring that all decisions are implemented in a synchronised and timely manner.

5. Within all centres and services which must be inherently fit for purpose there should be a comprehensive series of policies addressing the issues of the dignity of all children and staff and the manner through which these are given effect, monitored and managed.

6. All professional insight, knowledge and expertise should be promptly shared between all involved in caring for the child and transposed into a clear care programme for a child in care.

7. The availability of child care workers to work alongside a child admitted to care is highly desirable

8. The availability of supported lodgings across all geographic areas thus enhancing service localisation opportunities is most desirable

9. B and B accommodation should not form any part of the care arrangements for any child in state care, irrespective of their age or care status. Accommodation provided for children in care must meet basic standards at least equivalent to those specified by HIQA and where a stand alone special circumstance unit is urgently required it should be urgently assessed as to its compliance with these standards by HIQA staff.

10. Proper planning for the movement of a child who is in care is a prerequisite to fulfilment of the statutory responsibilities and should be overviewed and signed off at a designated senior management level

11. Where practical dilemmas arise relating to the care of children and how an individual's needs are to be balanced against a group's needs this should be considered as part of the review of the individual care plans, the philosophy of the centre and the sum of the available expertise

12. All staff engaged in care under whatever employment system or care provision process for children should be properly Garda vetted.

13. All centres should have a clear statement of philosophy underpinned by working policies known and understood by all who work there and who have reason to refer there. A

nominated manager external to the actual service should have accountability for ensuring that such frameworks are in place and actively used.

14. Pre admission planning and regular monitoring and management meetings when a child is placed in care are processes that should be diaried, recorded and acted upon in a systemic manner

15. The desirability of having the capacity to deploy a rapid care group from within existing resources to meet urgent and demanding care need should be examined

16. Clear and accurate communications – especially when bad or negative news has to be conveyed – are fundamentally important and must be well managed. Where services cannot be delivered as promised by an agency, it should be the responsibility of the agency to inform the service user at the earliest practicable opportunity and certainly before the service user presents at the service.

17. Where a placement is sought that presents specific care requirements and behavioural issues beyond the capacities of the service such additional external professional supports as may be required should be made available to the service to support the achievement of the care objectives for the child

18. Fundamental courtesy such as returning phone calls should be regarded as a sine qua non of all care services and all care plans

19. Where a child is placed in the care of the Health Board, a copy of the order entrusting or committing the child to the care of the Health Board should be available at every placement and be a part of the standard information provided to all professionals with involvement for the child in care.

20. In the event of a service not being required for a short period of time it is desirable that a formal appraisal be undertaken of the necessity or otherwise for continuing to have it available for its primary purpose

21. Children with a difficult educational record including prolonged absence from the formal education system should be provided with formal educational psychological assessment.

22. In the event of a cessation of services by a provider, be this involuntary or planned, the relevant key professionals involved in the care of the child should meet and review the issues arising as a consequence of the closure that must be incorporated into the future care plans for the child.

23. All future service agreements should include a requirement that all cases presenting to services must incorporate a planned handover and review process and have clear processes for managing waiting lists and clarity as to the factors that will form part of the decision making process as to the grant or refusal of services and the timelines appropriate to these elements

24. Where adult services are required after a child leaves care they should be seamlessly introduced into the leaving care and after care plan for the child

25. Where physical assaults occur they should be appropriately recorded from a health and safety perspective as well as from a therapeutic view. Careful risk analysis should be undertaken of such occurrences and a clear protocol in relation to involving the Gardai is desirable

26. Balancing staff safety and care requirements is a demanding role that is not unique to child care settings. There is a substantive body of knowledge and expertise within the wider care systems. Such expertise should be made available on an ongoing basis to staff in care situations such as arose in this case.

27. The importance of consistent external management oversight of risk situations and their amelioration cannot be overemphasised.

28. Where there are siblings of a child in care it is desirable that their child protection requirements are also assessed to ensure their safety

29. Management should satisfy themselves that the appropriate steps are taken to ensure the shortcomings identified in this case cannot recur

30. Where there are concerns that a child in care has been sexually abused a formal review of the issues should always be undertaken in accordance with the child protection policies in currency at the time.

31. Allegations and/or concerns of a child being involved in prostitution whether or not in statutory care should always be the subject of a formal referral to the Garda authorities and be immediately considered by the care services in the context of the child protection policies and procedure.

32. A protocol for dealing and engaging constructively between the Guardian Ad Litem and care professionals should be developed so as to provide the most constructive and dynamically effective and productive relationship and where there are multiple Guardians Ad Litem involved in a case a working process that minimises the need for replication of information giving should be put in place

33. Where a child in care presents with drug misuse issues, these should be promptly explored and assessed in a formal case review process. Where expertise is not available within or to the immediately responsible professionals, management should ensure that such is made available and integrated within the overall care plan for the child.

34. The need for residential care for young people who misuse drugs and for existing residential facilities to re-examine their policies in this regard as was recommended in the 1998 Eastern Health Board Annual Review of Adequacy of Child Care services is endorsed by the conclusions of this report.

35. Priority access for homeless children to psychiatric and psychological services should be provided.

36. All requisite documentation relating to a child in care should be integrated into each child's file and properly signed and dated

37. Where complaints are made a comprehensive record should be made of the investigation, the outcomes and actions taken

38. Case closure should only occur when a systemic review of all the interactions between the child, their family network and professionals within and without the health service has occurred to ensure that all matters are properly addressed and completed prior to closure

39. Services working with children in care should work and be managed in a coherent, integrated; focused, planned, needs led service provided in a non adversarial manner

directed at achieving the best interests of the child as the primary and sole focus of their work.

40. An examination of the strategic and policy considerations of the needs of individual children whose needs cannot be met within conventional or available settings without being so disruptive of the needs of other children in the same care settings should be undertaken to ensure that the individual rights of each child are upheld

41. Services for children in care require vigilant management ensuring through audit, structured case reviews, appraisal and feedback from all involved in receiving and delivering the service that the service is being provided to acceptable standards of care and practice.

42. Every effort should be made to avoid costly legal cases being taken with regard to the provision of services for children in care. Where feasible non adversarial processes should be used to ensure the best interests of the child are achieved. Conflicts where they arise should preferably be resolved in a facilitative, mediated or arbitral manner.

43. When a child in the care of the Health Service Executive becomes pregnant when in care a review of the care arrangements should be undertaken by management in consultation with all those involved in providing such care and the child's Guardian Ad Litem or other responsible adult. The purpose of such a review would be to ascertain what further actions might have been appropriate to have been put in place to prevent such a pregnancy occurring.

44. When a child in the care of the HSE dies, a formal review of the case in its entirety independent of the services should be undertaken

45. The operation of the policy regarding children in care absconding or going missing could be usefully reviewed in the light of experience and insights acquired since its original introduction

46. Conflicts between the policies of different sections of the HSE must be resolved by management in the best interests of the child

47. This case emphasises the requirement to examine how the needs of children whose needs cannot be met within conventional settings can be best provided

T – Background information on her life

T was born in the Rotunda Hospital in Dublin on 26th May 1983. Her mother was 25 years old. Upon discharge from the hospital, T lived with her mother D at her maternal grandparent's house. Within the immediate family network T's mother was one of 10 children comprising five brothers and four sisters. At the time of T's birth, all but two of D's brothers and sisters were married. One unmarried uncle lived in the house and an unmarried aunt lived in England. T's father did not want to have any interaction with her or with her mother and there are no records of any subsequent contact between them.

Health Board records show that T received the routine childhood vaccinations during her first year. Concerns were expressed by the nursing staff in Temple St Children's hospital staff regarding the care of T when she was admitted for treatment of whooping cough in her first year and again in this year the local public health nurse expressed concerns regarding T's mother as "quite immature and somewhat concerned about the way she cared for her baby". No further records of any contact with the Health Board were identified until 1988 when T was in her third year.

When T was almost three years of age her mother had another baby – a boy born on the 24th March 1988. The father of this child was not the father of T. D, the mother's baby decided to place her son for adoption and this proceeded in the manner normal for Eastern Health Board adoptions of the time. Notwithstanding the previous contacts with the family no linkages were made with the previous concerns expressed by health care professionals regarding the care of T to ensure that all was well with her.

The record shows that in August 1988, when T was just over three years of age that her mother's plans were [after the Final Consent to Adoption was signed] to travel to live in England with an ex boyfriend and to leave T to be reared by her mother. However, it is unclear what in fact happened to the family unit comprising T and her mother until February 1990, when T was aged 6¾ years old. Her granny, as was recorded in the social work notes of the time expressed her concerns to the social work department about her daughter D as that "Her actions, language and behaviour towards the child is often inappropriate and she remains impervious to any attempts to aid her. Her parents are extremely worried about her and fear that if they put her out, the child would suffer."

Follow up contact with D about these concerns, which were rejected by her, led to no child protection mechanisms being invoked. During the remainder of 1990 when T was seven years old, there are records of T being in Haven House and that foster care was requested for her by her mother, a request that was withdrawn a month later. The Health Board professionals at that time expressed the view that the verbal aggression and abusive behaviour of T's mother towards her family was a "matter (which) appears to be a family conflict over which we have no jurisdiction." Some two months after the initial request for foster care had been made by T's mother, a further incident arose when T was again with her mother in Haven House. The social work notes record that the social worker had called to Haven House [and that] T had lost two front teeth due to a smack in the face from D. D after suggestions from myself, felt it would be better for T if she stayed in her Granny's for the present." These facts were not reported to the Gardai nor are there any records to show that the NAI guidelines were invoked on foot of this knowledge being acquired by the then Health Board.

After the period in Haven House, D acquired a flat quite close to her mother. T then aged 7 years, was living with her at this juncture. D was again pregnant and on 12th September 1990, a baby boy was born. The father of this child was different again to any of the previous two children born to D.

It then appears from the documentation that T along with her mother and baby brother went to England to live with the baby's father until at least mid January 1991. The contacts made with the Health Board regarding T by her school teacher over the period mid January to June 1991 would

indicate that T was in Ireland and living with her granny along with her mother and partner. During this time T's teacher related her concerns for T's safety as that T was not liked by her mother's partner and that blood stains were reported by D to her as having being found on her underpants. The teacher advised that D had told her that having brought T to a doctor who said T had not been interfered with sexually. D also advised the teacher that she beats T and on one occasion she had not sent T to school for a week because she had a black eye and bruising.

The social work team discussed these matters and on the basis of previous reports which "were found to be untrue" it was decided to assess the current situation by writing to D to make an appointment for her to visit the social work service. Three appointments were offered but D did not attend any of those offered to her. The school teacher said the situation "had improved and would phone of there is any further cause for concern." There is no record of any evaluation of all the documented information relating to T and her mother notwithstanding the totality of all the allegations and concerns expressed regarding T's care against the prevailing child protection guidance. Given the concerns it is most unclear as to why no face to face meetings took place.

By August 1991, T then aged 8 years old had returned to England and was living with her mother, her half brother and her mother's partner. The family came quickly to the attention of the police and social services. Subsequent investigation led to a child protection conference being held and the decision being taken on the basis that the "couple's relationship had deteriorated culminating in various domestic incidents which involved violence. As a result Miss D and the children had spent two short periods in the women's refuge ....in Salisbury one an overnight stay and the second time 12 –16 August. The evidence presented concluded, "The risks to T were considerable. There had been two incidents of physical abuse which her mother had confirmed and later withdrawn and this retraction would place T more at risk in the future...it was also doubtful whether Miss F would protect T because she seemed afraid of her partner. It was decided that T's name would be placed on the County Child Protection Register in the category of Physical Abuse."

The Child Protection Conference agreed that to would be in T's best interests to return to the care of her grandmother provided they were both agreeable to this plan and D was willing. Financial support and assistance with transport arrangements would be provided by social services if necessary. T returned to live with her grandmother by 6th September and her name was subsequently removed from the Child Protection register in November 1991 as she had returned to live with her grandmother.

In December T's grandmother informed the Health Board that T's mother wanted her daughter to leave her grandmother and come to live with her in England on a permanent basis. The grandmother advised the Health Board that if T came back to live with her, "she may ask the Health Board to take T into care as she did not wish to care for T on a long term basis." The English social services were advised of these developments.

No further contact between the family and the Health Board are documented until April 1994. In the interim, T's mother had had a baby boy, fathered by her partner, born on 1st April 1992 when T was almost nine years old.

In April 1994. T, her mother and siblings returned to Dublin from England having left an abusive relationship (with D's partner) and stayed with their maternal grandmother. T's mother and grandmother separately requested counselling for T who had suffered because of mother's abuse by her partner. Her mother felt that T "is depressed verging on suicidal at times." The local Public Health Nurse who had been contacted about overcrowding in the grandmother's home by an Environmental Health Officer advised the social work department of the issue and the concerns about T, as expressed by her mother.

T's school referred her to the Mater Child Guidance Clinic but despite being offered an appointment T did not avail of it. Appointments were offered to T's mother by the social work department but she did not attend and the case was closed in August 1994.

For the next three years, there are no recorded contacts with T or any member of her family on the social work files. It appears from later notes that T lived with her mother and siblings in a local authority house in Dublin sometime in 1996 and returned to England with her partner and children in December 1996. A 1997 English child protection report noted that T was living in England with her mother, her partner and T's siblings until she returned to live with her grandmother in May 1997, just ten days short of her 14th birthday.

Within a week of T's return to live with her grandmother in May 1997, a request was made by an aunt for health board support. An appointment was offered to discuss the matter but no one attended. T's grandmother was advised at the end of May "we were closing file pending further contact." Wiltshire social services contacted the Health Board in mid June asking them to request T's grandmother to contact them. A social worker made contact with the family and explored the issues and options. T's grandmother was finding it difficult to cope with T's behaviour and stated that she was not in a position to care for T long term due to her age and health problems. The possibility of relative foster care was explored but was found not to be an option. T herself did not want to return to England as her mother's partner "has beat her." Her wish was to be placed with a foster family in Ireland and was disappointed that this could not happen immediately.

A social worker was allocated to be T's individual social worker who met T on a weekly basis while in the care of her grandmother and explored the reasons for T not wanting to live with her mother and partner. From this and ensuing discussions a number of options were to be explored. These were relative foster care, counselling support for T, possible referral to one of the child care workers and care in a number of residential settings. From discussions with T's grandmother it was clear that she finding T's behaviour very difficult to live with – "she is refusing to do what asked and was coming home late at night" Her grandmother felt her age and health problems would prevent her from providing the care she felt T needed. T was herself confused as to where she wanted to live and her views on this vacillated. Eventually T decided to return to live with her mother in England at the end of July shortly after her 14th birthday. Within a month of her return to England, the social services there were considering taking her into care due to family violence. By the end of September 1997, Wiltshire social services advised that T's name was placed on their Child Protection Register under the category of physical injury and emotional abuse. The social work report for the child protection conference contrasted how in 1991, T "presented as a bouncy, energetic eight year old who was very articulate. She presented as a well adjusted child but appeared to miss Dublin and often talked about it, now presents as an isolated, lethargic and frightened adolescent"

In October, T's grandmother contacted the social work department stating that her daughter (T's mother) was seriously assaulted by her partner in England and had received a fractured skull. The grandmother said she was willing to accommodate her on return to Dublin until she got settled. Social worker support was offered and the case was closed pending further contact. Wiltshire social services were in contact with the Health Board social workers and advised that the family was now living in a hostel. In mid December 1997 T returned to Dublin with her mother and siblings. T was 14½ years old. On first returning to Ireland, D and family stayed with her mother but arguments arose between D and her mother.

In January 1998, D together with her children left her mother's house and stayed in two women's refuges Coolock & Rathmines. These did not work out due to allegations that D and T intimidated and threatened staff and residents. T's mother said she came to T's defence when she was being bullied by other children and women and felt she was victimised. T's mother also alleged that T had bullied her and had hit her.

The family left the refuge at the end of January 1998 and stayed in B&B accommodation for a number of months until the end of May 1998. During this time T engaged in unsafe behaviour spending a lot of time on the streets and going missing on a number of occasions. On one occasion T alleged she was almost raped when she went with a group of men to a squat.

A referral to Claidhe Mor for the family was made in February by the social worker who considered that the entire family would greatly benefit from therapeutic intervention and the opportunity to look at and hopefully improve their relationships as they stand and their past experiences. However, this was not immediately successful and they placed on a waiting list. The family never availed of or were offered again this opportunity of therapeutic family intervention.

In Mid February, the Child Protection Coordinator of Wiltshire Child Protection Committee advised the social work department that "it is my intention to remove the children's name from the Child Protection Register in this area. Please confirm whether or not you intend to hold a child protection conference in Dublin and provide us with any information which indicates that these children's names should not be removed from our Register." There is no indication that this inquiry was in fact ever replied to.

Parallel to being placed in B and B every support was being given by the social worker to D to secure accommodation from the Corporation. Unfortunately, nothing transpired of these efforts. Applications for housing with Focus Ireland met with a similar lack of success.

From early March the relationship between T and her mother broke down. T moved out of the B and B where her mother was staying and went to live with her grandmother. T's social worker made the first contact with the Out of Hours service regarding T's possible needs. T presented instances of sexualised behaviour in this month and the Gardai at the station which T presented to avail of the OOH service were sufficiently concerned to stop her leaving with an older homeless man. Support for T was also being provided by a child care worker who was focusing on working with T about how to make safe decisions incorporating into this educating her about sex and sexuality. Also as T had not been in school for approximately two years the child care worker was charged with trying to get T involved in a course and activities which would result in her mixing with her peers.

By the end of March, T's social worker advised the OOH service that the situation had stabilised somewhat and area had assessed her grandmother as a supported lodging provider, although there are no records of this assessment in the documentations supplied, and this was working well so far. In a social report prepared for the Claidhe Mor service referral the social worker had concluded that "T is an extremely vulnerable young girl whom at present is not receiving adequate care. It is imperative that she be given care and provided with the opportunity to develop herself and her talents and have interests outside of her family."

During April, it appears that T moved out of her grandmother's house and back to living with her mother. However, the relationship between T and her mother was very difficult with a social worker in the Corporation reporting to the health board social worker following a visit regarding an applications for housing that "I would consider D's behaviour (towards T) to be out of control and that her children are victims of physical and emotional abuse and are at risk." At the end of the month T's mother's partner moved to Ireland and stayed with T and her mother in a one bedroom bedsit. T did not want to stay in this situation and her social worker wrote that she " was concerned for her physical safety in this situation."

The following month, May 1998 was a very momentous period in T's life. It was the month she was put in care by her mother – on 12th May 1998 – who then returned to live in England with her partner. On her first night of being homeless and using the OOH service for the very first time T asked the Social Worker to stay with her until the OOH Social Worker came. The Social Worker told her this was not possible and left T at a shopping centre at 6.40 p.m. from where she was to start walking to Coolock Garda Station at 7.10. p.m. It was a very solitary experience for T whom the

OOH records that "T presents as very nervous, unstreetwise, spoke of fears of being bullied". T was placed initially in Sherrard House.

There is reference in the documentation that a case conference was held in May regarding the family but no records of same were sourced among those provided.

T stayed in Sherrard house – a hostel for adolescent girls – for nine nights and refused to return there alleging another girl bullied her. Hostel management advised the OOH service that T was barred from using the emergency bed for a week because she fought with another girl living in the hostel. The OOH service for the rest of the month placed T for a few nights in a number of different supported lodging providers and Parkview emergency hostel. Continued support from the child care worker was being provided and a place was secured for T on a Youthreach programme, an educational service aimed at young people for whom the normal education system was not best suited. T started this course at the end of May. Referrals were made by the social worker to six different residential care services seeking a placement for T. Efforts were also made to source a fostering placement with a person who had experience of dealing with troubled adolescents. All these efforts resulted in placement on a waiting list rather than immediate care placement. The social work notes that the "area plan is to secure cooperation of social services in the UK to return T near her mum." However, the ongoing intervention process focused on the day to day arrangements for T.

At the end of May T's social worker wrote "My observation of T is that she is very naïve and unable to recognise dangerous situations. She seeks the attention and approval of older men and boys. I fear she may end up being sexually abused/assaulted if she continues in this manner. Given her present homelessness this risk is further exacerbated. T has little knowledge of sexuality or contraception." In terms of the expectations of a placement for T these were itemised thus:-

1. "To provide T with a safe and secure home with clear boundaries and expectations of her
2. She is attending Youthreach – that she be encouraged and facilitated to continue this course
3. To engage her in therapeutic services around her experience of being a victim of violence and witness to violence. To give the time and space to reflect on her recent experiences with her family – a referral has been made to Claidhe Mor
4. That residential staff and Social Worker address with T how to make safe decisions. Incorporate into this educating her about sex and sexuality

In summarising the situation as of the end of May 1998 the social worker wrote "T is an extremely vulnerable young girl whom at present is not receiving adequate care. It is imperative that she be given care and provided with the opportunity to develop herself and her talents and to have interests outside of her family." During this month T was referred to an Area Medical Officer for treatment of scabies. This doctor stated T did not have scabies but an allergy.

During June 1998, T was placed in a variety of services including her grandparents home, in supported lodgings, Parkview and in Sherrard House. T also went missing on a number of occasions and experienced but did not participate in the drug culture. She did drink on some of these occasions. In addition, T told staff of the services that she had an older boyfriend who was aged 30 who wanted to have sexual intercourse with her, but she refused him. T's social worker spoke to this person advising him of the dangers of consorting with an underage girl. He agreed not to let her stay overnight again. During this month T related to care staff that a man had exposed himself to her while she was waiting at the Garda station to get her accommodation and on another occasion when she was missing that an older man had tried to touch her leg making her feel very uncomfortable. A family group conference was organised at the end of the month for T's extended family with transport provided for all but neither T nor any member of the extended family turned up for the conference. However, the application for Lefroy House proved successful and a place was available for T from early July.

T's placement in Lefroy House lasted until mid August and broke down as the staff felt she needed a more structured and secure placement. During her time in Lefroy House, T continued to attend Youthreach and staff on this programme were concerned about her attention seeking behaviour that was leaving herself open to a lot of slagging from other trainees. Within the first week of her placement in Lefroy T went missing and on her return told staff that she had had sexual intercourse with her 30 year old boyfriend. This resulted in T's social worker informing the Gardai of alleged sexual abuse by the boyfriend. Later in July, T alleged that she had been raped and was taken to the Rotunda Hospital for examination which she refused. Gardai, for four hours, sought to obtain a statement. T then retracted her allegation.

An observational report written in mid July by Lefroy House staff spoke of T's needs and issues thus:- "At present T is now living back here at Lefroy House but is grounded for the moment for her own protection and safety. As the project is designed for young women who are preparing themselves for independent living I am really concerned as to whether T is ready to be given this level of personal freedom and the opportunity to make personal decisions that need to be clearly thought out...T needs to be watched closely and persistently for fear of one day creating a situation that is totally out of control putting herself and others at huge risk. I am also aware of T's ability to stretch the truth to extreme levels, on numerous occasions I have noticed T's versions of events, changing dramatically, including her allegations of being raped and who it was that raped her. To conclude I would just like to stress that Lefroy House is not classed as a secure unit and girls are expected to be able to act in a responsible and mature way that is not going to hinder their development." Following on from discussions between T and her social worker, it was agreed that a referral for psychological assessment be made that was arranged over the course of the next month.

In August, T went to see her mother in England, but returned earlier than expected saying this was because her mother's partner had boxed her in the head with his fist. A notification of alleged physical abuse was sent by T's social worker to the Gardai and the UK social services were notified in October and her social worker advised the English social services "Since that time T's behaviour deteriorated, she had gone missing overnight on several occasions and said she stayed overnight with different men in flats, having unprotected sex and taking drink and drugs. T made another allegation that she was raped but was not cooperating with the Garda investigation. Moreover, T engaged in inappropriate behaviour in the hostel and Youthreach course."

September 1998 proved to be a very traumatic month for T. She lost her placement in Lefroy House due to her behaviour and it was not felt by them to be a suitable environment. They considered she required a more structured and secure placement. T resumed living in B and B and on the streets. In the first week of the month, T told the staff in Lefroy that she had smoked heroin. This is the first recorded instance of T using drugs. Towards the end of the month T was admitted to the Mater Hospital for assessment following her saying she was hearing voices. It was planned that T would go from the Mater to Warrenstown House. However, staff at Warrenstown House did not feel it would be suitable. During her stay in hospital T's grandmother died and T did not return to the hospital after the funeral. The consultant opinion after her discharge was that "we found no evidence of an active psychotic process, disordered thinking nor mood disorder. The sum of T's presentation points more towards a conduct disorder."

T subsequently returned to live in Sherrard House. In the meantime the Gardai who were investigating a second allegation of rape by T wrote to the social work department saying they were very concerned about T stating "it would appear that T, while away from Lefroy House, approaches men of all ages, nationalities and colour and goes with them after spending time in their homes...it is the opinion of the Garda investigating these allegations that TF, while able to leave Lefroy House, at will, is in grave danger"

Over the course of the following month, October 1998, whilst T then aged 15½, was moving between supported lodgings and Sherrard House an unsuccessful application was made for T to be admitted to Oberstown House. T's behaviour continued to deteriorate with it becoming clear she

was receiving money for sex. T was alleged to have stolen a staff member's watch in Sherrard and as a consequence she was granted only restricted accommodation with no washing facilities, such facilities had to be accessed through the Green Door service. T admitted to sniffing solvents and smoking hash and was advised on the dangers of so doing. Later in the month T was barred from Sherrard House for setting fire to some papers in her room. An application for a place in An Grianan was successful and T was able to move in there in November. It had been planned for T to move in there in October but confusion over recruitment of staff had delayed her admission. In the meantime T was accommodated in a mix of B and B accommodation and Parkview.

The Out of Hours service advised the area based social worker because they were so concerned that "on the basis of the Crisis Intervention Service Team's experience of T's presenting behaviour I would recommend you seek a comprehensive residential assessment of T's needs including psychiatric, psychological, educational and of course social. Whilst you are waiting for an appropriate residential placement and/or residential assessment you could consider placing T with either child care staff or psychiatric nurses in a "special" single unit arrangement which will at least provide her with a safe place and some level of stability." T admitted to being involved in prostitution with Romanian men. T was accommodated in Parkview until her place in An Grianan was available. The local Garda Superintendent wrote to T's social worker saying that in his view the calling of a case conference was warranted. Within three days of being admitted to An Grianan, T was found using hash, drinking and admitted to using other drugs.

A Consultant Child Psychiatrist met T at the end of the month and in a letter to the social work department concluded "There is no evidence of psychiatric illness but she presents as a severe conduct disorder"...in urgent need of a secure residential placement ..."at grave risk" in current inappropriate placement.

In December 1998, T was discharged from An Grianan due to her overtly sexualised behaviour and language together with violent and aggressive behaviours towards staff and other residents. T was again placed in Parkview and many concerns were raised concerning her significantly inappropriate behaviours towards staff and residents. From the end of December 1998, T was effectively barred from the Out of Hours service.

With T effectively barred from OOH, B and B accommodation became her primary source of accommodation from January 1999 onwards until a dedicated unit was quickly provided for her at 490 North Circular Road. A case conference took place in mid January at which a course of action to care for T was developed – T herself was not present at this case conference. A second social worker was allocated to co-work the case. Applications were made to high support units for T's admission.

The dedicated unit at 490 NCRd was staffed by nurses. A plan was developed to provide a tutor for T together with a referral to a child care worker regarding her self esteem. Some informal basic sex education work was also envisaged. T stayed at this unit until mid July when she went to England to her mother. During her stay at 490 T received weekly tuition on a one to one basis and this went well. Her tutor was pleased with her educational progress and considered her a bright girl. While residing at 490, T made allegations against her tutor but later withdrew them, Her behaviour again became a matter of serious concern with T engaging in prostitution and being arrested for shoplifting. Staff found her behaviour increasingly difficult to manage.

When T was leaving 490 NCRd to go to England, she told staff there she was pregnant and that she was going to England to have an abortion. The Gardai were advised but they were unsure of their jurisdiction on the matter. In any event, T was not stopped going to England and 490 NCRd closed down. English social services were advised of developments and asked to follow up on the issues. By the end of the month, Wiltshire social services had been in contact advising that T was likely to return. The swift response from the Dublin social work department was that as "we are not sanctioned to recruit new staff or procure premises for T. Obviously in the light of this situation we would recommend that T remain in England where she the opportunity to develop a relationship

with her mother and siblings. It is felt that since T would have no family or support networks in Ireland, it would be in her and her unborn baby's best interest to remain in England."

T returned to Ireland in mid August 1999. She was still barred from the OOH service and was four months pregnant with nowhere other than B and B provided to accommodate her. Over the course of the next two months T was accommodated in a variety of B and B services arranged through the Charles St service operated by the Community Welfare Service, the area social worker or by herself. On occasion T was provided with an overnight bed in one of the maternity hospitals. On occasion T's whereabouts was unknown to her social worker or any other service. Efforts to secure accommodation in Eglington House and other residential settings proved unsuccessful. Similar efforts to secure accommodation with T's granddad and aunts also proved fruitless.

T went back to her mother in England in November 1999 and returned to Ireland within five days. In her time in England social services had placed her in a children's home. Within a few days of her return to Dublin, a place was secured for T in the Sacred Heart Home in Cork. This placement ended within a month as the staff could not cope with T's behaviour. She was discharged and placed on a train to Dublin in a very peremptory manner. Over the course of the rest of the month T was placed by the OOH service with her granddad, slept rough, was placed in a hotel and had two staff assigned to care for her in the hotel.

In January 2000, T was placed in a hotel accompanied by two nurses and subsequently placed in two apartments at different times during the month. T attacked agency staff on one occasion with a knife and was brought to the Mater Hospital for psychiatric assessment, but left before one was carried out.

With T's baby due in February 2000 a case conference held early in the month at which it was decided that:-

1. "T's baby to be taken into care after it is born
2. T and N will be asked to voluntarily place their baby in the care of the EHB, if they do not agree to this a care order will be obtained through the courts
3. The name and address of the foster carers must be withheld due to T's violent and unpredictable behaviour
4. T to return to home address
5. Access will be regular between T and her baby and will be supervised by Social Workers"

T's baby was born on 9th February. T and her partner N were placed in a flat on their own. This arrangement lasted only one night as they found it too difficult to live together. Following a request by the paternal grandparents and the holding of a further case conference it was decided to place the baby with them. An application was made by the then Health Board to the courts for a care order and this was granted. In a social report made to the court the social worker recommended that "T to be referred for full psychiatric assessment in the Mater Child Guidance Clinic."

Subsequent to the birth, the OOH service continued to maintain its decision not to provide service to T who was placed in a variety of B and B over the next seven weeks by her area social worker. A placement in Eglington house was secured for T with its purpose being to provide for T to be supervised, guided and appropriately helped in the day to day care of her child L, with the plan being that T would be able to leave with L in her care. Within eleven days the placement had broken down for the following reasons:-

1. "Staff witnessed T on two occasions to be inappropriately kissing L on the lips
2. T needed to be constantly prompted to attend to L's needs e.g. making bottles, sterilising properly
3. T regularly provoked arguments with N – one occasion staff witnessed T punching N and on another occasion T went to hit N when he was holding L – staff had to tell T not to

4. Staff were of the opinion that T put her own needs before that of her son L"

Arrangements for very regular access visits were put in place and regularly reviewed.

At a court hearing in April 2000 the then Eastern Health Board was ordered to provide T with the most suitable accommodation and to draw up a care plan for her as soon as possible and T was to fully cooperate with the Health Board in the preparation of this plan.

In a Guardian Ad Litem report prepared with regard to the care of T's son L, the Guardian wrote that "Miss TF detailed her involvement with the Health Board indicating how unsupported she had been by the Board over the years, financially emotionally and practically. That this was the reason that she had struggled to build a working relationship with them as she felt that the relations were one sided, that she had to do everything they said, but that she would not receive accommodation, support or any other form of assistance over the years…Miss T is very concerned that the fact that she is monitored at all times, that this frustrates her and inhibits her from developing positive relationships with her son L during access visits….I recommend that both parents receive the input of a parenting course….the provision of family therapy services be made to N and T…"

Subsequent to her discharge from Eglington House T was placed in a number of different B and B's accompanied by two nurses – an arrangement that continued until July 2000.

A separate Guardian Ad Litem for T was appointed by court order in May 2000 with the responsibility to provide "such reports and assessments to be carried out in respect of the respondent as deemed necessary and appropriate by the Guardian Ad Litem". The brief as additionally advised by Counsel was "to guide T through the Court process given that she hasn't reached her majority."

From July to the first week of October 2000, T stayed in a flat in the Financial Services Centre that was staffed initially with double cover staff provided at 8 p.m. to 8 a.m. This was later extended to 24 hours cover. This placement broke down for the following recorded reasons:-

1. "T not adhere to curfew – often staying out until 2/3 a.m. ignoring the possible dangerous situations she could find herself in at such a late hour
2. T did not adhere to the visitor policy of the unit – she returned home with friends who in the opinion of the staff were under the influence of drugs – T failed to recognise the potentially unsafe situation she placed herself and the staff in
3. The social worker received a letter of complaint from the letting agency informing that T was seen attempting to gain entry into cars in the car park of the apartment complex. When approached by a security guard questioning her actions T became verbally abusive and threatening towards security guard
4. T was trusted with the responsibility of having her own keys to the apartment and to her bedroom. T abused this trust"

T went missing from this placement on a number of occasions and while in this placement was arrested for soliciting. Following a psychiatric assessment in October, the consultant wrote to the social worker stating that in her opinion "the provision of care for this girl since she left her grandmothers home some time in 1997 has been disastrous." In her recommendations the consultant stated "The journey to self esteem and self care for T will not be established easily and indeed this is the combined task for care and therapeutic services. Although she presents considerable difficulties in that she is explosive, argumentative and mistrustful, this has to be understood as emanating from the multiplicity of traumatic events she has experienced. As to whether or not she has a psychiatric disorder or not, I agree that although she is generally suspicious, this is understandable in her circumstances and it does not have the quality of paranoid projections…..Runaway girls are at risk of acting out in a sexual way and getting pregnant. In recognition of this fact, services need to be in place before the event that provides stable accommodation, emotional support and education for parenting. Long lists detailing the risk taking behaviours of these girls is a misguided exaggeration

and generates systemic mistrust, thus it becomes more difficult for children in care to establish positive regard for the worth of their own lives or the services put in place to help them"

T continued to be placed in various B and B accommodation accompanied by two nurses. Her Guardian Ad Litem in a preliminary court report summarised the position from T's perspective thus:- "....I can state that current care provision for T is grossly inadequate...the first was a privately rented apartment supervised by agency staff. Despite the best efforts of staff this was not conducive either physically or in milieu to a structured programme of care and personal development for T...the current alternative has been B&B – sometimes moving from one establishment to another – which T must vacate each morning. For substantial amounts of time, what is described as "24 hour double staff cover" for T exists in name only. In fact, she spends her days wandering aimlessly in public places, in all weathers, until she can return to the B&B in the evening....this places her health and personal safety seriously at risk."

The first draft of a care plan for T was developed in November 2000 and sought:-

1. "To provide T with stable accommodation. T is currently in the B&B and ultimately the Board would be looking and to work with T towards independent living
2. To encourage T to avail of education/training opportunities in St Vincent's Trust in order to assist her in acquiring the skills for future independent living. A referral has been made and we would be hopeful that T could attend
3. To provide T with the opportunity to engage with Claidhe Mor Family Centre and to enhance her parenting skill. A referral has been made and accepted and it is hoped work can commence upon receipt of the psychological report
4. To continue to enhance T's relationship with her son"

A social worker at Team Leader level was assigned to co-work the case with the social worker.

In December 2000, the health board had information that T was 18 weeks pregnant. In the meantime, whilst the then Health Board was sourcing dedicated accommodation for T, she remained in B and B accommodation. However, at times T had to be referred to the OOH service as no B and B accommodation could be sourced.

Just before Christmas 2000, a dedicated unit at No 2 Orchard View was opened exclusively for T's use. This unit was staffed on a 24 hour, 7 day basis by nursing staff with midwifery, psychiatry and general nurse qualifications and experienced in dealing with challenging behaviours. In a letter to T's solicitor the Health Board solicitor wrote that "The premises at 2, Orchard View will be available to T until her 18th birthday. This agency is being designed to facilitate T in developing skills towards independent living. In this respect the service will be available to T following her 18th birthday on the assumption that T wishes to continue to avail of our service." T lived in this area for the rest of her life. She had to change house when in August 2001 the kitchen ceiling fell in, and another house – No 5 – in the same terrace of houses was available.

In January 2001, the Health Board solicitor in a letter to T's Social Worker wrote "we note that Judge Collins expressed concern in relation to the duration of the proceedings to date." Initially T settled in well in the new home, however, her behaviour soon gave cause for concern and she was frequently confrontational in her behaviour towards staff. T went missing overnight from the house. T and her partner argued frequently and on several occasions T hit him. Access continued for T's first child as per court directions. In February T went to England to her mother for three days without telling staff where she was going.

Referral to Claidhe Mor for counselling was progressing. An integral requirement of this service was that T would have a psychological assessment. This was completed in February 2001 with T fully cooperating. While it was envisaged that parenting skills counselling for T in conjunction with a named community child care worker, couple counselling for T & N and individual counselling for T

would be provided, they in fact never were. A referral to St Vincent's Trust was also progressing well and T herself expressed a strong desire to attend the programme after some initial vacillation.

Up until the birth of her second child T displayed volatile behaviour towards staff in the house. Episodes of aggressive and threatening behaviour occurred. The court regulated access visits with her first child were difficult occasions for T and when they were over T often became upset and abusive towards staff. Over the course of her pregnancy T attended three maternity hospitals and at times engaged in behaviour that could have – in the opinion of her social worker – put the safety of the unborn child at risk. These factors together with the concerns arsing from the difficulties encountered during access visits and the domestic violence between T and her partner gave rise to the decision to take the second child into care once born.

In May 2001, The Circuit Court upheld the decision of the District Court to grant the health board an Interim Care Order on condition that a case conference was organised by the health board. The judge directed that neither T nor N were to be present but must be represented at the case conference. The judge also instructed the topics to be discussed were as follows:-

1. "T's behaviour since the birth of D at both the hospital and in the house
2. The fact that T is continuing to breast feed
3. The impact that a parenting course may have
4. T's agreement to go to St V's Trust
5. The suggestion of Mr B S (T's Guardian ad Litem) that there be a hiatus period of six weeks where both D and T remain in the house at Orchard View
6. The impact on D of separation from her mother in view of the fact that she is being breast fed
7. The impact on T if she was separated from D in light of the view that she is breast feeding
8. The absence of a therapeutic programme for T and whether one can be put in place – the court noted from the documentation the absence of such a therapeutic programme
9. The recommendation from T's Guardian Ad Litem that staff in Orchard View adopt a less obtrusive role
10. The availability of any services that could assist D and T
11. The role of NC"

T was allowed keep the baby with her at Orchard View and was provided with a lot of nursing support, perhaps too much as in the view expressed in mid May by the local Superintendent Public Nurse "We both agree that the level of support being provided to T at this point is excessive insofar it is not provided with space to develop – relate to her as one would with any young mother who needs time out and plenty care to recover her strength and allow her emotions adjust."

During this time T had extremely poor relationships with most of the staff in the house. She was very abusive and physically aggressive to them and on occasion used knives to threaten staff.

T reached her 18th birthday on 26th May 2001 and enjoyed a birthday cake provided through the house funds.

In a house coordinator's report drawn up in late May 2001, to assist the new staff team which was being changed to accommodate T's concerns a very helpful benchmark assessment and future care process was outlined for the supportive care of T "....it is the result of observations formed over eleven months...[and]..may be a signpost in the difficult work that lies ahead....it is important that all staff working with T set boundaries around how they expect to be treated by T...has in the past responded very well to staff refusing to allow her manipulate or verbally abuse them...staff have little to gain from direct confrontation with T as she does not listen to logic as such....T needs compassion that is backed up with the understanding that staff will at least expect to be respected by T or they will refuse to engage with her...she says she likes to be given a lot of space by staff and to be left alone most of the time. She likes to cook for herself and to feel she is independent, yet at time

she wants staff to become her absent parents and look after her as best they can. T at times seems to experience great loneliness and sadness....has admitted to hating men....the need for affirmation is a double edged sword....T may spend some of her time manipulating the various bodies and organisations that have been charged with her care. I feel that a systemic approach to her situation would be very beneficial. Monthly meetings between all the parties concerned would I believe provide a far more effective approach to this particular case."

During this period it fell to T's social worker to act as de facto manager of the house including mediating conflict between the staff and T as well as simultaneously dealing with the access arrangements for her first child and providing therapeutic support to T.

The court directed case conference on T's ability to care for her new child took place over two days in mid June. It was not altogether a satisfactory process with the health board clearly "of the opinion neither T nor N either solely or jointly can provide D [the new baby] with appropriate care to ensure her emotional or physical welfare." Her Guardian Ad Litem wrote to the case conference participants thus "I request the Health Board "to re-orientate itself" and at least explore the options with an open mind and reserve its decision to the end." No radical changes arose from this event.

T started to attend St Vincent's Trust in early June but within four weeks, due to her behaviour becoming increasingly more challenging and aggressive towards staff and other participants her place there was stopped until one to one tutoring could occur. The then Health Board agreed to pay for this service, but T never availed of it.

On the day following the cessation of her placement in St Vincent's Trust, 6th July 2001, T behaved in such a manner as to cause the gravest of concerns to health board social workers who took the decision for the safety of her baby to remove the baby from her care.

Over the course of the next months there were continuing significant legal interventions regarding the care of T's two children and the access arrangements for them - an issue that had started following the birth of T's first baby.

T's own behaviour became even more rude, hostile, aggressive, physically threatening and abusive. The Gardai were called on several occasions to deal with the threatening behaviour towards staff who feared for their safety. The environment in the house moved from that of being a supportive unit to becoming a secure unit with rule upon rule and little therapeutic focus or advantage being provided. T was came and went into the house at varied times and did not always stay overnight as had been agreed. Increasingly T became even more verbally and physically argumentative and aggressive towards N and yet they tried to support each other and attended counselling organised by N on two occasions.

N himself was seeking a separate legal entitlement to be guardian of the children and increasingly he became less involved with T until by year end the relationship had ceased.

Following the removal of the second child from T, access arrangements were put in place under court regulation as to the frequency, duration and location of these visits. It was a logistical nightmare for everybody and for the children it entailed long journeys across Dublin. So much was there concern about the deleterious effects of these multiple movements and contacts that the court decided following an application by the Health Board with reports on their findings in relation to their assessment of T's capacity to parent, and involving the Guardian Ad Litem for each of the children and T as well as the foster parents and the legal teams representing both T and N to reduce the frequency of these visits in the best interests of the children.

The key contents of the social work reports made to the courts over the course of the year include notes that Gardai were called ten times to Orchard View to deal with T; taxi driver reported her counting out £350 in his taxi; another reported she had offered him sexual favours; she was

cautioned twice for soliciting while heavily pregnant and arrested once for soliciting; numerous incidents where T was physically abusive to N; when L was in the care of N's parents, T made nuisance calls to the household – up to thirty times a day; on another occasion she got a male acquaintance of hers to ring the house and threaten to burn it down unless they returned L to T. Initially T denied this but later admitted to so doing. The social worker's report concludes...T requires a great deal of support and care in order to keep her safe and help her deal with the trauma of her life experience to date...T has interacted positively with her children...we believe that T has not the capacity to provide emotional and physical care for her children on a consistent basis....the board believes that it cannot guarantee a stable environment for D and L in the care of their parents." Seventeen particular concerns were then listed. The principal recommendation was that the "...children need to form a significant attachment to one main carer. If the children are to remain in long term care and therefore form an attachment with their foster carers access [by their parents] needs to be at a minimum...children should remain in care of health board under a full care order"

A report from the Clanwilliam Institute sourced by the Health Board as part of the court mandated assessment regarding the then Health Board's application to take T's two children into care was prepared by a team of psychologists and a psychiatrist and they reported "We have concluded that T does not demonstrate the abilities and the capacity to be an adequate parent to her children." Continuing they wrote "we are regrettably forced to conclude that T is not a good candidate for therapeutic intervention on this issue [can T learn with appropriate support to provide such care in the future?] We have not found any indication of ADD. We conclude that there is a risk to the children of extending the present frequent access arrangement...not in children's best interests to have T caring for children or for N to do so on his own or for both jointly"

T's Guardian Ad Litem in his own report to the Court in respect of this application stated "T complained of not getting along for several months with the staff member designated to be her key worker – no details of her qualifications given to Guardian Ad Litem. The health board said in court that the keyworker was "not qualified to do therapeutic work with T." The report continues in regard to the care arrangements for T after D's birth.... that the prior regime and staff structure was found by the new manager designate to be unsuitable and some of the care practices to be "inappropriate" particularly in regard to the manner and level of surveillance imposed on T with D. He also considered the accommodation to be unsuitable. Consequently there was a complete change of staff at very short notice but within the same accommodation. There have been three different versions, by the former staff, the current manager and the social work dept, as to why this change was necessary.....to my knowledge and opinion the new arrangements have been significantly unsuitable as well. Most if not all the staff have been recruited part time in addition to existing employment elsewhere. This gives rise to an inordinately large number of staff to whom T must relate in circumstances where she already has difficulty dealing with imposed routines and structures. This adds significantly to T potentially coming in conflict with staff who cannot know her well. It is questionable that all are psychiatric nurses given that T has not been diagnosed with a psychiatric disorder.....information I requested regarding social care qualifications and experience among staff has not been made available. There is as yet not indication of a therapeutic programme for T."

The diverse and strongly contrary opinions expressed by the professionals were reconciled only in the judicial system. By November a court decision directed that the care plan for T was to be reviewed and that it was to set out the procedures and provision of assistance which T needed in the interim period. The court also ordered separate access for N with D and L in his parent's home. The Court further ordered neither T nor L to go near the foster placement without the consent of the court as they had stood outside the foster parents' house and were making the foster parents fearful.

The access visits were often a source of great concern to the social workers and staff of the house where T lived insofar as the welfare of the babies were concerned. T's interaction was monitored at all times without exception while the children were with her. This T found to be very intrusive and many flash points arose during these access visits. On occasion T delayed the return of the children

to the care staff and Gardai were called to ensure the child's return to the Health Board staff. Similarly when the children had left, T's behaviour became very difficult and at times threatening to staff. T would often go out and not return or return at a very late hour and on return act in a very hostile and aggressive manner towards staff.

In the latter months of the year T became more physically aggressive towards staff and on a few occasions to members of the public resulting in Gardai arresting her for assault. T also became involved in stealing and was arrested and jailed in Mountjoy prison where access was arranged for T and her children with the cooperation of the prison staff.

Continued efforts were made to provide counselling and support but they did not succeed not due to any lack of willingness or support but more due to a variety of circumstances over which neither party had direct control as the services being accessed were without the direct control of the health board.

By mid December the relationship between T and N had broken down. N moved into a new relationship. T herself intermittently moved out of Orchard View to stay with her uncle. T herself became more aggressive so much so that a taxi company was refusing to provide a service to her following an assault by her on a taxi driver. T became involved with a new male friend who was in the view of the house staff involved with drugs. Over the course of late December and January T became more engaged with different males and presented on a number of occasions with drug related behaviour and appearances. During this period staff in the house noted that T's manner became less aggressively hostile and truculent towards staff in the house and the staff group currently caring for T said that she was very pleasant and engaged well with them and was making a real effort to get on with people.

In the last week of her life staff noticed that T's right arm was swollen with obvious bruising [black blue purple and green]. In a report prepared by the social worker for the Gardai following T's death she wrote..."since December 2001, the staff caring for T have felt that T was under the influence of drugs on a few occasions, in that T presented with dilated pupils and behaviour was extreme whereby she was overly affectionate, which is very unusual for T. On 17th January I questioned T during access visit as to whether she was under the influence of drugs, T denied same saying she never took drugs. On weekend of 18th January the staff also noticed bruising to T's arms and questioned if the bruising was drug related. T's uncle D also noticed same and asked T if the marks were as a result of attempts to inject drugs. T denied injecting drugs to her uncle but admitted to taking E tablets sometimes. After T's death her mother informed me that when she was home at Christmas T was taking E tablets and T had shown her mother tablets she was taking."

T spent her last evening 19th January 2002 in Orchard View watching TV and chatting with staff. She appeared in good form. T requested a taxi at 21.00 and again at 21.30. She had not returned at the shift handover.

Following her non return to Orchard View calls were made to her mobile the following day. On the 20th January T was reported as missing to the Gardai. Over the course of the next few days an extensive number of contacts were made to locate T without success. On the 22nd T's mother was finally contacted by phone to advise her that T was missing. On 25th January the Gardai advised the social work department that they had located a body. A photograph of T and her clothes were shown to the social workers who confirmed they were that of T. Her uncle formally identified T. Following this, T's extended family organised the funeral until her mother arrived from England. T's mother was met by T's social worker and went to Orchard View with her partner to take possession of some of T's belongings. Many professionals involved in her life also attended T's removal to Church at which her extended family were present.

T Following an inquest held on 7th February 2002 the death certificate recorded the date of her death as 24th January 2002 and her cause of death as resulting from ingestion of gastric contents, heroin toxicity, death by misadventure MDMA (Ecstasy) ingestion.

T is buried in Balgriffen cemetery.

Psychological and Psychiatric issues regarding T

Over the course of T's involvement with the Health Board a number of psychological and psychiatric interventions were recommended by various parties who had direct interaction with T. In the first instance the recommendations for such professional expertise being sought but that did not actually occur are examined. These were as follows:-

Date	By whom and why	Actions taken
22/11/91 T aged 8 years and 5 months	From social work notes "Office interview with granny re T and her mother – partner of D in UK smokes hash – [also noted in UK child protection minutes] – seems as if T pushed out with birth of new baby…T very jealous …displays a fear of men [not those she knows within the family]…– query psychological assessment if necessary"	No record of psychological assessment being requested or carried out
20/7/94 T aged 11 years and 2 months	T was referred to the Mater Child Guidance clinic by her school St Catherine's. An appointment was offered on 20/7/94 but not availed of - Social Worker tried to make contact by letter but to no avail.	The social work department made efforts to contact T's mother however she did not keep appointment. The case was closed by the Health Board by letter dated 29th August 1998.
13/7/98 T aged 15 years and 2 months	Concerns were expressed by Youthreach staff where she attended on a daily basis and the staff of Lefroy House where she stayed at night that because of T's disturbed behaviour. T was under constant supervision. T's behaviour is attention seeking, seeking approval, looking at every man who passes her…need to know her ability – mental age….probably will get raped/killed if she continues as she is…	14/8/98 AT Social Worker in fax to Capt Cavell – Salvation Army - …I have referred T to the psychologist Mater Child Guidance My intention is that T would engage in therapeutic services around her life experiences. However, before this it is important to have an indication of what her level of understanding and ability is. T is aware of this referral and is willing to attend. T was not psychologically assessed until February 2001 – almost two and a half years later.
6/11/98 T aged 15 years and 6 months	Extensive letter from Team Leader Crisis Intervention Service to A/Team Leader CCA8 concerning T….on the basis of the Crisis Intervention Service Team's experience of T's presenting behaviour "I would recommend you seek a comprehensive residential assessment of T's needs including psychiatric, psychological, educational and of course social."	No documented follow up on this specific recommendation.
Sept 1999 T aged 16 years and 4	Manager Eglington House "it was suggested to Social Worker that an overall assessment be done on T.	This was never addressed at the time.

months		
9/1/00 T aged 16 years and 7 months	T attacked agency staff with a knife. Brought to Mater for psychiatric assessment, but left before one was carried out [this not on any file but is in letter to PD LHM from Manager CIS service 13/2/02]	No further outcome identified in documentation.
27/9/01	Over the course of a meeting between T, her social worker and the social work team leader a note was made "T did not want to attend a psychiatrist – not mad – if needed to would use Samaritans – saying she had some contact with them in the recent past"	Nothing further occurred
6/12/01	T in Mountjoy – Governor of prison phoned to say meeting should be cancelled as T's behaviour resulted in her being placed in isolation.	T wanted sleeping tablets and was refused same. Said she was going to hang herself, was taken to isolation unit where she then said she was not going to hang herself. No psychiatrist was available until the afternoon. Had not arrived.

Recommendations for T to be psychologically/psychiatrically assessed were made when she was 8 and 11 years respectively. The assessments of the social worker dealing with T's granny and aunts regarding T's behaviour did not result in any assessment. Similarly when T was referred by her school to the Mater Child Guidance Clinic, the follow up was limited to letter contact and case closure without ascertaining from the Clinic what issues might arise from a child protection perspective for T particularly having regard to the responsibilities detailed in the then current guidelines on non accidental injury.

During 1998 when T was first in care a referral was made for psychological assessment of her at the Mater Child Guidance Clinic. Unfortunately, T presented with psychiatric symptoms and in the process of care, for whatever reason, that is not discernible from the documentation, T was never psychologically assessed until February 2001 – almost two and a half years later. The implications of this for informed case management and care planning cannot be adequately emphasised.

In respect of a further recommendation that T have an overall assessment undertaken when resident in Eglington House in 1999 it is not discernible from the documentation as to why this recommendation was not undertaken. There is no evidence that this recommendation was considered in any case review process.

Similarly, the final referral to the Mater Child Guidance Service, which T did not attend, is undocumented other than for a reference in a letter. The lack of adequate documenting of such a referral and the reasons for same is prejudicial to the best care being provided to T as well as not providing a fair reflection of the work actually taken by professional staff caring for T.

Formal psychological and psychiatric assessment of T

Over the course of T's involvement with the Health Board a number of psychological and psychiatric assessments and interventions were conducted on T. These interventions are set out in tabular form and focus on the reasons for the recommendation, when it occurred, the findings and recommendations and views of the professional concerned. These were as follows:-

Assessment No 1

Date	By whom and why	Findings	Recommendations - Views
21/9/98 T aged 15 years and 4 months	Dr McQ – Con Psychiatrist following concern of staff in Lefroy and social worker	See subsequent letters of 29th September and 13th October	Admission of T to hospital on 23rd November 1998
29/9/1998 T aged 15 years and 4 months	Dr N – SHO to Dr McQ Admitted to hospital on 23/9/98 following assessment by Dr McQ on 21/9/1998	"No evidence of an active psychotic process, disordered thinking nor mood disorder. The sum of T's presentation points more towards conduct disorder"	"We will continue to liase with your service regarding offering T any sort of help we can."
13/10/1998 T aged 15 years and 5 months	Dr McQ – Con Psychiatrist Discharge follow up letter	"I have nothing to add (to the report of Dr N) except to say that this department shall be happy to assist further if requested.	"Unfortunately as you know, this hospital has no appropriate unit or in patient facility to treat adolescents such as T and, indeed no such facilities exist on the north side nor within the ambit of services provided by this hospital, the Children's Hospital Temple St and St Vincent's Hospital Fairview. Altogether a very unsatisfactory situation."

Assessment No 2

Date	By whom and why	Findings	Recommendations - Views
3/12/1998 T aged 15 years and 6 months	Dr H – Con Psychiatrist Referral by AT social worker	"There is no evidence of a psychiatric illness but she presents as a severe conduct disorder."	"I consider this very vulnerable and immature girl to be in urgent need of a secure residential placement. I regard her as being at grave risk and accordingly I believe that the current open hostel placement is inappropriate to her needs."

Assessment No 3

Date	By whom and why	Findings	Recommendations - Views
23/10/2000 T aged 17 years and 5 months	Dr B – Con Psychiatrist At request of health board solicitors and Guardian Ad Litem	"As to whether she has a psychiatric disorder or not, I agree that although she is generally suspicious, this is understandable in her circumstances and it does not have the	"Runaway girls are at risk of acting out in a sexual way and getting pregnant. In recognition of this fact, services need to be in place before the event that provides stable accommodation, emotional support and education for parenting. Long

		quality of paranoid projections. I also agree that the symptoms with which she presented in August 1998 were stress induced in relating to the imminent death of her grandmother and thus were not an established feature of a major mental illness"	list detailing the risk taking behaviours of these girls is a misguided exaggeration and generates systemic mistrust, thus it becomes more difficult for children in care to establish a positive regard for the worth of their own lives or the services put in place to help them."
23/1/01 T aged 17 years and 7 months	Dr B – Con Psychiatrist in an elaboration of her report of 23/10/00 at request of T's Guardian Ad Litem	"As a young mother, without family supports, she requires a range of supportive and educational services to sustain her in this role."	"As a troubled adolescent with depleted resources she requires services that acknowledge her level of immaturity, her inability to be independent and to utilise the resources made available to her without significant support and direction. Most importantly it must be recognised that she experiences overwhelming anxiety relating to events of rejection and abandonment, and which get expressed in volatile outbursts of resentment and angry accusations. Usually such young people require a residential care placement in conjunction with specialist psychological and psychiatric input."

Assessment No 4

Date	By whom and why	Findings	Recommendations - Views
15/2/01 T aged 17 years and 8 months	Dr McR – Sen Clinical Psychologist Referred by Social Worker MF to clarify T's current level of intellectual ability in order to guide the Health Board in making appropriate recommendations	"In summary T is currently functioning intellectually at the low range of intellectual ability with verbal skills in the low average range of mental ability. T has good reading and writing skills although her impulsive learning style interferes with her completing tasks successfully"	"T would have no difficulty coping with a parenting course...T should also be facilitated in achieving her vocational aims i.e. hairdressing course but unless her accommodation and future plans are secure it is unlikely that she could achieve these aims, without intensive support from social work services. She may also benefit from individual counselling to

	for ability parenting courses.		address bereavement and loss."

Assessment No 5

Date	By whom and why	Findings	Recommendations - Views
23/7/01 T aged 17 years and 8 months	Dr C – Locum Con Psychiatrist Assessment at request of Health Board wondering if T would benefit from medication- ref incident 9/7/01	"T had no death wish and no suicidal ideation of any kind. There was no evidence of any psychotic or paranoid symptoms… I found no evidence of any psychiatric illness at this interview."	No recommendations made
7/9/01 T aged 17 years and 8 months	Dr B Clinical Director to Health Board solicitor as a follow on from the assessment conducted by Dr C	"Please note that this patient has not been seen further at the psychiatric clinic. Clearly whilst she has difficulties in the realm of personality functioning she is not suffering from a formal psychiatric illness."	No recommendations made

Assessment No 6

Date	By whom and why	Recommendations - Views
4/9/01 T aged 17 years and 7 months	Dr McH – Sen Clinical Psychologist & Dr V K – Consultant Psychiatrist & L F – Psychologist Referral made as part of the application being made by the Health Board to take T's two children into long term care	"We have concluded that it is not in the children's best interests to be returned to the care of T or her partner N or to them jointly. We have also concluded that it is not in the children's best interests to extend the present frequent access to allow for this possibility in the future. If the court adopts this recommendation, it is to be expected that it will be emotionally distressful for T and for N. We consider it essential that she be offered appropriate support immediately to come to terms with the implications of this decision. This should be available on an ongoing basis and ideally a comprehensive programme should be made available to her.

T was clinically assessed on six occasions between the age of 15 years and 17 years when at all times she was in the care of the Health Board. On three of these occasions the assessments were undertaken on foot of court proceedings in the latter part of T's life. The clear opinion from the

consultants with clinical responsibility for T's care was that she did not ever have a psychosis or any psychiatric illness. There was a clear opinion that T had difficulties in personality functioning and conduct disorder. There are no records of having been prescribed any medication by any consultant psychiatrist.

The overwhelming consultant opinion was that T required a highly supportive stable environment rather than the loose unstructured provision of B and B or other temporary accommodation arrangements. The need for emotional support to T in the various roles she had as a mother and a very troubled young person with significant difficulties in her personal life was consistently emphasised. In the earlier reports the lack of structured accommodation and support arrangements was clearly stated.

The nature of the assessments provided for court purposes related to the legal issues surrounding the care provided to T by the state and the decisions of the Health Board to take T's two children into care. These requirements certainly drove a care agenda for both T and her children. Whether this legal emphasis impinged on the quality of care provided is a moot point as there appears to have been "pointed" written suggestions that documentation was not being properly read by one or other side and that services to T could not be provided until assessments were available. It is unclear as to why interventions might be delayed on the basis of such an argument when assessments undertaken prior to the court proceedings had clearly detailed a clear pathway in respect of a future care action programme for T.

Conclusions

There are six documented instances of recommendations for T to be assessed by a psychologist/psychiatrist that did not lead to such an outcome within a reasonable period. The delay of over two years in actually getting a psychological assessment of T undoubtedly led to delays in ensuring T's needs, abilities and competencies fully informed her care provision process in all settings.

The lack of knowledge of what happened to some of these referrals clearly demonstrates the benefits of having consistent supervision, consideration and oversight the decisions made in respect of the recommendations for such assessments. There is no evidence of any purposeful neglect of following up on such recommendations, but it is clear that neither adequate systems of oversight were in place or in action to ensure that actual decisions were taken on the merits and issues raised in the original recommendations.

Recommendations

- All recommendations made in respect of a child in care should be documented clearly and explicitly evaluated as to their contribution to the whole life plan for the child. All recommendations should be clearly recorded as to expected outcomes with the prerequisite actions and responsibilities clearly recorded with the responsible professional clearly named and accompanied by the action timeline appropriate to the circumstances of the case.

- Priority access for homeless children to psychiatric and psychological service should be provided.

B and B accommodation provided for T

There are three distinct phases in the use of B and B accommodation by T. These are as follows:-

1. The time spent with her mother and siblings on their return from England fleeing the violence of the relationship between her mother and her partner – this period spans the time from January to March 1998. Accommodation was provided by the Charles St Homeless Persons Unit in at least four separate locations during this time
2. The period during which T was intermittently but very frequently at times in B and B accommodation, in the care of the Health Board and accompanied by psychiatric nurses. This period lasted from May 1998 until December 2000 when T was placed in a house specifically brought into use to accommodate her
3. The final short phase for the use of B and B accommodation in T's care was for a period of three nights when the ceiling fell in, in No 2 Orchard View necessitating major repairs. T was then moved to No 5 Orchard View

In all of these B and B accommodation arrangements, which the then Eastern Health Board itself acknowledged as being totally unsuitable in its 1994 Review of the Adequacy of Child Care services report wherein it states "It is acknowledged that Bed and Breakfast accommodation is not satisfactory accommodation for young people. The situation is constantly under review and active measures are taken to address the issue. In the meantime, the Board has initiated provisions to both support young people who are in bed and breakfast and to reduce and eventually eliminate reliance on this form of accommodation." Four years after that was written there was significant reliance in continuous use of B and B accommodation to provide care service to T while in the care of the then Eastern Health Board.

The extent of use of B and B for T over the period 1998 to 2001 is set in the following table. In the initial period of using this accommodation arrangement T stayed on her own. From December 8th 1998 an agency nurse was assigned to stay with her and it was increased to two agency nurses with effect from 13th December 1998.

Year	No of episodes of use of B and B	No of nights in B and B	No of different B and B's used over course of year
1998	4* T with mother and siblings	114	4
1998	2	15	2
1999	7	20	5
2000	20	217	17
2001	2	3	2
Time spent by T in B and B without her family	31	255	20* some were used on more than one occasion
Total time spent by T in B and B with and without family	35	369	24*some were used on more than one occasion

During 1999, for which period T was pregnant for the latter part of the year her effective accommodation was intermittent B and B's. One file comment paints a very graphic and horrific picture of the care being received by T thus – *T ...was poorly clothed for someone so heavily*

pregnant and expressed fears with the process and the future care of her baby as she feels it will be taken from her...Could someone please tell me how this extremely vulnerable girl is still wandering around with no (?proper) care in her condition.[1] "

During the period T spent in B and B accommodation it is clear from the documentation that she engaged in very confrontational, abusive behaviour to others including staff. T also engaged in sexually provocative behaviours and staff were concerned that she engaged in prostitution, a concern denied by T. T also made a number of allegations against staff members accusing them of molesting her. There were no records located that these allegations were investigated.

There were occasions when T returned very late to some of the B and B houses and on some occasions she did not return at all. At times, T could not get a B and B placement and was told on at least two occasions to find her own accommodation. This occurred at a time when she was still sixteen years of age and in the care of the Health Board.

Many efforts were made during this period of being accommodated in B and B to link T into the wider service network including community child care workers, other longer stay residential care units both in Ireland, Northern Ireland and England and the Focus Ireland coffee shop and support services from that organisation's wider service range. In addition to these services T was accommodated in a three different apartments for various periods, all of which broke down due principally to the unacceptability of T's behaviours to the apartment owners or managers.

Conclusions

The use of B and B accommodation is a very unacceptable and unwelcome feature of the care of T while she was in the voluntary care of the Health Board. In essence, this facility was not in accordance with any principles of good practice much less the Health Board's own stated objective that use of such accommodation should be eliminated.

The files note[2] that in his High Court judgement Justice Kelly relating to T's application for better care stated "from what I have heard today, it would appear the way in which the health board went about discharging its statutory obligations to accommodate her, were to accommodate her in bed and breakfast accommodation which she had to leave every morning at 10 o'clock and could not get back to it until 6 in the evening or in the premises where she is at present or similar premises thereto where apparently during the course of the day she was free to come and go as she pleased. There was neither shape nor form to her daily life and I must say I find it disquieting that the Health Board would see that as an appropriate way of discharging its statutory obligation to a person as disturbed and as vulnerable as this young woman....."

During the time that T was accommodated in B and B, there appeared to be no care plan or programme of therapeutic engagement with her direct carers. Nothing in any document shows that any consideration was given to the development of such a role nor was any record found that indicated such a role was envisaged for her direct carers. There is no record to indicate that the staff assigned to be with T in her accommodation had Garda clearance nor was that provided to the Board when it asked for such information.

Recommendations

- B and B accommodation should not form any part of the care arrangements for any child in state care, irrespective of their age or care status.

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[1] 27/12/1999
[2] 27/4/01

- At all times while a child is in care there should be an operational care plan in place that is monitored, managed and adjusted as required by a designated responsible professional.

- All staff engaged in care under whatever employment system or care provision process for children should be properly Garda vetted.

Sherrard House

The use of Sherrard House as a care option for T was first explored, as part of the overall option analysis, by T's allocated social worker in June 1997 when T was 14 years. It was almost a year later when T's mother advised the social work department that she was returning to England and that she did not want T to return with her and that she wanted to place T in the voluntary care of the then Health Board. The social worker wrote that "T is unable to go home because of the risk of violence to her if she were to return to her mother." T's mother's partner (not T's father) had recently come over from England to be with T's mother.

On her first referral, in May 1998, on becoming homeless, T presented to the OOH service and was placed in Sherrard House, on a night by night basis initially, for just over a week. Following this the OOH service and Sherrard House were prepared to offer T a longer term bed. However, after this initial short period of night by night admission, T was barred from the emergency accommodation as a result of her fighting with another resident whom she alleged was bullying her. In the following weeks T was placed in a number of other emergency bed providers and supported lodging providers.

On re-presentation to the OOH service T was offered a bed in Sherrard House on 3rd June 1998 and it was proposed that she have a bed there until the 29th June. In the meantime, T was due to attend the Youthreach programme she had enrolled in, on a daily basis but did not always do so. Over the course of a number of meetings with T, her social worker and Sherrard House staff the importance of attendance at Youthreach on a daily basis was emphasised to her. T was specifically advised that she could be excluded from Sherrard House were she not to do so and in that event the OOH service would not be able to place her. T while placed in Sherrard House did not always stay overnight on a number of occasions. On some of these nights it is known where she stayed but not on others.

As events transpired, T secured a place in Lefroy House over the next few months. During this time T went to England to see her mother, her granny died and T was admitted for psychiatric evaluation to the Mater Hospital. On her discharge from the Mater, T was again admitted to Sherrard House and over the next period of time she moved between a range of placements including Sherrard House. T grieved a lot over the death of her granny and her behaviour was difficult for staff in all services to address.

The most difficult management issue for the Sherrard House staff arose on the 10th October 1998 when they contacted the OOH service at 8.15.p.m and advised them that they would be asking T to leave the unit as she had set fire to a few papers on the floor of her bedroom. She told staff she did this because she was cold. When interviewed by OOH staff T claimed it was accident. She said she had set fire to papers after she dropped a match on them when lighting a cigarette and that she told the other story because she thought she would into more trouble for smoking in the room.

This was the last time T resided at Sherrard House.

Conclusions

The option analysis identifying Sherrard House as a care placement for T was an important process in preparing T for the reality of future life in a care setting. There is no distress or pain free way in which a child is admitted to residential care. When T was first admitted to Sherrard House it was clearly done to ensure her personal safety. The support given to T to handle her rejection by her mother is less clear from the file information. It was a good decision to ensure the support of a childcare support worker for T over the first weekend in Sherrard House. What is less clear is were the processes of introducing T into the milieu of residential care of the best standard but the insecurity of requiring T to present on a nightly basis to ensure access to an emergency bed must be considered even at this remove, an undesirable practice, notwithstanding the scarcity of available

residential resources prevalent at the time. It is commendable that this issue was quickly resolved and T was assured of a full time placement quite quickly.

While the suggestion as recorded in the files that a failure by T to attend a Youthreach programme would possibly lead to a loss of her placement in Sherrard House might be seen to have a motivational context, it appears in retrospect a harsh incentive mechanism. Given the trauma of the recent past the provision of grief/separation counselling would have perhaps been a more appropriate process.

There is no evidence from the files that the insights provided by the psychiatric assessment of T were brought to the knowledge of the residential care staff and appropriate advice as to the ways in which they might adapt or redefine their care roles in the light of those important insights.

As it transpired the events leading to the barring of T when she lit some papers in her room proved the last straw for the Sherrard House management. Such is understandable especially in the context of the responsibilities a manager has towards all other persons in their care as well as those for the staff. It does emphasise the essential need for multidisciplinary team working, expert back up for unusual care issues and a system that ensures the care of the child as its first priority.

Recommendations

- Within all centres there should be a comprehensive series of policies addressing the issues of the dignity of all children and staff and the manner through which these are given effect, monitored and managed.

- All professional insight, and information should be promptly shared between all involved in caring for a child and transposed into a clear care programme for a child in care

Parkview

Parkview was a service used by the OOH service to provide T with overnight accommodation whilst she was homeless. T spent a total of 54 nights in this service, all but three of which, occurred in 1998, the year she first came into the care of the Health Board. T's first admission was in May 1998 and her last night in Parkview was in early January 1999.

The service was one in which T was able to relate very well to the staff and whilst in this service she first disclosed her involvement in prostitution. This was appropriately referred to the area social worker for follow through. In staying at Parkview, the staff experienced T demonstrate serious dysfunctional behaviour of a sexual nature on a number of occasions. T while staying in the service was also known to have sniffed nail varnish.

It was decided by the staff in Parkview that they would no longer be in a position to offer T an emergency bed due to her sexually inappropriate behaviour and lack of social skills in living with other people and that her behaviour over the post Christmas period posed too much of a risk to other residents and staff members. This decision was conveyed to the area staff by fax on the same day from which it was to have effect, the 3rd January 1999. The OOH service said it was imperative that the area services should organise alternative arrangements for T. The area placed T in a B and B with an agency nurse.

The SWIS system has a notation that T was effectively barred from the OOH service in 1999.

Conclusions

The service in Parkview initially proved supportive of T enabling her to be safe from the street scene and its attendant dangers. T found it a service in which she was able to disclose her involvement in prostitution and received a lot of support to enable her break loose from being pimped. This was a most important outcome and the staff involved are to be deservedly commended.

The dilemma that first presented in T's residential placement in Sherrard House again presented to the residential placement of T in Parkview. The dilemma is at what stage the needs of those other residents do as a group take precedence over T's individual needs notwithstanding her behaviours. Ultimately it was decided by the staff of Parkview that they could no longer cope with T's highly sexualised behaviours and that she must leave the service.

Regrettably, the immediacy of taking the decision and implementing it on the same day meant that T was placed in a B and B service. The lack of time to properly manage the future accommodation for T, as opposed to the crisis management approach that occurred did not contribute to T's care programme in any way and cannot be considered as properly managing T's care. The decision to cease allowing T to be placed in Parkview is all the more problematic when the OOH service had expressed clearly the view that "she (T) is extremely vulnerable and volatile and is highly likely to end up in dangerous situations. It is imperative that T be removed from the street scene as a matter of urgency." Creating a scenario that required a decision that placed T into B and B was not a constructive movement of T from the street scene and did not demonstrate a cogent interlinking of corporate Health Board responsibilities towards a child in care by exposing that child to possibly greater risks than were presenting in Parkview.

Recommendations

- Proper planning for the movement of a child who is in care is a prerequisite to fulfilment of the Board's responsibilities and should be signed off at senior management level.

- Where practical dilemmas arise relating to the care of children and how an individual's needs are to be balanced against a group's needs should be considered as part of the review of the individual care plans, the philosophy of the centre and the sum of the available expertise and the deficits that need to be addressed across this spectrum.

- All centres should have a clear statement of philosophy underpinned by working policies known and understood by all who work their and who have reason to refer there.

- A nominated manager external to the actual service should have accountability for ensuring that such frameworks are in place and actively used.

Supported Lodgings

Planning for the use of supported lodgings as a means of providing care to T was originally mooted in mid June 1997 when T was just over 14 years of age, having returned from the UK and was living with her grandmother. Initially T did not want to use supported lodgings. However, the use of supported lodgings became a part of the service network used during 1998 when T was 15 years of age when T availed of it as a service some fourteen times. The financial terms of the scheme were used to provide financial support to T's grandmother whilst T lived with her, on the basis that if it were not so, T would have to present to the OOH service. There is no record of the requirements of the Child Care (Placement of Children with Relatives) Regulations 1995 having been applied to the placement of T with her grandmother.

As a service, T availed of its provision from a number of non family providers, none of whom were from her local community care area. It was a service initially enjoyed by T but on becoming bored with it she moved on to other services. An important role was played by this service in giving T the opportunity to talk of adverse experiences from her childhood, including sexual abuse of herself and her current sexual experiences.

Conclusion

Despite it being a service limited in its use by T, supported lodgings provided an important but time limited role when T was 15 years old. The most important role, in addition to safe care, being the opportunity it gave T to speak of difficult issues in her past and current life. There was limited availability of the service and none, apparently, within her own community care area. A pragmatic and safe care decision was made to extend the financial terms of the scheme to enable T's granny care for her without financial difficulty.

Recommendation

- The availability of supported lodgings is highly desirable and especially in ensuring its availability across all geographic areas thus enhancing service localisation opportunities.

Lefroy House

T spent two periods of her life living in Lefroy House. The first of these was the period 2nd July 1998 to the 21st September 1998 when her admission was planned and second was over the period 7th October 2000 to 9th November 2000 when she spent five separate unplanned nights there, having been admitted through the OOH service.

The exploration of Lefroy House as a potentially suitable placement was mooted in the first instance in a supervision session in the middle of February 1998. It appears that application was actually made sometime between then and the middle of June 1998. A meeting was held between T, her social worker and staff in Lefroy House prior to her admission on 2nd July 1998.

In the first few weeks of residing in Lefroy T was unsettled and encountered some bullying from some of the other girls residing there, but this appeared, in the view of T's social worker to be well managed by the staff of the House. In this period, T also made allegations of being raped, which she subsequently withdrew, and separately of having sex with an older man. The support and responses of the staff in Lefroy were positive and helpful to T in these matters. Again in this period, T was to experience the drug scene being offered heroin, which she refused as well as being subject to unwelcome advances of a sexual nature from friends of her then boyfriend.

T's mother was appropriately contacted by T's social worker regarding her daughter's safety issues. These issues led staff at Lefroy to undertake a review of her placement in light of the presenting behaviours and issues. The views of the manager were summarised thus:- "T is very difficult to manage .....at present T is now living back here at Lefroy House but is grounded for the moment for her own protection and safety. As the project is designed for young women who are preparing themselves for independent living I am really concerned as to whether T is ready to be given this level of personal freedom and the opportunity to make personal decisions that need to be clearly thought out...T needs to be watched closely and persistently for fear of one day creating a situation that is totally out of control putting herself and others at huge risk. I am also aware of T's ability to stretch the truth to extreme levels, on numerous occasions I have noticed T's versions of events, changing dramatically; including her allegations of being raped and who it was that raped her. To conclude I would just like to stress that Lefroy House is not classed as a secure unit and girls are expected to be able to act in a responsible and mature way that is not going to hinder their development."

Subsequent to this T seemed to settle in Lefroy. T went to England to see her mother for four days in August 1998 – returning earlier than planned on foot of her mother's partner allegedly boxing her on the head with his fist.

In the latter part of August 1998 T's behaviour was recorded as deteriorating very badly and it is noted in the file notes that "In the hostel she has stood naked in her room and called staff into her bedroom. She lay on the carpet in the hostel living room saying she is swimming in the Liffey."

T was referred for psychological evaluation and was assessed by consultant psychiatrists at the Mater Hospital. It is clear from their opinion that T "was neither psychotic nor showing suicidal tendencies" hence there were no grounds for keeping her in hospital. It was also emphasised by that at no time did T show any signs of psychosis, notwithstanding the fact that a junior doctor had initially described T's condition as such.

During this period of her stay in Lefroy T was concerned that she was pregnant. Two pregnancy tests were carried out, both of which were negative.

Conclusions

The period of residence by T in Lefroy was an eventful period in her life encompassing a range of events including psychiatric symptoms, allegations of physical assault, allegations of rape that were subsequently withdrawn, exposure to a drug culture, highly sexualised behaviours and the death of her grandmother. In the second period of her episodic referrals T was in late pregnancy with her first child.

There was a good degree of planning for her first admission to the service but in comparison with current day practice lacking a personalised and detailed plan with expected outcomes. The end of T's initial period of residence in Lefroy was so unplanned as to appear chaotic. Subsequent admissions were opportunistic and did not form part of any coherent care planning process for T in the period leading to her confinement.

The response of the psychiatric services in providing care, diagnosis and advice was clear. The involvement of T's mother was appropriate given T's age and her ongoing desire to be in contact with her mother.

Recommendations

- Pre admission planning and regular monitoring and management meetings when a child is placed in care are essential processes that should be diaried, recorded and acted upon in a systematic manner

- The desirability of having the capacity to deploy a rapid care group from within existing resources to meet urgent and demanding care need should be examined

An Grianan

Initial consideration been given to securing a placement in An Grianan from 1997 when T was allocated her first social worker. However, efforts to secure a place did not succeed until T resided in An Grianan for just over four weeks, 10th November to 3rd December 1998, during which time she was 15 years old.

Pre admission meetings and discussions took place with the management of An Grianan emphasising the importance of well planned admission processes and acclimatisation of the child to be admitted. This process appears to have been handled professionally. However, no clear expectations of the placement for T or her future were identified in the documentation. Neither was any clear statement of purpose for An Grianan, current at the time of admission, identified.

The actual admission process was severely hampered and delayed by the fact that An Grianan wanted to recruit an additional child care worker to enable them care for T. This resulted in a delay from the original planned admission date of 17th October, some five further weeks during which period T relied on the OOH to access services including B and B, Parkview and Sherrard House. On some of these nights T did not return or stayed overnight with her uncle in Fatima Mansions.

Suggestions were made by the OOH staff to expedite the recruitment process and enable T's admission to An Grianan be facilitated as early as possible including recruiting in the short term a psychiatric nurse and using applicants who had applied to another residential centre to provide the immediate care for T in her new setting. These suggestions were not acted on. The nett effect of this recruitment difficulty was to delay T's admission. The lack of knowledge of what was happening caused T to be sent to the centre for admission when in fact it was not ready to admit her.

In her short stay in this unit T engaged in very difficult behaviour and this is cogently summarised by her then social worker thus:-

1. "sexually inappropriate behaviour
    a. overly sexual language
    b. advances towards staff
    c. T actually masturbated in front of staff and residents
2. Violent and aggressive behaviours
    a. T assaulted a resident and a staff member
3. T brought friends to An Grianan to threaten residents on a few occasions – the Gardai had to be called at one stage to remove these people"

These concerns expressed by the staff of An Grianan led to them requesting a psychiatric and psychological assessment. This was agreed to and in her report back to the social worker Dr N H Consultant Child Psychiatrist who had met T concluded "I consider this very vulnerable and immature young girl to be in urgent need of a secure residential placement. I regard her as being at grave risk and accordingly I believe the current open hostel placement is inappropriate to her needs…there is no evidence of a psychiatric illness but she presents as a severe conduct disorder."

Subsequent to this assessment, T became violent attacking a staff member with a knife and separately had kicked doors and windows and was fighting with other residents. The staff concluded that it was not safe for themselves or the other residents for T to continue to reside there. Accordingly she was discharged on 3rd December 1998.

Conclusions

The brief stay of T in An Grianan was one of a number of residential placements T experienced in first year of being in care. The efforts at planned admission and ensuring a clear and well thought

out process of integrating went somewhat askew when the admission date was deferred through delays that arose in recruiting an additional staff member for the service. There was a lack of clear communication by the service to the area that did not match the expected professionalism of the service. No clear expectations of the placement for T or her future were identified in the documentation. Neither was any clear statement of purpose current at the time of admission identified.

The service clearly did not have the in house expertise or external professional support made available to it to cope with the very difficult behaviour presented by T. This is not a criticism of the service, rather it is a statement of the service reality presenting at the time. In retrospect it was a service that was no different to other services at the time in putting the needs of the wider group of service users as a higher priority than those of T.

Recommendations

- Clear and accurate communications even, and perhaps especially, when bad or negative news has to be conveyed are fundamentally important and must be well managed.

- Where services cannot be delivered as promised by an agency it should be the responsibility of the agency to inform the service user at the earliest practicable opportunity and certainly before the service user presents at the service.

- Services should be fit for purpose and where additional expertise and supports are required it should be clear to the service where and how such supports can be accessed and by whom.

- All services should have a clear statement of purpose in place

490 NCRd

Over the period January to July 1999 when T was aged 16 years of age, accommodation solely for her was provided at 490 North Circular Road. Staffing, comprising nursing staff, who were to live in the house, were also provided. In addition, arrangements were put in place, through the Dept of Education and Science to have a home based tutor provided for nine hours per week.

During her time at 490, T was supported by her social worker in a consistent and planned manner that had a robust plan that was adapted as circumstances arose and set out in some detail the expected norms of behaviour from T and the type and range of support that would be provided. Contracts of behaviour were drawn up between T and all the staff involved in her care as a means of strengthening the bond of care between T and her carer.

Over the course of her time in 490, T made allegations that male staff inappropriately interacted with her. These allegations were investigated and subsequently withdrawn in writing by T. On occasion T was verbally abusive to staff in 490. While staying in 490, evidence was that T was involved in prostitution was noted clearly in the documentation

In undertaking the home tuition, her tutor noted that T was "a very bright girl and is progressing well." Clearly there were good educational benefits arising from this support.

In the latter part of her stay in 490, when T was aged 16 years, it emerged that she was pregnant. On a number of occasions T said she would be going to England for a termination. The Gardai were alerted regarding the matter. The staff at 490 were unsure if in fact there was a care order and if there was one, they did not have a copy. When T left 490, to go to England to stay with her mother, contact with the English social services was initiated. No court orders were sought in relation to T going to England having indicated she was going to have a termination. When T did return from England in August 1999, the accommodation at 490 was no longer available nor was there any prospect of a regular placement being available in it at a later period for T.

Conclusions

The unit at 490 provided stability for over five months to T when she was aged 16 years. It proved a relatively successful placement in that T was able to access on a weekly basis some nine hours of personal tuition, which in the opinion of her tutor was very positive. The robust plan for T was well monitored and managed by the social worker and supervisor and was adapted over the period to incorporate some of the challenges that emerged over the course of her stay at 490.

The unit represented a period of stability in T's life that was to be welcomed after her previous difficult year in various accommodations. The lack of availability of 490 on T's return to Ireland is regrettable and arose without any seeming assessment of the consequences for T were she to return.

Recommendations

- Where a child is placed in the care of the Health Board, a copy of the order entrusting or committing the child to the care of the Health Board should be available at every placement and be a part of the standard information provided to all professionals with involvement for the child in care.

- In the event of a service not being used for a short period of time a formal appraisal should be undertaken of the necessity or otherwise for continuing to have it available for its primary purpose or if it should be closed down.

- In the event of it being decided to discontinue the availability of any service, clearly available future options should be identified that do not compromise the standard of care provided.

Eglington House

The involvement of Eglington House in the care of T spans the period August 1999 to May 2001 when T was aged between 16 years and three months and four weeks before her 18th birthday.

The proposition to initially place T in Eglington House when she was six months pregnant was developed and agreed on foot of a meeting on 26th August 1999 between T, her boyfriend, T's social worker and the social work team leader. T was placed there from 23rd September to 15th October 1999. Unfortunately, this service broke down for the reasons as recorded in the manager's report "T continued to cause gross unrest in the house....she would do things like look into other residents' rooms in the small hours of the morning and generally giving the impression of creeping around." The manager of Eglington House asked T's social worker to source alternative accommodation, as it was felt that Eglington House was not addressing T's problems.

On her unexpected return to Dublin following departure from her placement in Cork on the 17th December 1999, Eglington House when requested by the OOH service declined to offer T a place. A further refusal occurred on 26th December 1999.

Following the birth of her son on 9th February 2000, a placement was secured for T for the period 27th March to 7th April 2000. The purpose of referral was that T was to be supervised, guided and appropriately helped in the day to day care of her son, with the plan being that T would be able to leave with her son L.

There was daily access for N to see his son for one hour and T was supervised and assisted with infant care, day and night

Unfortunately this second placement broke down for the following reasons:-

- Staff, including the manager on one occasion, witnessed T on two occasions to be inappropriately kissing her son on the lips
- T needed to be constantly prompted to attend to her son's needs e.g. making bottles, sterilising properly
- T regularly provoked arguments with her boyfriend N – on one occasion staff witnessed T punching N and on another occasion T went to hit N when he was holding L – staff had to tell T not to
- Staff were of the opinion that T put her own needs before that of her son
- Staff reported that T was seen to "shake" her son

At a meeting held on 4th April 2000 between T, the Social Worker and N, T's partner, T got very aggressive when N said he did not think she was ready to take baby out of the house. T became very abusive verbally to all present and physically to N. Staff were very concerned for T's safety. The house doctor came and on his advice the social worker took L to be examined by a paediatrician in Temple St. The Gardai had to be called twice because of T's inappropriate behaviour. The second time they took T to the police station accompanied by a staff member and N. At 6 p.m. T was examined in Donnybrook Garda Station. There is no explanation on file as to why these actions took place or what their purpose was.

In her summary overviewing T's stay at Eglington House, the manager wrote "T was twice in Eglington House in six months and her mental and emotional state was the same on both occasions. It is not surprising that T did not manage to parent L appropriately, as she never experienced this herself. Until such time as T has been fully assessed, in an appropriate manner fitting her age and history with due consideration given to where she is living and with whom, one cannot expect her to take on one of the most demanding, time consuming and sensitive jobs, namely, parenthood"

When T was pregnant with her second child Eglington House when approached by the Head Social Worker said they would consider an application later in her pregnancy.

Subsequent to the birth of the second child, the health board in making their application to have that child into care relied on the experiences of T's earlier stay at this service.

Conclusions

The service of Eglington House provided initially an opportunistic period of care at a time when T was pregnant and homeless. No other service specific to the needs of pregnant homeless girls was available. The second placement had worthwhile objectives from a parenting perspective but did not succeed in meeting them. This arose in a service that was not appropriately trained or experienced at that time in addressing the presenting behaviours of T.

Recommendations

- Where a placement is sought that presents specific care requirements and behavioural issues beyond the capacities of the service additional external professional supports such as experienced psychological, psychiatric and social care professionals should be made immediately available to the service to support the achievement of the care objectives and support all the professionals in achieving the care plan objectives.

Sacred Heart Adoption Society Residential Service – Cork

T stayed some four weeks in the Sacred Heart Adoption Society residential service in November/December 1999. The file data does not indicate a clear plan for this placement. Notwithstanding that it appears that initially T settled in well, over the period of time T stayed in this service her behaviour became so disruptive that Gardai were called several times in relation to her own as well as N's behaviour.

A letter from the manager of the this care service in Cork to the Principal Social Worker outlines the extensive (15) telephone calls made to various personnel in the Dublin services dealing with T that were not returned.

T was unilaterally discharged from the Cork service on Friday 17th December. The letter from Sr S (the person in charge) records that "She was taken to the station with her boyfriend. She was given a ticket to Dublin with some money for expenses. She was told to wait at Easons Magazine Store where she would be met by somebody from the Eastern Health Board. Staff in the Dublin office were informed of this when they rang at 3.05 and 4.20 p.m. approx. The train would arrive in Dublin at 17.56 p.m. At 19.20 p.m. T rang to say they were standing at Easons and there was nobody to meet them. Some hours later there was a call from a duty Social Worker stating that T was in his office. He appeared unaware of her history. Further attempts were made on Monday and Tuesday of this week to contact somebody in your department. To date we have not spoken with a Social Worker."

It was the manager's view that T appeared to be unable to cope with the group living situation.

Conclusions

The practical arrangements relating to T's care in Cork were not properly planned either as to what was to have been the desired outcome from this placement or the supports or otherwise to be used while T was availing of the placement. The unplanned manner of T's discharge from Cork was most unprofessional and cannot be regarded as a properly organised discharge. The failure to return telephone calls by the social work staff to the manager of the home was most unsatisfactory and exceptionally discourteous.

Recommendations

- Fundamental professional courtesies such as returning phone calls should be regarded as a sine qua non of any care plan.

- Any movement of a child into or out of a care setting should be carefully planned and where the circumstances require emergency movement, this should be managed in a supportive and caring manner.

Orchard View

When T was accommodated in Orchard View, the plan for her future care was based principally on rules that were devised in the absence of any comprehensive statement of purpose for the service, in the absence of any statement of ethos for the service or of any cogent, integrated, coordinated multi systemic plan that had timelines, costings, declared expectations of outcome or statement of the range and availability of professional supports to be provided both for T and the staff who cared for her.

What resulted in Orchard View was a building in which T was accommodated in a highly supervised, constantly observed and regulated environment with all her activities with her children minutely observed, detailed and recorded. There was no inbuilt capacity for T, on her own, to be on her own in the house which the Health Board had provided. The intensity of the physical presence of at least two other adults for the time she was there on her own in the house, together with the additional adults who were in the house when her children came on access visits combined to create a volatility that was not therapeutically addressed. When volatile moments arose; when T expressed anger; when arguments ensued between T and staff as to how loudly she could play music; about how she could not have her boyfriend in the house or about how she could not cook for her boyfriend were issues that were not managed in any therapeutic manner or according to any sourced therapeutic plan.

The 1998 Review of Adequacy of Child Care services for the Northern Area Health Board noted that "A number of young people within residential services present symptoms of distress including physically challenging behaviour....in recognition of the requirement for a consistent approach to the therapeutic management of these behaviours the Children and Families Programme has developed a training package and trained staff within the service to deliver training to all staff working in residential care. Therapeutic Crisis Intervention is a comprehensive training package....the primary emphasis of the programme is the avoidance of physical intervention." There is no evidence on file that any of the staff in any of the services had been trained in this programme or if they had there is no evidence of its use in addressing the violence that did present in T's behaviours while living in Orchard View.

Maintenance was a source of fairly continuous concern over the period T resided in both No 2 and No 5 Orchard View. In the case of No 2 Orchard View, where T lived for almost eight months there were issues regarding frozen pipes, blocked toilets, missing locks, a defective shower, a blocked drain, a leaking ceiling and eventually a ceiling that fell in. When the ceiling fell in No 2 Orchard View, alternative accommodation in an adjacent house No 5 was arranged. T lived in this house from August 2001 until her death in January 2002. During that time there were problems with the drains, the windows would not close, the back yard was unhygienic with raw sewage overflowing on occasion and full of rubble such that the children could not safely play there.

Conclusions

The quality of the building that was provided as a home for T in the last 14 months of her life was unsatisfactory given the both the content and frequency of the maintenance issues that arose with both houses.

Recommendations

- Accommodation provided for children in care must meet basic standards at least equivalent to those specified by HIQA.

Child Care Worker

The supportive role of the Child Care Worker when T initially became homeless was clearly a valuable asset for T. Through these workers issues such as linking her into services for children on the street, being able to talk about being bullied, helping her address issues of sexuality, handling moves between different services, providing support in matters of self esteem, personal hygiene and advising T. when it first became known she was substance abusing were among the range of documented supports provided by the child care workers during 1998 and the early part of 1999.

The services of community child workers also formed a part of the support network put in place for T in 2001 and again enabled T to disclose about her being abused when she was a child.

Conclusions

The supportive and facilitative role of the child care worker emerges strongly as a positive feature of the services made available to T. In all the twenty one documented interactions there is only one reference to T not keeping an appointment with a child care worker. This is valuable supportive role was important especially during the initial phases of homelessness encountered by T. The breadth of the support and the information that was able to be provided to and given by T was of positive significance in ensuring needs were addressed in a speedy manner. There are no documented times of abusive behaviour towards any of these workers. Clearly the supportive role and manner of its delivery were constructive and accepted by T as positive.

Recommendations

- The ongoing availability of the supportive and facilitative roles of child care workers is highly desirable.

The Green Door

The Green Door provided a daily support service to T during especially the latter part of 1998 when she linked in to it by the child care worker assigned to her. It was a practical source of service including washing her clothes when Sherrard House was not available to her when she was barred from that service.

Conclusions

The Green Door proved a valuable support service to T. Such services are an invaluable resource that must be available for children who are out of home.

Recommendation

- The availability of services such as the Green Door is an integral part of the suite of services that are desirable for homeless children.

Youthreach

Prior to attending Youthreach T had not attended school for over two years whilst living in England. During the short time T spent attending Youthreach she initially appeared to enjoy attending the service. During the time of her attendance at this service in June to September 1998 when T was aged 15 years she was also using Sherrard House. The documentation clearly indicates that the social worker with responsibility for T was quite assiduous in making all the staff aware of the need for T to attend the service.

It appears that as T more infrequently attended the service, she was spoken to and advised that she might be excluded from Sherrard House. While it might be considered as an incentive mechanism, doing so in the absence of any other accommodation service known to be available and in the absence of any clearly formulated documented plan it does not give confidence that the service could match the statutory obligations of the Health Board to care for a child in its care.

Conclusions

Placing T in an educational programme was a very important action especially since she was out of school for over two years. Strong support was provided by the social worker working alongside T to encourage her attendance. The fact that T while initially enjoying the programme, later sought to move away from it is indicative of the difficulty she had in participating in formal educational processes.

Recommendation

- Children with a difficult educational record including prolonged absence from the formal education system should be provided with formal educational psychological assessment.

St Vincent's Trust

T attended St Vincent's Trust for less than five weeks in 2001 when she was just 18 years of age. The proposal that she attend this service emerged from the care planning process arising from court proceedings relating to T's care. It was a service in which it was envisaged that it "would help T develop her life skills and assist her in achieving an independent life. It would also provide T with structure to her day and help her develop her social skills as T does not seem to have any close friends."

The process of introduction, supporting and encouragement of T to attend this service was very good and demonstrates clearly the capacity of the Health Board professionals to undertake their roles in a very competent manner. Unfortunately, T's behaviour over the course of her short time in attendance was summarised as "very aggressive behaviour towards a number of other female trainees following what seemed to be a normal conversation with them." It was noted that T was also verbally abusive to staff. This led to the decision of the service to terminate T's placement until there was a 1:1 staff ratio to work with T. The then Health Board agreed to fund this arrangement but was not availed of by T.

This decision to terminate the placement was taken on the same day as T's second child was formally taken into the care of the Health Board.

Conclusions

The attendance of T at the St Vincent's Trust service occurred during the course of the legal proceedings regarding T's care. The process of introduction, supporting and encouragement of T to attend this service was very good and demonstrates clearly the capacity of the Health Board professionals to undertake their roles in a very competent manner. The placement was terminated by the service due to T's behaviour and was not to be reoffered until 1:1 staffing was made available. The then Health Board agreed to fund the 1:1 service but T never availed of it.

Personal Tuition

Home tuition organised through funding from the Dept of Education and Science was provided following a decision of the case conference held in January 1999. The tutor started work in March 1999, providing nine hours per week one to one educational tuition to T. T made much progress with her literacy and educational development and her tutor commenting after almost two months tuition that the teaching with T "is going well, she is a very bright girl and is progressing well." However, over the course of the following month T made false allegations against the tutor and subsequently withdrew them. The tuition continued until T left for England at the end of June 1999. The approval for the provision of this tutoring service continued from the Dept of Education and Science until the last month of 1999 although it was not provided to T as was noted in the report of the Manger of Eglington House.

When T was attending St Vincent's Trust in 2001, T's behaviour was found not to be suitable to group work. The Trust advised that it could arrange one to one tuition if the Health Board were to pay £2000 per month. The Health Board very promptly reached a decision within nine days to pay for such tuition.

Conclusions

The Health Board when it decided to procure tuition services in 1999 did so promptly and to good educational effect. The provision of the service was just short of three months. Whilst there was approval for continuation of the service while T was resident in Eglington House in September/October 1999 it is not clear why the tutor service was not reactivated. Given the educational benefits ascribed to it earlier by the original tutor it would clearly have been of benefit to T.

The Health Board acted with highly commendable promptness in reaching a decision regarding the provision of one to one tuition for T while attending St Vincent's Trust. Such alacrity was most notable when contrasted with the tardiness in reaching other decisions such as the establishment of a dedicated care unit for T or the provision of dedicated care staff when T was in B and B accommodation. The role of case conferences to ensure a comprehensive oversight of needs is vitally important in complex child care cases.

Recommendation

- It is vital that case conferences are managed by experienced case managers and achieve clarity in the decisions taken, clarity as to the actions required to give effect to the decisions; who is to give effect to decisions and ensuring that all decisions are implemented in a synchronised and timely manner.

Claidhe Mor

Claidhe Mor was a service that twice considered as a service to provide support to T. In the first instance when T, her mother and siblings returned to Ireland in the early months of 1998 the services of Claidhe Mor were considered appropriate and it was considered "the entire family would benefit greatly from therapeutic intervention and the opportunity to look at and hopefully improve their relationships as they stand." The referral did not progress for reasons that are not clear in the documentation but are most likely to relate to the fact that T's mother was still in the relationship with her partner.

The second period of T's life in which Claidhe Mor was seen as a possible source of support was in November 2000 when the care plan furnished to the court envisaged this service as providing T with the opportunity to enhance her parenting skills. This referral was made and accepted subject to a psychological report being received. This report was completed in January 2001. Over the next two months further counselling requirements emerged which the social work service considered could be provided by Claide Mor including couple counselling for T and her partner and individual counselling for T in addition to the provision of parenting skills for T. This did not progress following further consideration by Claidhe Mor of the request and they stated "it is not appropriate right now to engage Ms TF in the parenting programme being requested. This decision was reached following discussions with other professionals involved at the case conferences on 13/6/01 and 14/6/01 around the complex issues relating to this case. However if appropriate in the future we will be happy to accommodate Ms F is she wishes to be re referred to our service."

Some eight months after the original referral to this service it was finally decided that the service was not to be made available.

Conclusions

The services of Claidhe Mor were explored during two separate periods of T's life – initially when she was 15 years of age and the service was proposed in the context of her then family context. The service request did not progress. The second referral related to the period when T herself was 17 and 18 years of age with her own two children born and both taken in to the care of the board. In this latter referral some eight months had elapsed between referral and the decision being taken not to provide a service. The referral process passed by without active management notwithstanding the fact there was regular contact on the issue.

Recommendations

- Where referrals are made to a service the time span of such a referral should be proactively managed by the responsible social worker and overviewed by their line manager.

- It is recommended that as part of service level agreements clear processes for managing waiting lists, making decisions as to the grant or refusal of services and the timelines appropriate to these facets should be included in such agreements.

Focus Ireland services

The housing, flat finding, food, money and day time support services of Focus Ireland were accessed by T's social worker when T was homeless. Applications for housing services did not result in any favourable outcome. There is no evidence of the day time services available from this organisation forming part of any coherent care plan for T.

When it was decided that the day time services of this organisation were no longer meeting the scope of T's needs, the information on file does not provide any insight as to what this meant and in what way other services would or would not appropriately assist T's needs. In other words in saying a service no longer met the scope of her needs would indicate that a needs analysis had been undertaken. If this is correct then there is considerable value in sharing this with the key social worker with responsibility for the case. There is no evidence on file to demonstrate what was learned of T's needs and how better they might be met from the interaction between T and this service that arose over a two and a half year period.

Conclusions

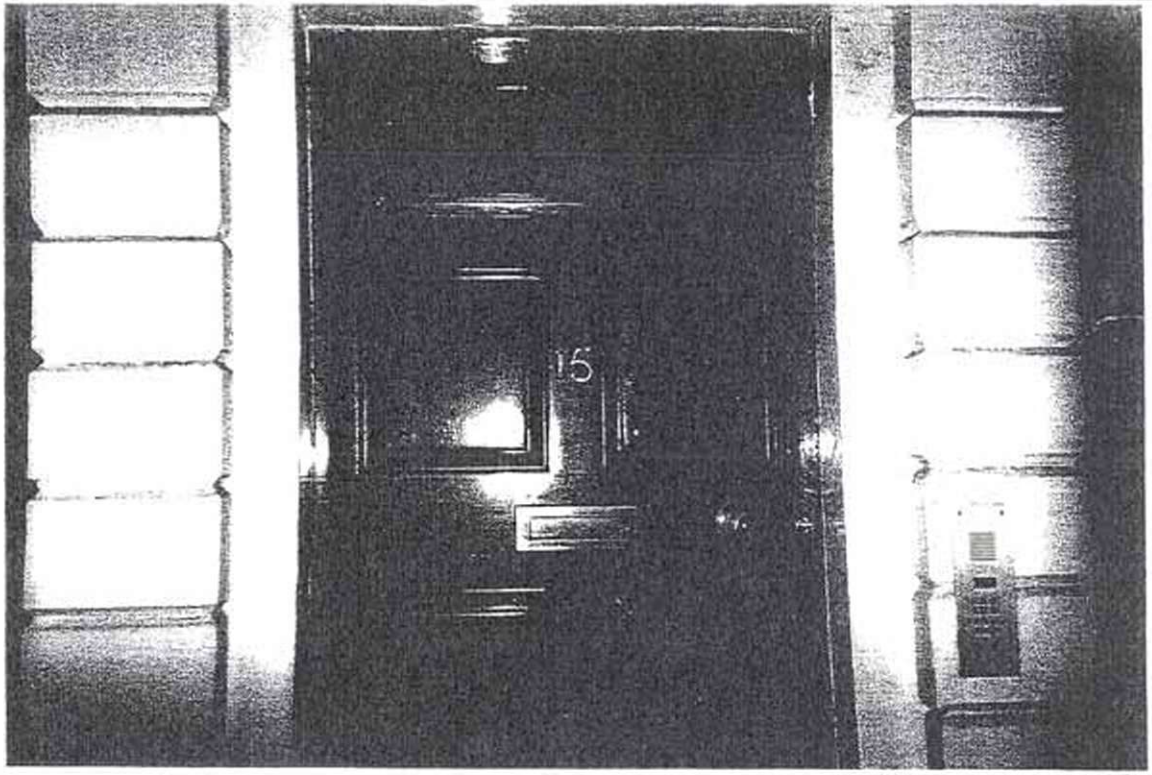
Intermittent contact arose between Focus Ireland services and T when she was aged 15 and 16 years old. In the latter part of her first pregnancy T made contact with these services some four times. On what was the last recorded contact with this service the OOH contact sheet records that "OOH T brought to Loft...was poorly clothed for someone so heavily pregnant and expressed fears with the process and the future care of her baby as she feels it will be taken from her...Could someone please tell me how this extremely vulnerable girl is still wandering around with no care situation in her condition." There is no evidence on the file that indicates what responses were made to the terms of this very distressing description.

There is no evidence on file to demonstrate what was learned of T's needs and how better they might be met from the interaction between T and Focus Ireland services that arose over a two and a half year period.

Recommendations

- In the event of a cessation of services by a provider – be this involuntary or planned – the relevant key professionals involved in the care of the child should meet and review the issues that must be incorporated into the future care plans for the child. Such reviews should be appraised by senior line managers as to the resource and skills implications that require to be addressed by those with responsibility for resource and skill allocation and developments.

- All future service agreements should include a requirement that all cases presenting to services must incorporate a planned handover and review process that integrates the knowledge and issues particular to each presenting service user.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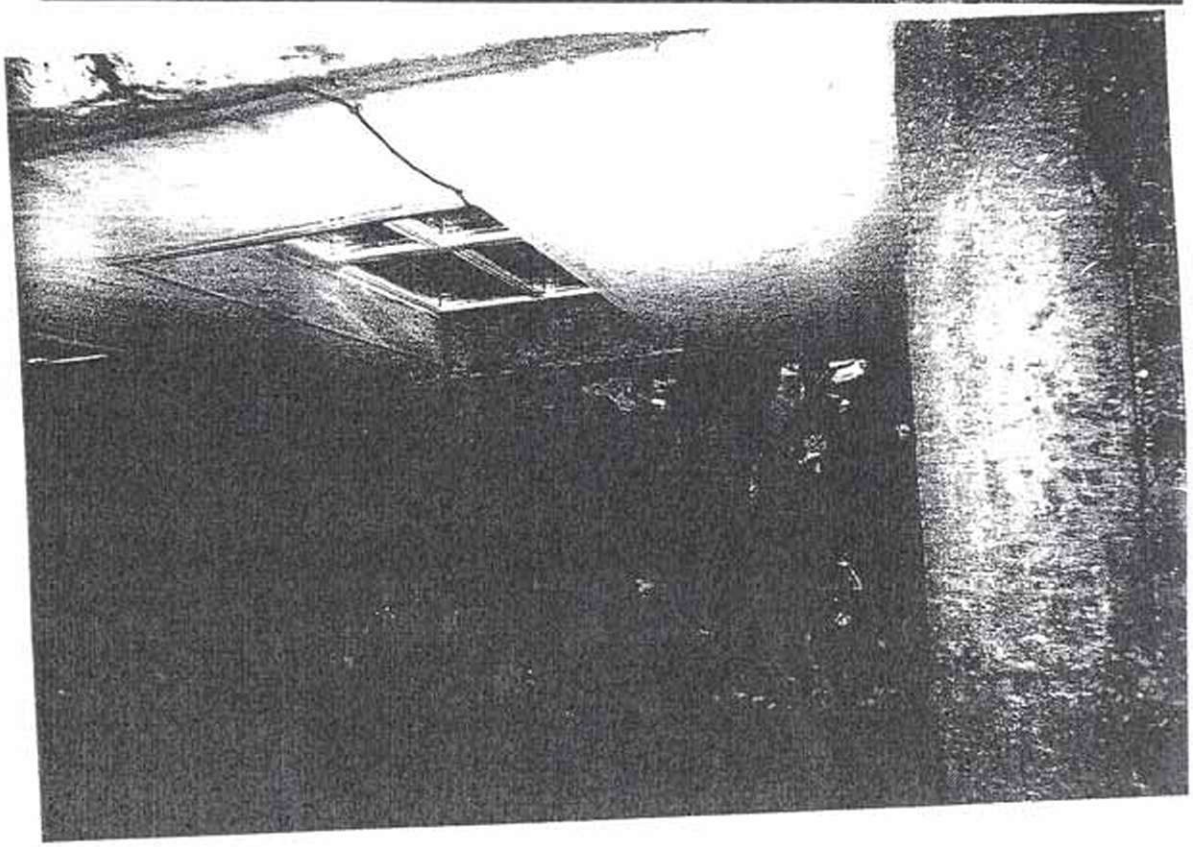


The Out of Hours Service and its relationship with T

The first contact between T and the OOH service was in January 1998 when T's mother who was living in a refuge in Rathmines with T and her siblings, made contact with them regarding T, because of her behaviour including an alleged assault on her by T. On two other occasions before she was formally admitted to Health Board care contact was made with OOH regarding T. In one instance this was from a manager of a guest house where T was staying who reported to OOH, that T was causing mayhem, staying out until all hours and assaulting her mother. In the second instance, T following a row with her mother in the B and B in which they were staying went to get a bed through the OOH service. The Gardai reported that T nearly left Garda station with a 20 years old homeless man. The Gardai considered that T was very vulnerable.

In the following table there is a summary of the range of recorded contacts made by T with the OOH service and the range of contacts regarding T between the OOH service and other service providers. In the main this latter group comprised T's area based social worker.

Year	T in contact with OOH	Others in contact with OOH re T	Total
1998	93	54	147
1999	16	33	99
2000	7	18	25
2001	0	6	6
2002	0	0	0
Total	**116**	**111**	**227**

During her first year in care T was in very frequent contact with the OOH service and even when in placement the service was in frequent contact with her when she sought to leave or did not return to her placement. The growing concerns of the service for T's welfare became more evident as the year progressed and they appeared to become reluctant to offer her a service as she was so vulnerable.

The social work record contains a notation that in 1999 "T was effectively barred from OOH due to her behaviour and risk to other young people. OOH have been very supportive on occasions and are currently providing agency nurses for T while she is in her current accommodation." On examining the assertion that she was effectively barred, the data on T's contact with the OOH service were about T going missing, not turning up at placements and accessing agency nursing staff clearly show that T was not provided with any accommodation services by the OOH during that year.

On the other hand the staff of OOH did suggest that night and day nurses be provided and gave good structure to the care arrangements that T required. Being pimped emerged as an issue and was very well tackled by OOH staff who are to be commended for the alacrity with which they dealt with the matter. An appropriate referral was made to the Gardai by the service regarding the matter of her having sex with an older man.

T presented on at least four occasions when OOH did not offer her accommodation but instead offered food, bus ticket or a service she had previously rejected. These actions were inappropriate responses to an extremely vulnerable girl while in the care of the then Health Board and cannot be regarded as an acceptable standard of care. Similarly, to suggest that T continue to avail of B and B as a health board care service when other non B and B services were available is indicative of a failure of senior management to resolve the conflicting positions adopted by different strands of the then Health Board particularly given the Health Board's own stated aversion to the use of B and B as a care vector for children in care.

The OOH service was incorrectly cast by the staff of Orchard View in the role of care manager on at least three occasions including when T was playing music too loudly; when care staff told T that if she did not come in before curfew she would have to refer in through OOH and finally when T attacked care staff OOH were asked for their advice. Such actions were not a correct use of the OOH service as its role is documented. The absence of an aftercare plan is visibly problematic as is the absence of a management structure within the unit. Equally it might be argued that the absence of a round the clock social work service was the cause of these inappropriate referrals.

The very emphatic reluctance of the OOH service to continue to provide a response to T might, in addition to the very deep concerns they expressed as to the inappropriateness of the OOH service for the care needs of T, also have had a concern that OOH were to solve all the problems that presented in T's case.

The Out of Hours services was established in 1992 to address the fear that, once on the streets, homeless children faced dangers to their physical health and emotional well being and were also vulnerable to the dangers of drug misuse, crime, exploitation and prostitution. A further objective was to prevent young people becoming "encultured" in street life, a process which, many feel, can occur in as brief a time as three weeks. Referrals were made by the Gardai station to which the child presented who communicated with the service through the ambulance control centre and where the child was met by the OOH team.

From the Annual Reviews of the Adequacy of Child Care services it is clear that the purpose of the OOH service was to manage emergency situations arising out of hours. These annual reviews recommended that direct referrals of young people from the areas to the OOH should cease. Instead the possibility of some of the existing emergency beds being available to the areas as part of a central pool from which they can draw should be explored. In addition, it was recommended that each community care area should develop a local pool of emergency beds for their own use. This should enable the OOH service to more fully develop their role in managing situations that arise out of hours and should decrease their function as an accommodation service. There is no evidence that there were sufficient or indeed any emergency beds available in the area in which T lived, nor indeed were there sufficiently available supported lodgings providers within the local area.

A recommendation from the 1998 Eastern Health Board Annual Review of Services that case reviews should be held of young people presenting to the OOH service more than three times does not appear to have been adopted in this case in particular. The view was expressed by the CIS service "that the amount of information received by OHS from the area social work team was considerable which reduced the need for review meetings, one of which purposes is to gather up to date information on a case." That being so there are no records of review meetings taking place on a less frequent but regular basis.

Conclusions

A total of 227 recorded contacts between or on behalf of T and the OOH were sourced over the period 1998 to 2002 with the most significant number occurring during her first year being in care. There was regular and good communication between the OOH service and the area based social work team regarding all contact with T. Good recommendations for T's future care were made by OOH staff who became very concerned about the increasing problematic behaviours of T that made her very unsafe.

Being pimped emerged as an issue and was very well tackled by OOH staff who are to be commended for the alacrity with which they dealt with the matter. An appropriate referral was made to the Gardai by the service regarding the matter of her having sex with an older man. The OOH service was incorrectly cast by the staff of Orchard View in the role of care manager on at least three occasions. Such actions were not a correct use of the OOH service as its role is documented.

T presented on at least four occasions when OOH did not offer her accommodation but instead offered food, bus ticket or a service she had previously rejected. This cannot be construed as an appropriate response to an extremely vulnerable girl while in the care of the then Health Board nor cannot it be regarded as an acceptable standard of care. Similarly, to suggest that T continue to avail of B and B as a health board care service when other non B and B services were available is indicative of a failure of senior management to resolve the conflicting positions adopted by different strands of the then Health Board particularly given the Health Board's own stated aversion to the use of B and B as a care vector for children in care.

Recommendation

- Ensuring that conflicts between the operational policies of different sections of the HSE are resolved in the best interests of the child is a fundamental responsibility that must be resolved by appropriate management action.

The issue of High Support and Secure Care services in the care of T

During 1998 and 1999 a range of residential options were tried to provide care for T, including care in Lefroy House, An Grianan, 490 North Circular Road, and the Sacred Heart Home in Cork. However, on the breakdown of each of these placements T reverted to care principally in B and B accommodation – a most unsatisfactory arrangement and totally contrary to the recommendations of care pathways for any child in care.

In December 1998 T's then social workers recommended as follows:- "it is clear that T is in desperate need of a placement in a High Support unit and continues to be at risk and living in a way which is harmful and damaging to her. We are aware that no such placement is available at present. We would like to suggest the setting up of interim measure. The establishment of a flat/home which could be staffed during the day and night and provide her with a base. This would enable workers to begin to provide structure to her day and a place to which she can be returned should she abscond."

During 1999, when T was effectively barred from the OOH service, efforts were made through the community care area to provide T with secure accommodation and a structured living environment through the renting of an apartment staffed on a 24 hour basis was tried on two occasions. Both of these lasted for a very short time – in both instances for approximately a fortnight.

The attempts to provide a degree of security to T led to the set up of a dedicated unit at Orchard View in December 2000. She lived for the rest of her life in a house that was owned by the Health Board. While living there T did not pay any rent or utility costs of the accommodation. While there were no formal contracts giving security of tenure, it was the intention of the Health Board that T would not be evicted from this accommodation.

The reasons for almost twenty four months elapsing before permanent accommodation dedicated to T was in fact provided is not clearly discernible from the documentation. It does appear that the referral of the issue of T's care to the courts had a direct impact on the provision of this service for her.

Conclusions

The provision of permanent supported secure accommodation while T was in the formal care of the Health Board did occur some six months prior to her reaching her 18th birthday. Previous to that transient arrangements had broken down for a variety of reasons occasioned by T's behaviours but also clearly contributed to by the lack of trained, experienced professional staff of different backgrounds such as psychology, child care and psychiatry in those residential centres where she was placed.

When T was placed in B and B accommodation she was very definitely not in a placement with which then Health Board was satisfied to use. The extensive and almost continuous use of B and B is incomprehensible given the several strong recommendations made by T's social workers, the OOH service and the psychiatrists who had assessed for secure and supported accommodation. When the dedicated accommodation was provided it was delivering on the recommendation but almost two years after the event. Why dedicated accommodation of the type finally provided by the Health Board through Orchard View was not provided at a very much earlier stage is extremely difficult to understand.

While T had many instances of disruptive behaviour there is only one instance of her actually damaging or defacing property. The major issues relating to managing T's behaviour related not only to the impact it had on the other residents of where she lived but also the implications especially of her sexualised behaviours for male residents and staff, and her demonstrably violent

threatening behaviour with knives towards staff. The specific issue of dealing with the sexualised behaviours appears to have been addressed through correctly warning male staff to be cautious, but could have more effectively been addressed if this had been accompanied by specific therapeutic inputs to staff on the management of such issues or of addressing these issues in a therapeutic plan or process with T.

While it is acknowledged that there were significant difficulties in relation to the recruitment of residential child care staff and in the provision of actual buildings to act as high secure units the quality of the accommodation provided at Orchard View was bleak. Concomitantly, the absence of a structured plan developed in the context of an ethos of care with short, medium and long term objective was a significant default in the care provision to T.

Relying on a basic grade social worker and team leader to develop the rules of the house was expecting too much from staff members who professionally worked to a very high standard. The provision of one to one professional care should not have been compromised by the actual requirement to manage the care delivery system within the house. These separate roles and responsibilities should always have been separately managed in an integrated process removed from those directly involved in the care to and of T.

Recommendations

- When any accommodation is being used for children in the care of the HSE, it should at a minimum conform to all the standards required by HIQA and where a stand alone special circumstance unit is urgently required it should be urgently assessed as to its compliance with these standards by HIQA staff.

- The management processes and structures for all services should be clearly outlined with respective roles, responsibilities and accountability arrangements well known to all operating and using the service.

- The provisions of the Child Care (Special Care) Regulations 2004 detail many of the issues adverted to in this review and while they are not strictly applicable to the circumstances of the case, they provide a comprehensive bedrock to manage a care process and service.

Drugs and alcohol as an issue in T's life

While it was noted at a 1991 UK child protection case conference on T when she lived in England with her mother, that her mother's partner smoked hash, there were no other references identified in the early life of T or her family where drugs formed a part, however minor, of the family lifestyle.

There were two distinct periods when drugs are recorded as forming part of T's social life. These were during 1998 and again in the last three months of her life. In 1998, when T was 15 years and in the care of the Health Board, she began to dabble in drugs including hash which is recorded on three occasions in the records; sniffing nail varnish on three occasions and on one occasion in this phase T admitted smoking heroin. There were three other recorded instances when T was offered hash or heroin during 1998.

In the last few months of her life, it is recorded that T had started to use E tablets and was noted on a few occasions to have dilated pupils all indicators of drug misuse. On a number of other occasions during these periods T had also spoken of overdosing herself or going on gear.

Conclusions

T's involvement with drugs appears to have been limited to two time frames – the first occurring in the year in which she became homeless and was placed in voluntary care by her mother. This year, 1998, was traumatic, stressful and turbulent in terms of T's behaviour. When it became know that she was taking drugs she was advised of the dangers of so doing by her social worker and care staff. T's drug taking, identified eight times in 1998 must also be viewed in the context of her very unsafe sexual behaviour during that same period. The absence of any referral directly to the expertise in the addiction services is a serious lacuna in the care provided to T during this period of her life in the care of the Health Board.

In the latter period of her life, the physical descriptions of T's drug use indicates serious concerns as to the extent and type of heavy drug use in which T was involved. Notwithstanding the fact that trained nurses were providing care for her in Orchard View there is no evidence available from the documentation that any had professional expertise in addiction care. The absence of any referral to expertise in the addiction services is again a serious lacuna in the range of services either made known to or provided for T during this period of her after care life in the care of the Health Board.

Recommendations

- Where a child in care presents with drug misuse issues, these should be promptly explored and assessed in a formal case review process. Where expertise is not available within or to the immediately responsible professionals, management should ensure that such is made available and integrated within the overall care plan for the child.

- The need for residential care for young people who misuse drugs and for existing residential facilities to re-examine their policies in this regard as was recommended in the 1998 Annual Review of Adequacy of Child Care services is endorsed by the conclusions of this report.

Assaults by T

Over the course of T's interaction with care services instances of physical hurt by T or threats that T herself originated emerge from the documentation. In total, 39 such instances were identified. In addition there are instances of T herself causing physical hurt to her siblings on at least two occasions and a separate instance where she killed her brother's hamster with a pen.

Thus T's behaviour can be seen as physically dangerous to care staff, her social worker, other residents and to her own mother. It is of interest that T did not assault or threaten her Guardian Ad Litem or Child Care Workers.

The following table outlines in summary form the totality of the recorded assaults.

Year	Assault on Mother	Assault on residents	Assault on social worker	Assault on care staff	Assaults on members of the public	Threats made by T	Total assaults each year
1998	2	4	3	3		2	14
1999				1		3	4
2000				2			2
2001				9	4	6	19
Total 39	2	4	3	15	4	11	

The years 1998 – when T first came into care and 2001 when T resided in fully staffed small residence with at least two staff on duty comprise 85% of all the recorded assaults. These years were especially turbulent for T, in terms of being placed in care herself and of having her children removed from her into the care of the state. Moreover, some 17 of the incidents or 46% of all incidents occurred after T had reached 18 years of age and was no longer formally in the care of the Health Board.

Nothing can condone such assaults or threats to staff, residents or members of the public. However, issues are clearly raised as to how staff in particular were trained and prepared to cope with such unsafe and difficult behaviour at all stages of T's interaction with the care services.

Conclusions

The physical attacks by T led in a number of cases to the Gardai being called and statements taken. Only one recorded instance of prosecution being undertaken by the Gardai was found – and that in the case of a member of the public. There does appear to have been any systemic overview of the background factors that contributed to such unacceptable and dangerous behaviours. Neither was there any systemic or therapeutic process oversight as to what effective behaviour modification or other form of anger management or personal protection training was required.

The personal safety of staff was a significant health and safety issue that does not from the available documentation appear to have been addressed at management levels nor evaluated from a risk perspective at the time.

Important issues for consideration arise in relation to the impact of high staffing ratios and working in a confined physical space, at times of significant stress for T during restricted access times to her children and the implications of such a matrix of factors for behaviour management. There appears to have been a reliance on the fact that the staff in the main had psychiatric nursing backgrounds and that of itself this would be a suitable to ensure appropriate care for T. Such professional expertise

did not have support provided from any other expert source – such as psychology, psychiatry, social work or in the matter of, personal safety protection. This was a significant lacuna that impacted directly on the safety of staff and the care provided.

In any situation where a carer is subject to threats or actual assault by the person being cared for, it would be expected that debriefing would be available as a support to staff. Equally important is the benefit of such support to enable any negative aspects of the threat or assault for the professional relationship between the carer and the person being cared for to be addressed. The absence of same in this case indicates at the very least evidence of inadequate review of care and possible default in the expected standard of care that should have been provided.

Recommendations

- Where physical assaults occur they should be appropriately recorded from a health and safety perspective as well as from a therapeutic view. Careful risk analysis should be undertaken as well as the development of appropriate planning encompassing care, safety and risk issues. The plans should be signed off by a senior manager and their implementation monitored.

- A clear protocol in relation to involving the Gardai and the laying of charges is desirable so that the staff and person in care are clear as to the outcome of any assault or threats made against the safety of staff.

- Where cases require it, additional expertise should be readily available to assist in managing the significant responsibilities that the organisation has towards those in its care and its staff.

- A senior manager should be assigned the responsibility for overseeing the implementation of the processes associated with the span of care and employment issues

Assaults on T

The documentation records instances where T was observed to have been or claimed she was assaulted by a variety of people. Some eleven assaults on T by her mother, by her boyfriend and other unknown persons are recorded. There are no medical or nursing records of any bruising that may have occurred in such cases. Similarly, in the recorded instances where T was observed to have hit her partner N especially on access visits – no record of any physical evidence was recorded.

Conclusions

In addition to the physical violence experienced by T and given by her to others, the emotional impact of the assaults on her children was well recognised by the care staff. These assaults combined with their emotional on the children created clear and strong concerns for the safety of the children born to T. The then Health Board properly and promptly sought to have the children taken into care. Such action is emotionally exhausting and draining for all concerned but it was necessary in the interests of the children. The staff concerned acted promptly, professionally and correctly in undertaking this demanding and necessary role on two occasions.

Notwithstanding the level of physical assaults by T, there does not appear to have been any focus on anger management, harm reduction or other therapeutic process insofar as the recorded care planning process shows. Whilst there are notes in the documentation advising staff to be careful of ensuring knives were to be taken from T, and to be cautious of her boyfriend who on occasion is alleged to be carrying a knife, there is no evidence of a wider overview of the safety aspects for staff of her abusive behaviour towards them. Neither was any knowledge of the coping strategies used in other high support or secure units being sought or shared with the services in any of the units in which T lived over her time in care.

Recommendations

- Balancing staff safety and care requirements is a demanding role that is not unique to child care settings. There is a substantive body of knowledge and expertise within the wider care systems. Such expertise should be made available on an ongoing basis to staff in care situations such as arose in this case.

- The importance of consistent external management oversight of risk situations and their amelioration cannot be overemphasised.

Physical Abuse of T

During her life T was subject herself to physical abuse from her mother, her stepfather, her boyfriend and other persons whom she encountered when homeless. The incidents of intra familial physical abuse occurred in both England and Ireland.

From the files it is clear during the early months of 1990 that T, then 7 years, was living in Ireland in an environment in which her mother's "actions, language and behaviour towards the child (i.e. T) is often inappropriate..." T's granny threatened in May 1990 to put her daughter, T's mother and T out of the family home. While the granny was not complaining of physical abuse or neglect of T there appeared to be serious concerns about the emotional care of T. After this period of time T and her mother had stopped living with her granny and had moved to Haven House. Whilst in Haven House in July 1990, a community care social worker called to them. The case notes record that "T had lost two front teeth due to a smack in the face from her mother D. D after suggestions from myself felt that it would be better for T if she stayed in her Granny's for the present." This detail was again reported in April 1991 to the health board by T's school teacher who related that "D [T's] mother spoke of beating T and on one occasion knocking out two of her teeth; that D told Brid that T had blood stains on her underpants and that she took her to doctor who said that T had not been interfered with sexually; D's current boyfriend does not like T; T has poor concentration at school – is mildly disruptive and attention seeking – (T's teacher) pointed out that T is clean, tidy and never hungry.." The April 1991 files record that "when the previous allegations on file were made by mother of D they were subsequently found to be untrue by previous Social Workers."

The information on the file in respect of the incident in July 1990 when T lost her two front teeth together with the information relating to the poor quality of relationships are highly suggestive of the need to follow the procedures detailed in the July 1987 Child Abuse Guidelines. There is no evidence in the files provided to the inquiry that any of the procedures detailed in those Guidelines were put in place. If this is correct then a most serious breach by the Health Board of its duty of care to T occurred.

In the case of the instances of physical abuse that occurred in England where the family had lived from 1991 to 1997 these resulted in the child protection conferences in respect of T being held on 22nd August 1991 and again on 28th November 1991. This 1991 conference was provided with information on T – then aged 8 years – having being beaten with a stick by her mother's partner as well as another instance of being hit by him. These instances together with T's witnessing of incidents of domestic violence between her mother and her partner led to the child protection conference deciding to place T's name on the Wiltshire child protection register in the category of child abuse. A child protection plan was agreed and put into place. At the review child protection conference in November 1991, T's name was removed from the child protection register on 28th November 1991 as she was no longer resident in the area.

On 30th September 1997 a child protection conference was held in respect of T, who was just over 14 years of age, on the basis that she had returned to live with her mother. On reviewing the history and all current information the decision of the child protection conference was that T's name should be placed on the register in the category of physical injury and emotional abuse. A detailed child protection plan was put in place. Following the return of T to Ireland the Wiltshire Child Protection Committee wrote to the Area HQ in Dublin advising that the Committee intended to remove the names of T and her two siblings from the child protection register for the area. The area was asked "to confirm whether or not it intended to hold a child protection conference in Dublin and provide them with any information which indicates that these children's names should not be removed from our register." There is no record of this letter being replied to.

In May 1998, when T was aged almost 15 years, T's mothers partner moved to Ireland and stayed with them in a one bedroom flat, the then social worker expressed the view that "T did not want to stay in this situation and the social worker herself was "concerned for her physical safety in this

situation." A further incident is recorded when in August 1998, T returned back to Ireland and revealed to staff in Lefroy House that her mother's partner had boxed her in the head with his fist and that she had headaches as a result. The UK social services and Gardai were informed of the alleged assault and asked that they notify the relevant police authority in England.

During 1999 and 2001, there are a number of recorded instances of T being bruised in her stomach and after fighting with N.

Conclusions

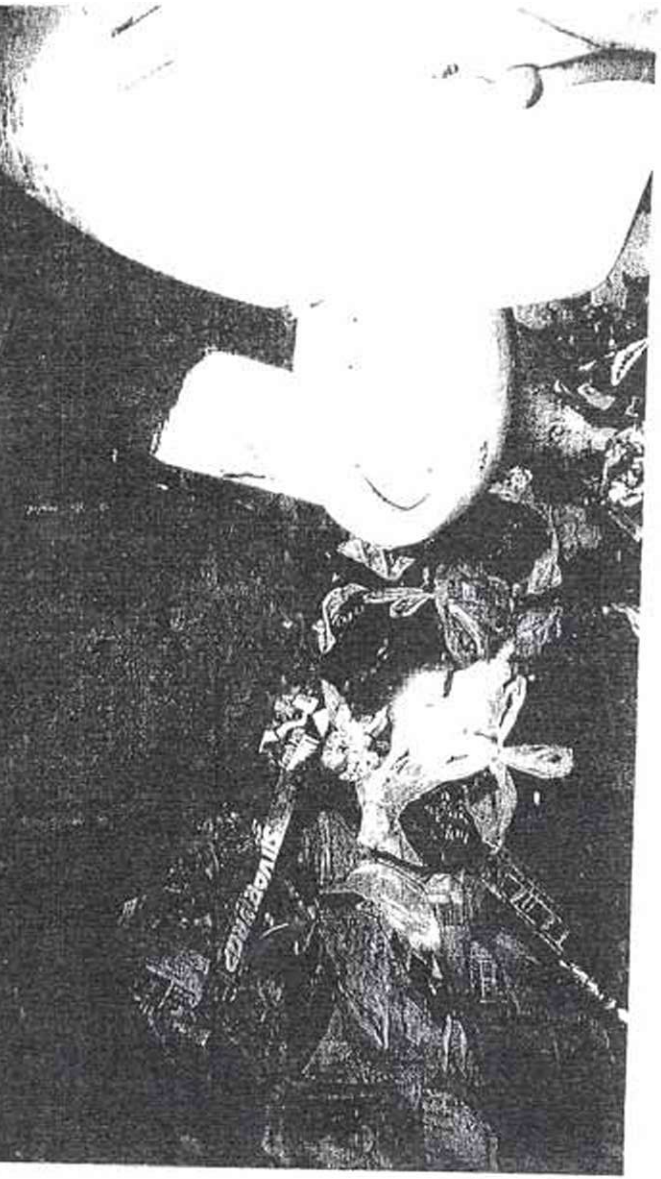
Significant concerns about the physical safety of T should have been raised in Ireland when T was living with her mother in a hostel in July 1990 and two of her teeth were knocked out when her mother slapped her. This allied to the concerns raised by her grandmother in May 1990 should have been better managed as a child protection issue. It was not. Neither when in April 1991 these same issues relating to T's safety were raised with Health Board staff by T's teacher were the processes detailed in the July 1987 Child Abuse Guidelines brought to bear on the facts of the case. There is no documented evidence that any of the procedures detailed in those Guidelines were put in place. If this is correct then a most serious breach by the Health Board of its duty of care to T occurred.

By contrast the child protection processes in England were promptly utilised on two separate occasions, in 1991 when T was 8 years old and again in 1997 when T was 14 years old. On both occasions T's name was placed on the Child Protection Register. In both instances a detailed child protection plan for T was drawn up and circulated to all relevant persons. When in February 1998 the children had returned to Ireland the Child Protection Coordinator of the Wiltshire Child Protection Committee wrote to the social work department in Area 8 regarding T and her siblings D and L saying that "it is my intention to remove the children's name from the Child Protection Register in this area. Please confirm whether or not you intend to hold a child protection conference in Dublin and provide us with any information which indicates that these children's names should not be removed from our Register. There is no evidence on file to indicate that any procedures detailed in the 1987 Child Abuse Guidelines or the 1995 Guidelines concerning the notification of suspected cases of child abuse between health boards and Gardai were ever followed.

The lack of any documentation actions on these substantive and well documented concerns is a matter of very grave concern in relation to the safety of T and her siblings. The available evidence clearly indicates individual and systems failures at all levels within the child protection system as it operated during the period 1991 to 1998.

Recommendations

- Where there are siblings of a child in care it is desirable that their child protection requirements are also assessed to ensure their safety
- Management should satisfy themselves as to the extent to which the individual and systems failures in this case cannot recur and from the issues identified ensure that all steps are in place, regularly monitored and accounted for through the overall governance processes to ensure that child protection guidelines, processes and care obligations are fully delivered in accordance with best practice and statutory requirements.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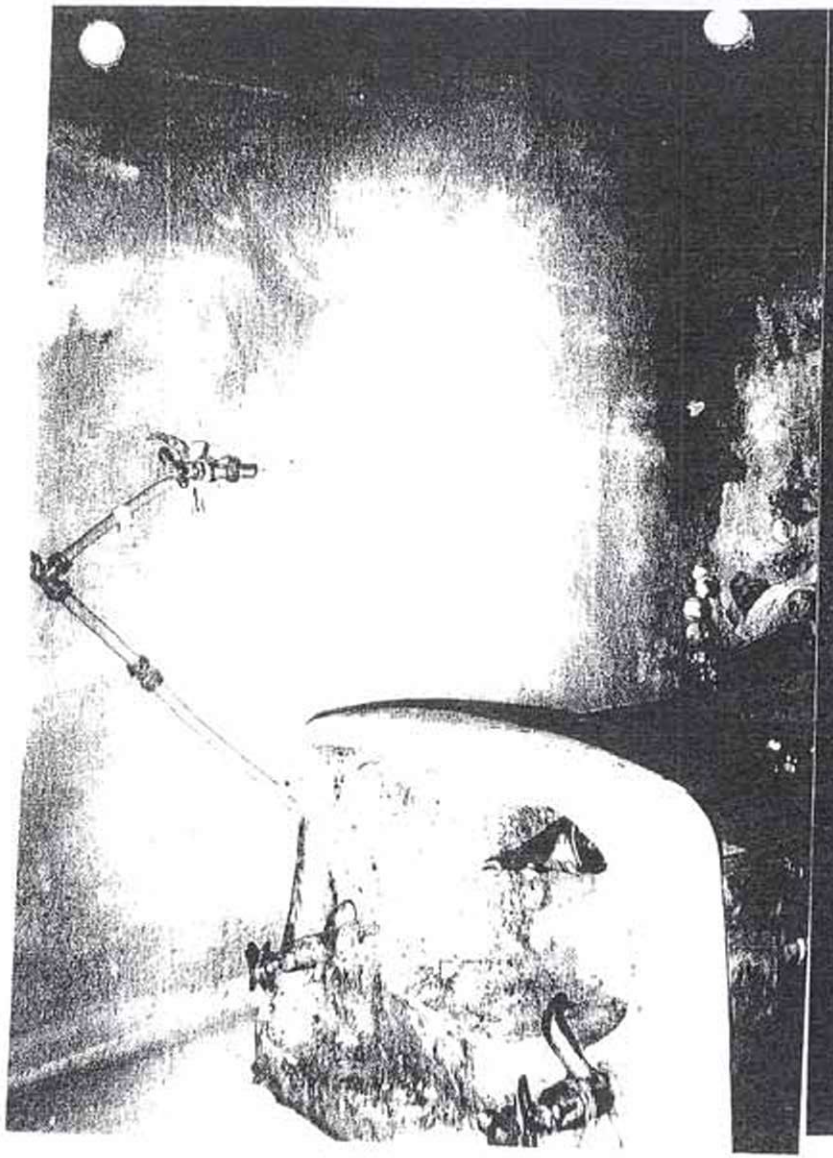

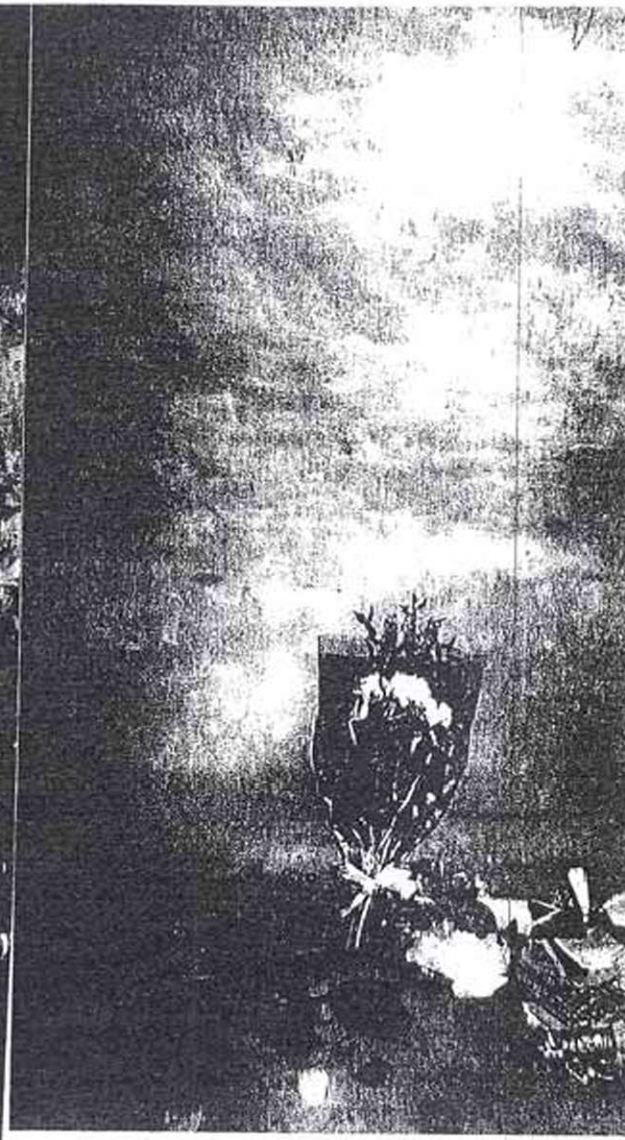

Sexual Abuse/Behavioural Issues of T

This case involves serious elements of child sexual exploitation whilst T was in the care of the Health Board, significant allegations of sexual abuse whilst T was in the care of her mother and residing in England together with significant and frequent manifestations of highly sexualised behaviours that were not addressed in any therapeutic manner.

There is clear evidence on file that T, while in the voluntary care of the Board stayed away from accommodation provided for her, with men much older that her and in one documented case at least twice her age. This occurred particularly during 1998 and 1999. Documentation on file shows that social workers and other staff challenged those older men about their actions and advised in clear terms of the illegality of sexual relationships with under age children. While this had a transitory effect it did not stop the relationship that T had with one person in particular. The Gardai were advised of these underage sexual liaisons and officers were assigned to investigate the referrals from social workers. The files do not contain the outcomes of such Garda investigations.

Some important work was undertaken in identifying the need for and providing appropriate sex education for T especially during 1998 and the following year. Such information, advice and support was provided through the child care workers who worked alongside her, the general practitioners involved in her care, family planning services and in one instance that provided by a nurse involved in caring for her.

Over the course of her time in voluntary care T made many allegations – some eighteen in total – were identified in the documentation supplied. These allegations included being raped, being fondled, being flashed at, being abducted and having her clothes ripped off her. None of these allegations were ever substantiated. The staff involved made every effort along with the Gardai to fully investigate these allegations. Sometimes T changed her story, on other occasions she withdrew her allegations, on yet other occasions she presented different versions of the same allegation such that they could not be reconciled. Allegations were made against a number of staff members. These were investigated and nothing was found to substantiate the claims made against them. In the case of two staff, T withdrew in writing the allegations she had previously made.

On at least three occasions T in speaking to carers within the system revealed that she had been sexually abused as a young child by her mother's partner and without her mother protesting at such activities. The files do not reveal any formal assessment of these revelations when they were initially made during 1998 and again in 2001 when T was aged over 18 years and still supported by the health care system.

T particularly during 1998 was questioning if she were pregnant and saying to carers that she was, when in fact, she was not pregnant. While it may have been informally known that she was pregnant while homeless, this was not a documented feature of her care when going through the B and B services. Neither was there any clear plan for ante natal care identified in the documentation for T and her unborn first or second baby.

Unsafe behaviour was a consistent and disturbing feature of T's presenting behaviour during 1998 and to a lesser extent when in Orchard View and over 18 years of age. The manifestations were disturbing to others while she was living in group situations – both to staff and residents. Male staff in particular were required to be especially vigilant to ensure they did not find themselves in unprofessional situations. Some of the behaviours exhibited deep distress on the part of T. There is nothing in the documentation that shows this behaviour was systemically addressed in any therapeutic manner. The gravest of documented concerns relate to the impact of these behaviours on others residing in group living situations.

The involvement of T in prostitution is clearly identified in the documentation especially during 1998 and to a lesser documented manner for subsequent years. The staff caring for T in the various care settings were very aware of her involvement in prostitution and were deeply concerned about

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her being pimped. The Gardai were alerted at all times but it was not until 2000 that T was in fact first arrested for soliciting. The involvement of such a young girl in prostitution while in the care of the Health Board is of the gravest concern.

Conclusions

The highly sexualised behaviours exhibited by T over the period of her time in the care of the Health Board was immensely challenging to those who cared for her. There is no information on file to demonstrate that these issues were ever looked systemically and in detail to consider and decide how T might be stopped from being sexually exploited.

The challenges of addressing T's behaviours were considered principally in the context of the impact these behaviours had on the wider group when she was living in a group situation rather than a focus on the needs of T as an individual. While this may be understandable in retrospect it does not take from the fact that the then available highly specialised professional advice and professional services expertise in Ireland and the UK was not sought to address the individual needs of T as regards her sexual behaviour.

There is no evidence that those considered to be pimping T were ever brought formally, by way of written complaint, to the notice of the Garda authorities.

Recommendations

- Where there are concerns that a child in care has been sexually abused a formal review of the issues should always be undertaken in accordance with the child protection policies in currency at the time.
- Allegations and/or concerns of a child being involved in prostitution – whether or not in statutory care – should always be the subject of a formal referral to the Garda authorities and be immediately considered by the care services in the context of the child protection policies and procedure.
- An examination of the strategic and policy considerations of the needs of individual children whose needs cannot be met within conventional or available settings without being so disruptive of the needs of other children in the same care settings should be undertaken to ensure that the individual rights of each child are upheld
- Where significant care issues present that are beyond the expertise of the immediate carers it should be a managerial responsibility to ensure that such issues are systematically and readily identified and appropriate external expertise is provided to enable the best care be given in the best way to the child who needs such care.
- Where concerns have been identified that a child is involved in prostitution or has been the subject of sexual abuse in childhood these should be urgently addressed in the currency of a child's minority
- Adult services should become seamlessly introduced into the leaving care and after care frameworks for children who have been in state care

Missing from services

While in the care of the Health Board T went missing on quite a number of occasions, the majority of which occurred while she was in her first year of care but she did go missing a number of times every year. Analysis of the documentation summarising the known periods of T being missing are outlined in the following table.

Year	Days missing*	Episodes of being missing*	Unknown	With friends	With others	Gardai notified	Missing at Weekend
1998	21 + several occasions	15 + several occasions	12	4	5	2	4
1999	5 + a few occasions	5 + a few occasions	3				1
2000	3	3	3			1	2
2001	4	4	4				2
2002	3	2	3			1	2
Total	36	29	27	4	5	4	10

*Data incomplete in respect of the unspecified occasions T went missing

T went missing on 23 occasions before she reached 18 years of age totalling at least 29 days missing from the care of the Health Board. For at least 18 of those days there was no knowledge as to where or with whom she was staying. For those instances where the documentation records with whom she stayed it is clear T was involved on these occasions with actions that are inappropriate for a child who had not reached her majority. The documented information shows the Gardai were only notified of T being missing in a small minority of cases – 4 out of at least 29 episodes of her being missing. T went missing from B and B as well as more structured placements. The episodes reduced over the years.

Conclusions

T went missing from care placements on at least 23 occasions while she was less than 18 years of age and in the care of the Health Board and a total of 6 occasions when she was aged over 18 years of age. Gardai were infrequently notified. In the majority of instances it was not known where T spent her time when missing or what she was doing during this time. On those occasions when it became known where T was, what she was doing and with whom, it is clear that what transpired would be of grave concern for her physical and emotional well being. When it was known that T had had sexual experiences when missing, there is no evidence that referral to her GP was considered as part of the care process for a child in care.

No concerted effort appears to have taken place to overview the incidents of T going missing or what implications for her care arrangements and planning might be until one occasion when aged over 18 T was requested to state whether she would be returning to the place she was residing. It is noted that a policy for dealing with the matter of a child in care going missing was developed by the CEO's of the then Health Boards in December 2001 – a copy of the policy was made available to the review after the submission of the draft report.

Recommendation

- The operation of the policy regarding children in care absconding or going missing could be usefully reviewed in the light of experience and insights acquired since its original introduction

Guardian Ad Litem

T's Guardian Ad Litem was initially appointed by court order on the 10th May 2000 and this was subsequently confirmed by a further court order on 15th June 2000. The brief of the Guardian Ad Litem was to provide "such reports and assessments to be carried out in respect of the respondents as deemed necessary and appropriate by the Guardian Ad Litem. In addition, as advised by Counsel the role of the Guardian Ad Litem was "to guide T through the Court process given that she hasn't reached her majority." Over the period of the Guardian Ad Litem's appointment significant time was devoted to understanding the background details to the case and representing T's interests to the Health Board professional staff.

Over the course of the relationship between the Guardian Ad Litem and Health Board professionals and services a number of issues arose in relation to the interaction as between the respective parties. From the documentation there are indications that they were delays in providing information to T's Guardian Ad Litem and which were raised in the court hearings. Similarly there appeared to be difficulties in appreciating the role of the Guardian Ad Litem as representing T's needs as not necessarily being of the same view as those of senior social work management. There were clear differences of view as to the adequacy of the plan from the perspectives of both parties.

In relation to each of T's children for whom a separate Guardian Ad Litem was appointed, there was at times on the part of the care staff, confusion as to the roles, awareness of their responsibilities and uncertainty as to their identity.

Conclusions

The role of the Guardian Ad Litem for T was assiduously followed through. There was clarity of purpose and action by the Guardian Ad Litem that enabled T's needs and views to be clearly articulated. It is of interest that there are no records of any difficulties in T's behaviour towards her Guardian Ad Litem.

The provision of information to the Guardian Ad Litem was slow and fragmented and was the subject of discussion in the court hearings. There appears to have been some difficulty in accepting the views of the Guardian Ad Litem as presented. Notwithstanding the apparent clash of roles, the efforts of all were such as to ensure that both the social workers dealing with T and the Guardian Ad Litem were able to sit down and thrash out a plan under the oversight of the court.

For the care staff in Orchard View, there undoubtedly must have been some confusing moments with three separate Guardians ad Litem coming to the house and interacting with the staff at different times. There appears also to have been confusion regarding the identity of the Guardians ad Litem and solicitors and barrister for T. Confusion in these circumstances is understandable, but a better quality of communication might possibly have eased uncertainties.

Recommendations

- Where a Guardian Ad Litem is appointed for a child in care – a written note of this appointment incorporating the role and responsibilities of such an appointee should be made available to and understood by all staff engaged in the care of the child in care.

- The development of a protocol for dealing and engaging constructively between the Guardian Ad Litem and care professionals should be developed so as to provide the most constructive and dynamically effective and productive relationship

- Where multiple Guardians ad Litem are involved in a case, a senior social work manager should develop a working process that minimises the need for replication of information giving, taking up time that otherwise might be of possibly greater therapeutic benefit and ensures that any hiccups are professionally addressed and ameliorated.

Issues in the case management and planning aspects of T's care

1985 to 1997 From birth to 14 years

Within eight months of T being born, the Public Health Nursing Service were raising concerns with the social work service regarding T's care. Further concerns were raised by hospital staff when T was thirteen months old and an inpatient in a children's hospital being treated for whooping cough. Some follow up is recorded as occurring relating to this referral to ascertain more clearly the factors spoken of with concern but the outcome was not very clear. No actions were identified from the documentation that would lead to the conclusion that any forms of discussion or consideration of concerns germane to child protection issues were in fact undertaken. Such factors as obvious familial discord and distress; the concerns of experienced children's nurses and children's hospital staff; the reluctance of the mother to actually engage with the social work services would be more than sufficient to have the concerns considered in a child protection context.

When T was almost five years old, her mother gave birth to a baby boy, whose father was not T's father. This child was placed for adoption. There is no evidence that concerns relating to the care of T in earlier years formed any part of the family history or circumstances review. An opportunity to review the issues that gave other professionals cause for concern regarding T's welfare was not undertaken.

When T was seven years old, her granny made contact with the social work department regarding the behaviour of T's mother towards adults and T. The social work notes record that "Her (T's mother) actions, language and behaviour towards the child is often inappropriate and she remains impervious to any attempts to aid her. Her parents are extremely worried about her and fear that if they put her out, the child would suffer." Again, notwithstanding the previously documented concerns for T's welfare there is no evidence of any systemic overview of the issues in a child protection context – for a third time. Subsequent familial disharmony became clear over the course of contacts between the social work department and the family during 1990. Concerns were explored directly with T's mother and again with the Granny leading to the conclusion that "this matter appears to be a family conflict over which we have no jurisdiction." A fourth opportunity to review in a child protection perspective was not systemically followed through. When in July 1990, the social work department was advised that "T had lost two front teeth due to a smack in the face from D. D after suggestions from myself, felt it would be better for T if she stayed in her Granny's for the present." This first episode of recorded physical hurt was neither reported to gardai nor treated in any way as a case in which the national guidelines on non accidental injury might be considered. This is of serious concern bearing in mind it was the fifth and perhaps clearest indicator for the initiation of the child protection processes that did not happen.

Referral from T's teacher led to further consideration of the issues of T's safety between T's mother and the social work department. Whilst there is a written note that "when the previous allegations on file were made by mother of D they were subsequently found to be untrue by previous Social Workers", there is no record of such considerations or discussions in the files maintained over the same period.

T returned to England sometime in June/July 1991. By August 1991, the English Social Services had established a Child Protection Case Conference at which the social worker had written "The risk to T were considerable. There had been two incidents of physical abuse which her mother had confirmed and later withdrawn this retraction would place T more at risk in the future...it was also doubtful whether Miss F would protect T because she seemed afraid of RC herself....in any case Miss Fay had been raised in a family which accepted corporal punishment as normal and in these circumstances she would probably not report every incident which occurred." T's name was placed on the Wiltshire Child Protection Register in the category of physical injury on foot of these

concerns. Subsequently T returned to live with her granny in September 1991 and her name was taken off the UK Child Protection Register in November 1991. The UK authorities closed the case in May 1992 as they considered that matters had improved for T and her siblings.

T's next contact with the Irish social work department occurred in April 1994 when T together with her mother and two siblings had just returned from England fleeing an abusive relationship with her (T's mothers) partner. The social work notes record that counselling was requested for T and it was noted that T was depressed verging on the suicidal at times. The response decided and recorded was to place T on a waiting list. There is no recorded discussion, case oversight or referral to any further services, such as child psychiatry or psychology given the suicidal behaviours spoken of by T's mother. There appears not to have been any discussions, at least none recorded, as regards further professional support despite the referral from the Public Health Nurse concerning T's disruptive behaviour within the family and her history of physically abusive behaviour towards her siblings. When T was in fact referred to a child guidance clinic, it was undertaken at the initiative of her school rather than the social work department. This appointment was not availed of. The Health Board social work department by letter sought to make contact with T's mother on two occasions but on not receiving a reply to either letter, a decision was taken to close the case and this was confirmed in writing to her. The decision to close the case does not have any recorded regard to the previous history of T in either Ireland or the UK, much less to the fact that T had in fact been placed on a child protection register in the UK. It is unclear why no referral was made from the social work department to the child guidance services when T's school felt sufficiently concerned to make such a referral and for the child guidance service to offer an appointment.

For just over the next two years there is no record of any contact between T and/or her mother being in contact with the social services in England or the social work department in Dublin.

When T returned in May 1997 to live with her maternal grandmother, contact was made by T's aunt for support from the social work department. Appointments were offered to both T and her granny but neither availed of this offer and they were advised that the file was being closed pending further contact. T then returned to England but came back to Ireland in June of that year. On her return, T was allocated a social worker who met her almost weekly and developed a plan based on the available accommodation options to address T's accommodation needs. This proved the start of a more structured and continuous process of social work involvement that had purpose, context and direction. When T returned again to England, there was good handover and information sharing. The case was closed from an Irish social work perspective. In England, further concerns had arisen regarding T's safety while living with her mother and her partner. A Child Protection Conference was held in England at which the decision was taken "that T's name was placed on the Wiltshire Child Protection Register under the category for physical injury and emotional abuse." The description of T, contained in the English child protection report in 1991 as "a bouncy, energetic eight year old who was very articulate. She presented as a well adjusted child" was contrasted in 1997 as being a child who "now presents as an isolated, lethargic and frightened adolescent who has expressed feelings of hopelessness." Two further contacts were made with the Irish social work department in this period. The first instance was when T's granny made contact following an assault on her T's mother by her partner. As this occurred in another country the case was appropriately closed.

In December 1997, T returned along with her mother and siblings from England due to the abusive relationship between her mother and her partner. Initially, the family lived with their granny but difficulties arose and they moved into two refuges in Dublin. Social work contact was maintained both through the health board staff and the refuge staff.

Conclusions

Concerns raised when T was in her first year of life by nursing staff in the community and paediatric hospital setting were not adequately addressed in a child protection context. Again when T was five

years old her mother had another child who was placed for adoption no integration of the issues raised concerning T when she was a year old with the child care issues of the wider family network occurred. When T was seven years old her grandmother raised her concerns for her granddaughters care at the hands of her mother but these were not systemically addressed in a child protection context.

Subsequent familial disharmony became clear over the course of contacts between the social work department and the family during 1990. Concerns were explored directly with T's mother and again with the Granny leading to the conclusion that "this matter appears to be a family conflict over which we have no jurisdiction." A fourth opportunity to review in a child protection perspective was not systemically followed through. When in July 1990, the social work department was advised that "T had lost two front teeth due to a smack in the face from D [her mother]. "D after suggestions from myself, felt it would be better for T if she stayed in her Granny's for the present." This first episode of recorded physical hurt was not reported to gardai or treated in any way as a case in which the national guidelines on non accidental injury might be considered. This is of serious concern bearing in mind it was the fifth and perhaps clearest indicator for the initiation of the child protection processes that did not happen.

Within two months of T's return to England in mid 1991, her name was placed on the Wiltshire Child Protection Register on foot of the decision of a child protection conference which had been advised of two instances of physical assault on T by her mother's partner. When T in 1994, then aged eleven years old, next came to the attention of the Irish social work services counselling was requested for her as it was noted that she was depressed, verging on the suicidal at times. Her school rather than the social work services initiated the subsequent referral of T to a child guidance clinic. T did not avail of the offered appointment. T returned to England where she lived for two years.

In 1997, when she was 14 years old, T returned to live with her grandmother for a short time. Contact was made looking for support for both, by an aunt of T's. Appointments that were offered were not availed of. T returned to England but returned a short time later. On her return, T was allocated a social worker who met her almost weekly and developed a plan based on the available accommodation options to address T's accommodation needs. This proved the start of a more structured and continuous process of social work involvement that had purpose, context and direction. The social worker was focused and clear thinking on the presenting issues and worked hard to follow up on the decisions taken with respect to T's care.

When T returned again to England, there was good handover and information sharing. The case was closed from an Irish social work perspective. In England, further concerns had arisen regarding T's safety while living with her mother and her partner. A Child Protection Conference was held in England at which the decision was taken "that T's name was placed on the Wiltshire Child Protection Register under the category for physical injury and emotional abuse." Two further contacts were made with the Irish social work department in this period. The first instance was when T's granny made contact following an assault on her T's mother by her partner. As this occurred in another country the case was appropriately closed.

In December 1997, T returned along with her mother and siblings from England due to the abusive relationship between her mother and her partner. Initially, the family lived with their granny but difficulties arose and they moved into two refuges in Dublin. Social work contact was maintained both through the health board staff and the refuge staff.

Case closure occurred on four documented occasions over this period and on one occasion the case was put on a waiting list.

Recommendations

- Where concerns regarding a child's safety are voiced by experienced professionals the requisite child protection procedures and practices should be immediately implemented to assess the actions required to protect the child.

- All records concerning a child about whom there are child protection concerns and the wider family should be routinely integrated into the child protection assessment process.

- Where concerns regarding the mental health of a child are identified a clear plan of action and who is to be responsible for the appropriate follow up of the identified actions should occur.

- Case closure should only occur when a systemic review of all the interactions between the child, their family network and professionals within and without the health service has occurred to ensure that all matters are properly addressed and completed prior to closure.

1998 – T aged 15 years

Significant efforts were made in the early part of 1998 to secure housing for the family in conjunction with Dublin Corporation by the health board social work department in conjunction with their colleagues in the other statutory services. During this period of time the family stayed in B&B for a number of months and while so doing T engaged in unsafe behaviour a number of times, spent a lot of time on the streets and went missing on a number of occasions. On one occasion T alleged she was almost raped when she went with a group of men to a squat. This occurred while T was in the care of her mother. There is no record of any referral to other services e.g. child guidance services or specialist social workers dealing with homeless children and their behaviours.

In May 1998, her mother placed T in the voluntary care of the Health Board. The social work services record some 37 episodes of contact, during the year, with or on behalf of T in their efforts to provide her with a range of appropriate services. These included, emergency residential services provided by the Board itself and a voluntary organisation. A residential service was also sourced and provided for T in Cork. Supported Lodgings, a then newly developing concept of supportive care was sourced across a number of families in Dublin. Referrals were made to secure units to source care for T, to no avail. A single unit was established specific to meet the requirements of T. Referral was made to voluntary and housing services without result. B and B accommodation, which the Board itself acknowledges is an inappropriate service was used on a number of occasions to provide T with a place to stay. A huge amount of time and social work resource went into arranging accommodation for T

While T was placed with her Granny, no records were sourced as are required under the provisions of the Child Care (Placement of Children with Relatives) Regulations 1995.

T was linked in to education services dedicated to children for whom the mainstream educational service was not suitable. Support services were made available to T when she was placed in emergency residential accommodation through the then titled Community Child Care Workers.

Regular supervision, discussion and planning of actions to support T took place and outline clearly the actions envisaged of the Board in supporting T. Referral reports are comprehensive, thoughtful and present a clear rationale for the actions of the Board together. When a complaint was made by relative of T, it was properly reported by the social worker to her supervisor and so recorded. The documentation does not show the subsequent process for managing the complaint nor its outcome.

The difficulties experienced in placing and more particularly retaining T in residential services required considerable investment in sourcing alternative residential services. Increasingly the concerns for T's own physical and emotional safety together with the knowledge that she appeared

to be sexually involved with older men, concerns about her being pimped, about her beginning to take drugs and went missing on a number of occasions did not result in the calling of a case conference under the provisions of the extant Child Abuse Guidelines. In mid November, such a case conference was called for by the Garda Superintendent in the area where T had lived prior to her admission to care.

Social work management properly brought the range and extent of T's care needs to senior health board management for their attention. While discussions did result in some developments – including dedicated nursing staff accompanying her whenever she was placed in B and B from September onwards – these were in themselves ad hoc responses to T's needs rather than a structured longer term service. These needs were explicitly detailed thus by her then social workers "We would like to suggest the setting up of interim measure. The establishment of a flat/home which could be staffed during the day and night and provide her with a base. This would enable workers to begin to provide structure to her day and a place to which she can be returned should she abscond. At present given T's behaviour it is unlikely that a b and b will hold her for more than a few days. This leads to more confusion, as she has to move every few days. Having a base may provide her with some sense of normality; this would also address her primary care needs such as personal hygiene, regular meals, experience of nurturing, laundry which in turn could possibly offer her some security. Her placements in the past have failed because the staff in the homes have had to consider the safety of the other children. If a unit could be set up where she is the only child to be considered there is a greater chance of success. Social work intervention is limited to trying to meet her primary needs. T can be physically and verbally abusive to staff working with her. We have observed that her present lifestyle is placing and has placed her at risk from physical and sexual abuse. She is very confused and is having difficulty with her memory. She is lacking in consistency. Her current lifestyle is bound to impact on her current and long term development. We strongly urge approval to proceed with this recommendation."

However, the lack of actual secure care was a major deficit arising at this time not alone for T but also for a wider cohort of children, estimated by Board Officials at the time, of some 20 children. Significant legal actions were a regular feature of the then Health Board's management agenda as constitutional challenges and judicial reviews were increasingly used as vectors for securing care arrangements for children in care. Media interest was intense and the corresponding publicity was creating its own agenda of demand for more and better service with sophistication and expertise. Unfortunately, this expertise was not readily available in Ireland notwithstanding intensive recruitment efforts that continue to the present day. The construction process for new units had a timeline dictated by the physical requirements of construction projects rather than the needs of T or any other child. Finance of itself was not a stumbling block nor was the willingness of managers to push very hard to deliver on projects. In retrospect, the effort and time required to deal with these matters, can be seen to have diluted the focus on the actual prevailing service delivery to children in care.

T's psychiatric support was professionally and appropriately provided as was the ongoing support made available from this service. The increasing violence of T towards staff allied to her sexualised behaviour became significant factors in T's needs. The range and extent of contact between the area social work team and the Out of Hours service was significant and the sharing of views and experience was most beneficial in informing the better courses of action required to support and care for T. A family group conference was organised to involve T and her wider family in Ireland in planning her care. It must have been very disappointing that not one family member attended the family group conference.

In this phase of T's life in care there is clear evidence of significant interventions, planned and thoughtful responses guided by case review, supervision and discussions between T social worker and the wide range of care staff as to how best to meet T's needs. The breakdown in placements was principally related to the need to care for the needs of the wider numbers of children in residence as distinct from there being any unwillingness to care for T were these wider needs not at issue.

While the fairly clear expectations for each of T's residential placements were in general to be commended, the absence of clear and unique care plans as required in accordance with the Child Care (Standards in Children's Residential Centres) Regulations 1996 were not identified in the documentation provided.

Conclusions

T was formally taken into the care of the then Health Board in May 1998. A range of accommodation types were provided for her during the year including emergency residential services, a residential service in Cork; supported lodgings in a number of families in Dublin; a single unit was established specific to meet the requirements of T. B and B accommodation, which the Board itself acknowledges is an inappropriate service was used on a number of occasions to provide T with a place to stay. Support services were made available to T when she was placed in emergency residential accommodation through the then titled Community Child Care Workers. T was properly linked in to education services dedicated to children for whom the mainstream educational service was not suitable.

While T was placed with her Granny, no records were sourced as are required under the provisions of the Child Care (Placement of Children with Relatives) Regulations 1995.

The social worker dealing with T had regular supervision and oversight. Actions and plans were good and referral reports are comprehensive, thoughtful and present a clear rationale for the actions proposed. A complaint made by a relative of T was properly reported by the social worker to her supervisor and so recorded. The documentation does not show the subsequent process for managing the complaint nor its outcome.

The significant issues and concerns for T's own physical and emotional safety together with the knowledge that she appeared to be sexually involved with older men, concerns about her being pimped, about her beginning to take drugs and going missing on a number of occasions did not result in the calling of a case conference under the provisions of the extant Child Abuse Guidelines.

Social work management properly brought the range and extent of T's care needs to senior health board management for their attention. Ensuing discussions did result in some developments including dedicated nursing staff accompanying her whenever she was placed in B and B. These were in themselves ad hoc responses to T's needs rather than a structured long term service as envisaged by her social worker. The lack of actual secure care was a major deficit arising at this time not alone for T but also for a wider cohort estimated by Health Board management at the time of some 20 children.

T's need for psychiatric support was professionally and appropriately provided as was the ongoing support made available from this service.

In this phase of T's life in care there is clear evidence of significant interventions, planned and thoughtful responses guided by case review, supervision and discussions between T social worker and the wide range of care staff as to how best to meet T's needs. The breakdown in placements was principally related to the need to care for the needs of the wider numbers of children in residence as distinct from there being any unwillingness to care for T were these wider needs not at issue.

While the fairly clear expectations for each of T's residential placements were in general to be commended, the absence of clear and unique care plans as required in accordance with the Child Care (Standards in Children's Residential Centres) Regulations 1996 were not identified in the documentation provided.

Recommendations

- All requisite documentation relating to a child in care should be integrated into each child's file and properly completed.

- Where complaints are made a comprehensive record should be made of the investigation, the outcomes and decisions.

- Systematic, regular supervision of child protection cases is fundamental to best practice and must be a cornerstone of all child protection cases

1999

From a case planning perspective 1999 was a difficult year for service provision as the OOH service had effectively barred T from their services due to her disruptive behaviour over the preceding year and effectively creating unsafe environments for other children to live in and staff to work caring for them. Renewed applications were made for high support residential services in Dublin and Cork to no avail. Other services in the UK were considered but came to naught.

Whilst clear recommendations on T's support and residential services had been made in 1998, no substantive progress occurred during 1999. To compound the presenting care issues, T became pregnant about the middle of the year. There are no records of any antenatal care arrangements being discussed at any meeting with T or in any supervisory or review meeting. It appears that all such arrangements were left to T herself to organise.

Regular supervision sessions are recorded at which the circumstances of T's needs and suitable responses were clearly identified. A key case conference was held in mid January 1999 at which a dozen decisions were reached on how the health board would proceed in caring for T. These decisions were regularly monitored at social work supervision sessions and insofar as these supervisory arrangements related to the professional social work input into T's care it was a well managed process. On the other hand the lack of services to a child in care from the wider health board organisation became more accentuated when T became pregnant and for many nights the only structured care was that provided in B and B accommodation with one or two staff. On other occasions the organisational response was such that T was only offered food and no other service. Notwithstanding the individual efforts and the organisational decisions to provide care for T, it must be concluded that the actual scope and range of service to T during 1999 was unacceptable in the therapeutic context as well as the more mundane but essential services of accommodation, care and food.

The establishment of a dedicated service at 490 North Circular Road was a very positive development and initially appeared to suit T very well. However, it is not clear if there were particular objectives developed as to how this service was to provide for T's needs. Neither is there clarity on the managerial arrangements for this service. The provision of a one to one home tutoring service for T was very positive and showed good interagency cooperation. The management of allegations by T against the home tutor appears to have been well managed to the satisfaction of all concerned, although no evidence of a structured complaints process was identified.

A new social worker was introduced to co-work this case and the transition appears to have been well managed.

When initially it became known to the health board social work department from the UK social services the response the social work service was that the "department had been advised that we are not sanctioned to recruit new staff or procure premises for T. Obviously in the light of this situation we would recommend that T remain in England where she the opportunity to develop a relationship

with her mother and siblings. It is felt that since T would have no family or support networks in Ireland, it would be in her and her unborn baby's best interest to remain in England." This response appears to have been made without any recorded consultation between T's granny and wider family network in Dublin with the social work department.

Despite the view expressed that there were no services available in Ireland, T did return in August. Several meetings were held to identify the best accommodation and care arrangements for T and her unborn baby. Nothing substantive was immediately available and it resulted in T being placed in B and B accommodation and on occasions in the maternity hospitals as a social admission. To compound the complexity of the presenting care issues, serious concerns as to T being "pimped" emerged whilst she was pregnant. The OOH service was quite emphatic in its view that it had no placements to offer T.

T again returned to England to her mother for a short period in October and November 1999 but came back to Ireland as she was not wanted by her mother in England. On her return to Ireland, the social work service sourced a placement for T in a Cork based adoption residential service. The manner of this discharge from this service was completely lacking in adherence to any statutory or advisory standards of care.

Following this set back, T's principal accommodation arrangements were managed by the social work department through a combination of placement with relatives, B and B accommodation as well as voluntary service providers.

Although significant new care issues emerged including issues of T being "pimped" and of the fact that she became pregnant while in the care of the Board – none of these major issues – singly or together – led to any consideration of a case conference being called to consider the totality of the child protection issues.

Moreover significant intraorganisational conflicts became abundantly clear including the lack of emergency accommodation services being provided by the OOH services which were specifically established to provide such a services. Equally confusing was the "is she or is she not" entitled to supplementary welfare services from the Homeless Persons unit. While each section had its own rationale for deciding as it did there is no evidence of managerial cohesion in managing these conflicts which adversely reflected and impeded the Health Board's own capacity to properly and coherently deliver services to a child entrusted to its care.

Conclusions

The establishment of a dedicated service at 490 North Circular Road was a very positive development and initially appeared to suit T very well. However, it would have benefited from a clear statement of objectives and clear managerial arrangements for this service. The provision of a one to one home tutoring service for T was very positive and showed good interagency cooperation. A new social worker was introduced to co-work this case and the transition appears to have been well managed.

Renewed applications were made for high support residential services in Dublin and Cork to no avail. Other services in the UK were considered but came to naught. A key case conference was held in mid January 1999 at which a dozen decisions were reached on how the health board would proceed in caring for T. These decisions were regularly monitored at social work supervision sessions and insofar as these supervisory arrangements related to the professional social work input into T's care it was a well managed process.

To compound care issues as the year progressed, T became pregnant about the middle of the year a factor that added further pressures on the health board social work department. It also emerged in the

Significant intraorganisational conflicts emerged in the care of T over the year including the lack of emergency accommodation services being provided by the unit specifically established to provide such a services. Equally confusing was the question of entitlement by T to supplementary welfare services from the Homeless Persons unit. While each section of the then Health Board had its own rationale for deciding as it did there is no evidence of managerial action and/or cohesion in managing these conflicts which adversely reflected and impeded the Health Board's own capacity to properly and coherently deliver services to a child entrusted to its care. The effective barring of T from the Out of Hours service was an unacceptable action of the part of the service that was specifically set up to deal with the issues presented by children who were homeless. The lack of senior management action to redress this decision was unacceptable.

For many nights the only structured care was that provided in B and B accommodation with one or two staff. On other occasions the organisational response was such that T was only offered food and no other service. This was not an acceptable standard of care to a child in care of the Health Board.

A placement for T was sourced in a Cork based adoption residential service on the last two months of the year. This service broke down due to T's disruptive behaviour and the service's concerns about the impact on staff and residents. The manner of T's discharge from this service was completely lacking in adherence to any statutory or advisory standards of care.

Although significant new care issues emerged in 1999 including issues of T being "pimped" and the fact that she became pregnant while in the care of the Board – none of these major issues – singly or together – led to any consideration of a case conference or other systemic overview of the information that was known to the professional being called to consider the totality of the child protection issues. It was individual efforts and actions that were brought to bear on the resolution of these major issues rather than a coherent, robust plan that integrated all aspects of the child protection responsibilities of the then health board.

Recommendations

- All services working with children in care should work and be managed in a coherent, integrated, focused, planned, needs led service provided in a non adversarial manner directed at achieving the best interests of the child as the primary and sole focus of their work.
- Services for children in care require vigilant management ensuring through audit, structured case reviews, appraisal and feedback from all involved in receiving and delivering the service that the service is being provided to acceptable standards of care and practice.
- Discharge and handover arrangements between care services should be well managed to acceptable practice standards and it should be a key objective of every manager to ensure that this occurs in every case.

2000

The key issues emerging with regard to the care management and planning issues for T's care during 2000 related to the birth of her first child, that child being taken into care by virtue of a court order, management of the consequential access visits and placement of the baby, T becoming pregnant for a second time and the very significant initiation of judicial proceedings on behalf of T to secure better care for herself from the Health Board also presented challenging case management issues. By year end the Health Board had established a dedicated unit in which T was encouraged to develop household and budgeting skills and the unit adapted its nature of support to T in accordance to her changing circumstances. Moreover T was assisted in developing independent living skills and the ethos of the house was to build on T's strengths. T avails of supports in the community. This was the first time a clear statement of the philosophy of care for T was detailed in all her placements.

T's first child – a baby boy, initially called R but subsequently changed to L was born on 9th February when T was aged sixteen years and nine months. A case conference was appropriately held to consider the options with regard to the care of this child. Once the baby was born a further case conference agreed to the request of the paternal grandparents that they be allowed care for the baby. This occurred.

In accordance with the provisions of the Health (Eastern Regional Health Authority) Act, 1999 and S.I. No. 68/2000 — Health (Eastern Regional Health Authority) Act, 1999 (Establishment Day) Order, 2000 the Northern Area Health Board was established on 1st March 2000. This became the effective statutory authority with responsibility for the child care legislation as it related to TF, taking over the responsibilities previously excercised the Eastern Health Board. This change of itself did not result in any change of professionals caring for T. No changes in T's care arose from the change in the leglisation. All of the documentation detailing the involvement of the Eastern Health Board was available to the the newly established Northern Area Health Board. There were changes in senior management personnel.

By April 2000, the nature of the relationship between T and the Health Board had changed due to the initiation of judicial proceedings on T's own behalf for appropriate care. T secured a Court order that the Health Board should provide her with the most suitable accommodation and to draw up a care plan for T as soon as possible. T was required to participate in drawing up this plan. Part of these legal proceedings resulted in the appointment of a Guardian Ad Litem for T with the responsibility to ensure that "such reports and assessments to be carried out in respect of the respondent as deemed necessary and appropriate by the Guardian Ad Litem - the brief as additionally advised by Counsel was "to guide T through the Court process given that she hasn't reached her majority

T's serious problematic behaviour had according to the Health Board's legal team caused the breakdown of many of her placements and it became a condition of the provision of accommodation that T gave an undertaking not to abuse people charged with her care nor Health Board staff nor members of the public.

The preparation of the court ordered care plan for T was important in demonstrating the capacity of the Health Board to clearly focus on what was deliverable in meeting T's needs. The plan envisaged that it would:-

- To provide T with stable accommodation. T is currently in the B&B and ultimately the Board would be looking and to work with T towards independent living
- To encourage T to avail of education/training opportunities in St Vincent's Trust in order to assist her in acquiring the skills for future independent living. A referral has been made and we would be hopeful that T could attend
- To provide T with the opportunity to engage with Claidhe Mor Family Centre and to enhance her parenting skill. A referral has been made and accepted and it is hoped work can commence upon receipt of the psychological report
- To continue to enhance T's relationship with her son

With the appointment of the Guardian Ad Litem, T had acquired a voice to represent herself in a very articulate manner. The interactions between the Guardian Ad Litem and the Health Board social work staff while it had its "moments" proved a fruitful source in the delivery of the care plan for T.

While the stable home for T was established in late December 2000, for the rest of the year T was reliant on B and B accommodation and indeed on some occasions she had no accommodation service provided to her by the then Health Board. Effectively for the first seven months of her pregnancy T had no secure accommodation.

There are no records of case supervision as between the social worker directly dealing with the case and her supervisor. It is clear that discussions did take place between them but the issues and outcomes were not recorded with the clarity evident or in the format used in previous years.

Conclusions

The key issues emerging with regard to T's care during 2000 related to the birth of her first child, that child being taken into care by virtue of a court order, management of the consequential access visits and placement of the baby in foster care as well as T becoming pregnant for a second time.

The nature of the relationship between T and the Health Board changed due to the initiation of judicial proceedings on T's own behalf for appropriate care in April 2000. T secured a Court order that the Health Board should provide her with the most suitable accommodation and to draw up a care plan for her as soon as possible. A Guardian Ad Litem was appointed for T, and while the interactions between the Guardian Ad Litem and the Health Board social work staff had its "moments" it proved a strong voice in the delivery of the care plan for T.

By year end the Health Board had established a dedicated unit in which T was encouraged to develop household and budgeting skills and the unit adapted its support to T in accordance to her changing circumstances. T was assisted in developing independent living skills and the ethos of the house was to build on T's strengths. This was the first time in all her placements that a clear statement of the philosophy of care for T was detailed

A case conference was appropriately held to consider the options with regard to the care of T's first born child. Once the baby was born a further case conference agreed to the request of the paternal grandparents that they be allowed care for the baby. This occurred.
While a stable home for T was established in late December 2000, for the rest of the year T was reliant on B and B accommodation and indeed on some occasions T had no accommodation service provided to her by the Health Board. The fact that T while in the care of the social services became pregnant twice clearly raises significant concerns that the adequacy of the care being provided was in fact significantly inadequate.

Recommendations

- The use of B and B accommodation should never be an option used for children in care.

- Every effort should be made to avoid costly legal cases being taken with regard to the provision of services for children in care. Where feasible, non adversarial processes should be used to ensure the best interests of the child are achieved. Conflicts where they arise should preferably be resolved in a facilitative, mediated or arbitral manner.

- When a child in the care of the Health Service Executive becomes pregnant when in care a review of the care arrangements should be undertaken by management in consultation with all those involved in providing such care and the child's Guardian Ad Litem or other responsible adult. The purpose of such a review would be to ascertain what further actions might have been appropriate to have been put in place to prevent such a pregnancy occurring.

2001

Living in Orchard View provided T with the longest period of stability in accommodation from the time she was first admitted to the care of the Health Board. While she did in fact have to move from one house to another in the same terrace it was not a major relocation. The care needs of T were compounded by the birth of her second child – a daughter born on the 28th April 2001. T was aged one month short of her 18th birthday when she gave birth. Court involvement and decisions of the

court significantly influenced the overall care provision for T as well as her daughter. This directly influenced the fact that T was enabled to care for her daughter herself for a period of time in order to develop a bond and care for the baby. Unfortunately this did not work out due to concerns of the Health Board staff regarding the safety of this baby while T was caring for her. The baby was removed and placed in foster care, less than two months after the birth on 6th July 2001.

The other key issues emerging with regard to the care management and planning issues for T's care during 2001 related to fact that T herself reached 18 years of age and the future to be provided to her was being guided by the judicial process and the management of the consequential access visits for both children. The impact of these of judicial proceedings on behalf of T to secure better care for herself from the Health Board also presented challenging case management issues.

A number of additional factors compounded the case management and planning issues required of the social work department of the Health Board. The logistics of managing two sets of access arrangements for each of the children; the regularity of attending at court to secure extensions of the respective care orders for each of the children, dealing with the issues raised by the respective Guardians Ad Litem for the children allied to the requirements of managing the residential accommodation provided for T must have been a most difficult and problematic experience for the social workers allocated to the case. However, it the court approved access arrangements were carried out to the fullest extent possible. Difficulties did arise in the course of access visits between T and her children, which led to some of them being shortened due to a variety of reasons e.g. T shouting or arriving late. These reductions led T to being reluctant to hand over the children to the social worker and the Gardai requiring to be called to ensure they were returned.

It is not difficult to imagine the quandaries that presented to the Health Board and it is clear that the management of all the presenting issues, the different fora in which they were required to be addressed, the logistical array of access arrangements were time consuming in their execution and draining of the resources available to the case. The focus of service moved to rule making for manner in which the house was organised and conducted, rules surrounding the manner in which access visits were to be conducted, rules regarding T's own behaviour which had at times become extremely dangerous and violent and conflict between T and the staff of the house regarding issues not in the rules but yet which proved highly contentious e.g. the volume of the stereo, confiscation of magazines and videos – alleged to be pornographic and at times concerns regarding the inconsistency of staff in the care of T.

Concerns regarding the consistency of staff in the house who were caring for T were properly raised by the social worker for T and the Clanwilliam report noted that "in its opinion that it has some concerns about the manner in which some staff members engage with T which it judges to be hierarchical and judgemental." When allied to the repeated use of calling the Gardai as a means of controlling the explosive behaviour of T, rather than any TCI techniques in which no record of training has been identified or of calling the Guards to let the staff into their bedroom because the key had broken in a door lock or of keeping a record of the number of toilet rolls used, a clear lack of proper management of the residential service emerges. The overall effect of the increasing number of rules being made for the house was that it was increasingly becoming a secure unit with doors locked, kitchen locked after midnight, monitoring system in place when the children were on access visits and an overwhelming degree of observation of T at all times.

The nature of the residential arrangement of itself is unclear in that it does not appear to have been a registered centre operated in accordance with the provisions of the Guide to Good Practice in Children's Residential Centres even when T was under 18 years of age and formally in the care of the Health Board. It appears that the person responsible for recruiting the staff employed in the residence was also the person who decided the manner of the responses that staff were to make to some of T's clearly unacceptable behaviours. No staff member was clearly identified as being responsible for the actual day to day management of this service at Orchard View. This created significant concerns from the perspective of T's Guardian Ad Litem who sought a more structured

plan, with staff qualified in child care and greater certainty regarding the ongoing future of the service to be provided to T.

While there were significant and important worries about the care of T's second child and very intense and detailed observations of all aspects of her care of the child by the staff of the unit, concerns were being expressed by the Public Health Nursing service that "We both agree that the level of support being provided to T at this point is excessive insofar as T is not provided with space to develop – relate to her as one would with any young mother who needs time out and plenty care to recover her strength and allow her emotions adjust" The highly detailed nature of the records bear testimony to the concerns raised. The issue of the level of detailed observation illustrates the difficulty in achieving a balance as between concern for the safety of the child, the nature and content of how this was achieved and the balance between objective analysis and overbearing and intrusive observation. Whilst a designated coordinator was recruited and this appointment did work well for the duration of the post holder staying with the placement it is totally unclear who became responsible when he left.

This coordinator when he was leaving his post provided a status report for the benefits of the new staff team as a possible template of future care process. He stated "....it is the result of observations formed over eleven months.....may be a signpost in the difficult work that lies ahead....it is important that all staff working with T set boundaries around how they expect to be treated by T...has in the past responded very well to staff refusing to allow her manipulate or verbally abuse them...staff have little to gain from direct confrontation with T as she does not listen to logic as such....T needs compassion that is backed up with the understanding that staff will at least expect to be respected by T or they will refuse to engage with her...she says she likes to be given a lot of space by staff and to be left alone most of the time. She likes to cook for herself and to feel she is independent, yet at time she wants staff to become her absent parents and look after her as best they can. T at times seems to experience great loneliness and sadness....has admitted to hating men....the need for affirmation is a double edged sword....T may spend some of her time manipulating the various bodies and organisations that have been charged with her care. I feel that a systemic approach to her situation would be very beneficial. Monthly meetings between all the parties concerned would I believe provide a far more effective approach to this particular case." This was an extremely insightful (with hindsight) assessment of T and the capacities she possessed and the most appropriate responses to these needs. However, when later on in the year significant aggressive and dangerous behaviour was displayed by T, the absence or lack of identification of an on site coordinator or manager in the house or at least a designated senior responsible person within the staff on duty that would have engaged in a systemic process such as was outlined by the departing coordinator that would have enabled these concerns to be dealt with in a more structured and therapeutic context as distinct from only involving the Gardai in response to the presenting behaviour.

Very comprehensive efforts were made to secure educational and vocational support for T in St Vincent's Trust. Similarly, strenuous efforts were made to ensure appropriate counselling was available for T including individual counselling for T, parenting skills for T, couple counselling and appropriate psychological and psychiatric assessment. These interventions in which T sought to participate were appropriate and informed the ongoing care arrangements for T. The issue of domestic violence between T and her partner, T's continued involvement in prostitution and arrest for soliciting together with the obvious lack of concern for her personal safety were important personal care issues for T.

Court proceedings were a very frequent occurrence over the year and the Health Board services to T were very trenchantly criticised by Judge Kelly in a High Court judgement when he expressed strong disapproval of "a girl as vulnerable as this" being placed in B&B's which she had to leave between 10 and 6 and then in premises at Rathdown Rd where she could come and go as she pleased without any structure whatsoever. In these circumstances it was no surprise that she became

who stated "the court marks very strongly the absence of any therapeutic service to T." The High Court judgement of Justice Kelly was quite explicit in his comments regarding the services provided viz "from what I have heard today, it would appear the way in which the health board went about discharging its statutory obligations to accommodate her, were to accommodate her in bed and breakfast accommodation which she had to leave every morning at 10 o'clock and could not get back to it until 6 in the evening or in the premises where she is at present or similar premises thereto where apparently during the course of the day she was free to come and go as she pleased. There was neither shape nor form to her daily life and I must say I find it disquieting that the Health Board would see that as an appropriate way of discharging its statutory obligation to a person as disturbed and as vulnerable as this young woman"

Case conferences and reviews were properly held over the course of the year for both T and her children. The role of the courts in managing the care process became quite detailed in seeking to achieve a care pathway for T in particular, with a court directed eleven point agenda for consideration by the case conference. At times, especially towards the end of the year when the High Court was directly involved in addressing from a legal perspective there seemed to be an exhaustion with the many strands along which each element the case was progressing, T herself, each of her children, the court oversight of each of the three persons – T and each of her children – the role and interaction required with each of the Guardians Ad Litem.

Tensions between the role of T's Guardian Ad Litem and senior health board social managers are evident from the documentation. Of itself, this is not an issue so long as the issues giving rise to the tensions are themselves separately and individually addressed. It is not always clear that this is so. For instance, allegations made that T was given a dig in her side by a staff member was made but no record of the investigation or outcome was recorded as being advised to the Guardian Ad Litem, equally there is no record of the Guardian Ad Litem being responded to regarding his query about the social care qualifications and experience among staff. Of itself the lack of a recorded response to the Guardian Ad Litem is not a significant defalcation. However, if it impeded the provision of best care then it clearly must be identified as a major problem.

Conclusions

As with the first pregnancy, there are no records that any discussions took place concerning the ante natal care requirements of T, either with her or as part of any review processes. T was aged one month short of her 18th birthday when she gave birth to a daughter born on the 28th April 2001. Increasingly decisions of the court significantly influenced the overall care provision for T as well as her daughter. T was allowed by court order to care for her daughter herself for a period of time in order to develop a bond between them. Unfortunately this did not work out due to concerns of the Health Board staff regarding the safety of this baby while T was caring for her. The baby was removed and placed in foster care within two months of being born.

When T herself reached 18 years of age, her future care was being guided by the judicial oriented process and the management of the consequential access visits for both children. There was no clear, defined or planned therapeutic programme in place for her. A number of additional factors compounded the case management and planning issues required of the social work department of the Health Board. The logistics of managing two sets of access arrangements for each of the children; the regularity of attending at court to secure extensions of the respective care orders for each of the children, dealing with the issues raised by the respective Guardians ad Litem for the children allied to the requirements of managing the residential accommodation provided for T must have been a most difficult and problematic experience for the social workers allocated to the case.

All of these factors should have led to the assignment of a more experienced worker at Team Leader level to the case much earlier than November 2000 at which time the lead social worker was in fact concerned about becoming burned out from all the activity the case was generating.

The provision of stable accommodation was a major improvement in the care arrangements for T. Whilst there were many difficulties, it provided for the first time in two years the opportunity for T to have someplace to call home. There were significant operational defects in the manner of operating the service, including it not being registered, it not having a clear statement of purpose or function; not having effective management structure within the house once the coordinator left and not having some staff were qualified as child care workers or as currently titled, social care professionals. What therapeutic support there was for T was mediated in a matrix of difficult relationships with those caring for her. It was not a very beneficial therapeutic environment and many of the recorded exchanges between T and the staff of the house reflect the very proximity of the physicality of the arrangements and the microscopic nature of the monitoring e.g. one note records a need to count the number of toilet roles used. Concerns were expressed by external professionals about the staff being hierarchical and judgemental. The staff in the unit did not themselves have adequate external professional supports such as psychology or training in self protection to help them properly deal with the very difficult behavioural issues they were presented with.

Very comprehensive efforts were made to secure educational and vocational support for T. Similarly, strenuous efforts were made to acquire individual counselling and parenting skills for T as well as couple counselling and appropriate psychological and psychiatric assessment. The only counselling T and her partner actually got was that which they themselves secured.

There are no records of case supervision as between the social worker directly dealing with the case and her supervisor. It is clear that discussions did take place between them but the issues and outcomes were not recorded with the clarity evident or in the format used in previous years.

The Clanwilliam Institute's view that "T's history is a narrative of human tragedy. She has suffered abuse/neglect and a steady deterioration of her circumstances. In recent times she has been taken care of better but always short of adequately" represents a salient perspective on T's care.

Recommendations

- Only centres and services that comply with the national standards appropriate to care settings should be used to provide care for children in the care of the state.

- The use of residential settings must form part of a considered care plan that has the requisite resource provision and is monitored to ensure it is in place.

- Complex cases require experienced and senior managers to be assigned to ensure management of the issues as well as delivery of the therapeutic objectives by the responsible social worker directly involved in dealing with the principal client.

2002

In January 2002, T who by now ceased her relationship with the father of her two children, became involved with a number of males some of whom were considered by the staff to be involved in the drugs scene. There were a number of significant indicators that T was involved in the drug scene in quite a heavy manner. However, there is no record of T being referred to any of the substance abuse services provided directly by the health service or any of the voluntary organisations involved in such services.

A number of meetings were held at which more rules regarding the way in which in which T lived in and related to the staff of the house were crystallised.

T left Orchard View for the last time on Saturday 19th January 2002. Efforts to make contact with her by mobile phone proved unsuccessful. On Sunday 20th January T was reported to the Gardai as

missing. Her body was found in a basement flat in Granby Row by Gardai on 25th January 2002. Her funeral was attended by many of the staff who had been involved in her care over the years. T was buried alongside her grandmother.

Conclusions

Following an inquest held on 7th February 2002 the death certificate recorded the date of her death as 24th January 2002 and her cause of death as resulting from ingestion of gastric contents, heroin toxicity, death by misadventure MDMA (Ecstasy) ingestion.

While it was suspected that she had become involved in using drugs T had consistently denied this was so. However, there is no record of any involvement, even on an advisory level, of any of the substance abuse services to address the presenting concerns.

The death of a young adult is harrowing and painful.

Recommendations

- Where a child in the care of the HSE dies, a formal review, independent of the case management and services should be undertaken of the case in its entirety.

Conclusions

This case review concerns a girl TF born on 26th May 1983 and who died 24th January 2002. Her mother placed T in the voluntary care of the then Eastern Area Health Board in May 1998. In her eighteen years T, lived chiefly in Ireland but moved backwards and forwards to Wiltshire in England principally between the ages of eight and fourteen years. T grew up as a young child living with her mother in her grandparent's house and went to the local school. There were five instances between 1983 and 1987 where concerns that properly should have been considered in a formal child protection framework as provided for in the Guidelines on procedures for the identification, investigation and management of non accidental injury to children published in February 1983 did not occur.

The response of the English social services to concerns about T's safety was very different, more decisive and more prompt in 1991 when her name was placed on the Wiltshire Child Protection Register because of two instances of physical assault on her by her mother's partner. Again in 1997 T had her name place on the Wiltshire Child Protection Register for being physically and emotionally abused by her mother's partner. Both of T's half siblings were also placed on the Wiltshire Child Protection Register for emotional abuse. The then Eastern Health Board should have formally responded to the Wiltshire authorities when they were asked by them to advise regarding the proposition to take the children's names off the Child Protection Register.

When the relationship between T and her mother had broken down so completely after their return from England that her mother placed T in the care of the then Eastern Health Board there was little focus on developing any supportive programme on managing their relationships thus preventing an admission to care.

Over the course of the rest of her life in care T was accommodated in a very significant range of accommodation including B and B accommodation on thirty one occasions in at least twenty different residences; in three separate apartments; in two emergency accommodation settings, in supported lodgings with five different families; in two mother and baby homes; with her grandparents and uncles; in two services designed to focus on multi-issue children and in two dedicated services specific and solely for her. In addition, T also was admitted on a number of occasions as a social admission to whichever of the Dublin maternity hospitals that had an available bed, on another occasion she slept on a bench in the A&E department of the Mater Hospital, in a tent on at least one occasion, overnight in other houses on several occasions and slept rough on one occasion. Sourcing accommodation required a significant amount of social work time and effort, which if there had been a service appropriate to need available would have enabled a more therapeutic focus, rather than principally sourcing accommodation

In the first six months of being in care, T was accommodated in a minimum of nine different accommodation arrangements and in that time T became seriously encultured in the out of home scene becoming highly sexualised, becoming involved in prostitution, being pimped, using heavy drugs, drinking, fighting with residents, assaulting and being verbally abusive to staff.

While in the care of the Eastern Health Board T became pregnant twice, the first time when she was 16 years old and secondly when she was just over 17 years old. Upon the birth of her first child the Health Board sought to enable T to parent her baby but serious concerns as to her ability to do so resulted in the Board securing an Interim Care Order and placing the baby boy in foster care. Significant access to her son and support were provided to T. In her second pregnancy T who by now had had a Guardian Ad Litem appointed to represent her interests, secured the opportunity to care for her second child a daughter for a negotiated period of six weeks. Substantial supports were provided by the Health Board in the house in which T lived with her daughter including an intensely monitored environment aimed at providing T with very high level of advice on and practical

education on being a parent. However, within six weeks the Heath Board had to take emergency action taking T's daughter into care due to their concerns about the manner of her interaction with her daughter. The supportive role of the Health Board was very important and the efforts made were most commendable. On both occasions, when T became pregnant there are no records that any discussions took place concerning the ante natal care requirements of T, either with her or as part of any review processes for either of her pregnancies and it was left to herself to organise all this care which she did. This is not acceptable care planning.

The response of the psychiatric and psychological services in providing care, diagnosis and advice was clear and sensitive. Five psychiatric assessments and one psychological assessment of T were undertaken in her lifetime. In addition there are seven documented instances of recommendations for T to be assessed by a psychiatrist that did not lead to any outcome. There is no evidence of any purposeful neglect of following up such recommendations. There is no evidence from the files that the insights provided by the psychiatric assessment of T were brought to the knowledge of the residential care staff and appropriate advise as to the ways in which they might adapt or redefine their care roles in the light of those important insights. There was a delay of over two years in actually getting a psychological assessment of T and this undoubtedly led to delays in ensuring T's needs, abilities and competencies fully informed the care provision process in all settings.

During the time that T was accommodated in B and B accommodation and accompanied by assigned staff there appeared to be no care plan or programme for therapeutic engagement by her direct carers with her.

When T was first admitted to Sherrard House it was to ensure her personal safety. The support given to T to handle her rejection by her family is less clear. The insecurity of requiring T to present on a nightly basis to ensure access to an emergency bed must be considered even at this remove, an undesirable practice but it was good practice that T was assured of a full time placement quite quickly.

The immediate provision of a child care support worker for T over the first weekend in Sherrard House was very good and the supportive and facilitative role of these workers emerges strongly as a positive feature. In the twenty one documented interactions there is only one reference to T not keeping an appointment. There are no documented incidents of abusive behaviour towards any of these workers.

Supported lodgings also provided an important service when T was 15 years old. The most important role, in addition to safe care, was the cpportunity it gave T to speak of difficult issues in her past and current life. A pragmatic decision was made to extend the financial terms of the scheme to enable T's granny care for her without financial difficulty although there are no records of the appropriate statutory assessment being undertaken.

The service in Parkview initially proved supportive of T. T found it a service in which she was able to disclose her involvement in prostitution and received a lot of support to enable her break loose from being pimped. This was a most important outcome and the staff concerned are to be deservedly commended.

There was a good degree of planning for her first admission to Lefroy House, but in comparison with current day practice lacking a personalised and detailed plan with expected outcomes. The end of T's initial period of residence in Lefroy was so unplanned as to appear chaotic. In the second period of her episodic referrals to Lefroy House, T was in late pregnancy with her first child and these admissions were opportunistic rather than part of any planned process of care. No consideration was given to referral to or procuring advice from the addiction services in respect of the drug culture which T experienced.

The brief stay of T in An Grianan was one of a four residential placements T experienced in first year of being in care. The efforts at planned admission and ensuring a clear and well thought out process of integrating T into the service went askew when the admission date was deferred through delays that arose in recruiting an additional staff member. There was a lack of clear communication by An Grianan to the area social work service regarding the start date of T's placement. No clear expectations of the placement for T or her future were identified in the documentation. Neither was any clear statement of purpose for this centre, current at the time of admission, identified. This service along with all the other residential and accommodation services used by T where there were other children in residence clearly did not have the in house expertise or external professional support made available to it to cope with the very difficult behaviour presented by her. In retrospect this was a service that was no different to other services at the time in putting the needs of the wider group of service users as a higher priority than those of T.

The unit at 490 North Circular Road in which T lived on her own provided her with a period of stability for over five months. It proved a relatively successful placement in that T was able to access on a weekly basis some nine hours of personal tuition, which in the opinion of her tutor was very positive. There was approval to continue the tuition service while T was resident in Eglington House in September/October 1999 but it is not clear why it was not reactivated. Given the educational benefits ascribed by the original tutor it would clearly have been of benefit to T. The robust plan for T at 490 was well monitored and managed by the social worker and supervisor and was adapted over the period to incorporate some of the challenges that emerged over the course of her stay at 490.

The service of Eglington House provided an opportunistic period of care at a time when T was pregnant and homeless. No other service specific to the needs of pregnant homeless girls was available. The second placement had worthwhile objectives from a parenting perspective but did not succeed in meeting them.

T's placement in the Cork adoption residential unit was quite opportunistic and unrelated to any planned or structured care pathway. No outcomes were defined nor were any supports identified as being required which given her previous history one would have expected to have been detailed. It was not a successful placement and the manner of her discharge was completely unprofessional and cannot be regarded as acceptable. The failure of Health Board staff to return telephone calls was both unsatisfactory and exceptionally discourteous.

When T was accommodated in Orchard View, the vision for its operation was that T would be encouraged to develop household and budgeting skills and the ethos of the house was to build on T's strengths. Initially it was quite a good service led by a coordinator on site who interacted and managed the presenting care issues in a thoughtful and purposeful manner. However, when he left and was not replaced the reality of care became based principally on rules that were devised in an ad hoc manner responding to the most recent crisis. There were significant operational defects in the manner of operating the service at Orchard View, including ongoing maintenance issues, the fact it was not registered and not having some staff were qualified as child care workers. What therapeutic support there was for T was mediated in a matrix of difficult relationships with those caring for her. External professionals expressed concerns about the staff being hierarchical and judgemental. The staff in the unit did not themselves have external professional supports to help them deal with T's very difficult presenting behaviour.
There is no evidence that any of the staff in any of the services had been trained in Therapeutic Crisis Intervention, as was stated in the 1998 Review of Adequacy of Child Care services to have been established, or if they had there is no evidence of its use in addressing the violence that did present in T's behaviours while living in any service.

A range of non residential supports were provided to support T while in care including the Green Door into which T was linked into to receive practical daily support including washing her clothes at the time when Sherrard House only available to her on a bed and breakfast basis during the latter

part of 1998. Intermittent support was provided by Focus Ireland services to T when she was 15/16 years old. There is no evidence to show what was learned of T's needs and how they might be better met from these interactions.

T's placement inn St Vincent's Trust was very important for the opportunities it provided her. Strong support was provided by the social worker to encourage T's attendance. The fact that T while initially enjoying the programme, later sought to move away from it is indicative of the difficulty she had in participating in formal educational processes. The placement ended due to T's behaviour but the Trust were prepared to provide it to T if the Health Board agreed to fund 1:1 staffing. The Health Board quickly and commendably decided to fund this arrangement although T never availed of it.

The services of Claidhe Mor were sought initially when she was 15 years of age and the service was proposed in the context of her then family relationships but was not ever used. The second referral arose when T herself was 17/18 years old. A major effort was made to acquire from Claidhe Mor individual counselling and parenting skills for T as well as couple counselling. This did not happen and the only counselling T and her partner actually got was that which they themselves secured. Some eight months elapsed between referral and the decision being taken by Claidhe Mor management not to provide a service.

T's first involvement with drugs was in 1998, and she was advised of the dangers of so doing. When combined with the context of her very unsafe sexual behaviour over that same period the absence of a referral to the addiction services is a serious lacuna. In the second period of drug use, which occurred in the last few months of T's life when she was living in Orchard View there is no evidence available that any of the nurses had professional expertise in addiction care nor was any referral made to the addiction services notwithstanding the growing concerns of the network of professionals. There is no recorded incident of drug misuse by T when she was pregnant.

Despite the many physical attacks by T on staff and members there was only one recorded instance of a prosecution by the Gardai and that was in the case of a member of the public. While T had many instances of disruptive behaviour there is only one instance of her actually damaging or defacing property. No systemic overview of the precipitating and background factors surrounding these attacks was undertaken nor was there any systemic oversight as to what effective harm reduction, behaviour modification or other forms of anger management were required. The experiences of other high support or secure units in dealing with such behaviour were not used. Moreover, the health and safety issues for staff were not systemically assessed or addressed nor were debriefing processes put in place for staff. There does not appear to have been an appreciation of the importance of addressing any negative aspects of the threat or assault for the professional relationship between the carer and the person being cared was identified. These are significant gaps in the service management of T's care and the staff who provided care.

The emotional impact on T's children of her outbursts created strong concerns for their safety. The then Health Board properly and promptly sought to have the children taken into care. Such action is emotionally exhausting and draining for all concerned. The staff concerned acted promptly, professionally and correctly in undertaking this unfortunately necessary role on two occasions.

The highly sexualised behaviours exhibited by T were immensely challenging to those who cared for her. Unfortunately these were not systemically assessed to enable a clear plan be formulated and put in place. What did occur was that the issue of T's sexualised behaviours were considered in the context of the impact these behaviours had on the wider group where she was living in a group situation rather than a focus on the needs of T as an individual. Available specialised professional advice was not sought to address the individual needs of T as regards her sexual behaviour.

The role of the Guardian Ad Litem and this court appointment enabled T's needs and views to be clearly articulated to the Health Board. There are no records of any difficulties in T's behaviour

towards her Guardian Ad Litem. While the provision of information to the Guardian Ad Litem was slow and fragmented and was the subject of discussion in the court hearings there were constructive dialogues between the Health Board and the Guardian Ad Litem. The fact that there were three separate Guardians Ad Litem involved in this case at the same time was immensely time consuming to manage but all were facilitated in properly discharging their respective roles.

When T went missing from care placements the Gardai were infrequently notified of her going missing. Given that T went missing at least twenty three times while she was under 18 years of age and six times when she was over 18 years old there was clearly a need for a common policy for the notification of a child when missing. There was no systemic overview of the times T went missing or what implications it held for her care.

T and the OOH service had significant interaction between them with 227 recorded contacts over the period 1998 to 2002 with the most significant number occurring during her first year of being in care. Communication was regular and informative between the OOH service and the area based social work team regarding contact with T. Being pimped was very well tackled by OOH staff who are to be commended for the alacrity with which they dealt with the matter. An appropriate referral was made to the Gardai by the service regarding the matter of her having sex with an older man. When T was living in Orchard View, the OOH service on at least three occasions was incorrectly cast by the staff working there in the role of care manager. T presented on at least four occasions when OOH did not offer her accommodation but instead offered food, bus ticket or a service she had previously rejected. This was not an acceptable standard of care. The decision by the OOH service not to provide T with service was incorrect and should have reversed by senior management as it was fundamentally at variance with the legal obligations of the then health board towards children in its care in ensuring the welfare of the child had primacy in strategic, policy and operational terms. By way of positive contrast after an initial refusal by the Homeless Persons Unit to assist T, this service did reconsider its decision and ensured that T benefited from its support. This was a good example of T's care needs being properly managed and it is to the credit of the service that it promptly adjusted its policy when it was not found to be in her best interest.

T had five social workers who were principally involved with her care whilst she was in the care of the Health Board. There were also thirty nine other social workers nearly all of whom were basic grade social workers involved in chiefly one off contacts with T's care. Despite the chaotic accommodation arrangements the key social worker involved with T was focused and clear thinking on the presenting issues and worked hard to follow up on the decisions taken with respect to T's care. The social worker dealing with T had regular supervision and oversight. Actions and plans were good and referral reports are comprehensive, thoughtful and present a clear rationale for the actions proposed. There was generally good social work communication between the Irish and English social work departments. A complaint made by a relative of T was properly reported by the social worker to her supervisor and so recorded. Overall there appears to have been good supervision of the social work staff and strong efforts put in place to manage the very complex array of significant persons involved in T's care and that of her daughters.

Social work management properly brought the range and extent of T's care needs to senior health board management for their attention. Ensuing discussions did result in some developments including dedicated nursing staff accompanying her whenever she was placed in B and B. These were in themselves ad hoc responses to T's needs rather than a structured long term service as envisaged by her social worker and supported by the clinical opinions of those consultant psychiatrists who had assessed her.

Increasingly as T became older and sought to have rights vindicated through the legal system, decisions of the court significantly influenced her overall care provision as well as the access arrangements for her two children. The logistics of managing two sets of access arrangements for each of the children; the regularity of attending at court to secure extensions of the respective care orders for each of the children, dealing with the issues raised by the respective Guardians ad Litem

for the children allied to the requirements of managing the residential accommodation provided for T must have been a most difficult and problematic experience for the social workers allocated to the case. All of these factors warranted the assignment of a more experienced worker at Team Leader level to the case much earlier than November 2000 at which time the lead social worker was in fact concerned about becoming burned out from all the activity the case was generating.

Case conferences were in the main held at appropriate times particularly as regards to T's children. However, when the significant issues regarding T's own physical and emotional safety together with the knowledge that she appeared to be sexually involved with older men, concerns about her being pimped, about her beginning to take drugs and going missing did not result in the calling of one or more case conferences at earlier times. These were opportunities that with hindsight should have been used to chart the future care for T before it ended up in the judicial process. Similarly, there were missed opportunities for case conference when concerns for T's welfare were expressed in her early years.

Within seven months of T being taken into Eastern Health Board care the professionals involved in her care were of the view that secure accommodation was required. The escalation of the required care levels was supported by the assessment of experienced care professionals and seasoned expert child psychiatrists who had worked closely with T over these initial months of homelessness.

Efforts to secure a place in existing high support accommodation entailed contact across services throughout Ireland, Northern Ireland and the UK proved unsuccessful. The Health Board itself over the period of T's care was in serious difficulties in the provision of high support care units which led to many costly appearances before the High Court defending cases brought against it under the various statutes to vindicate the rights of the child. The difficulties in recruitment of suitably qualified staff and the difficulties in building planned units were frustrating, problematic and strongly managed by Health Board management within the presenting limitations and the constraints of what was in fact achievable.

The lack of actual secure care was a major deficit arising not alone for T but also for a wider cohort of children, estimated by Board Management at the time, of some 20 children. Significant legal actions were a regular feature of the then Health Board's management agenda as constitutional challenges and judicial reviews were increasingly used as vectors for securing care arrangements for children in care. Media interest was intense and the corresponding publicity was creating its own agenda of demand for more and better service with sophistication and expertise. Unfortunately, this expertise was not readily available in Ireland notwithstanding intensive recruitment efforts that continue to the present day. The construction process for new units had a timeline dictated by the physical requirements of construction projects rather than the needs of T or any other child. Finance of itself was not a stumbling block nor was the willingness of managers to push very hard to deliver on projects.

Concluding comments

This case review highlights the missed opportunities presenting over T's lifetime when she came to the notice of the child protection services. The lack of systemic review of key areas of T's life and behaviour including her sexual behaviour including becoming pregnant twice while in the care of the then Health Board, her going missing from placements, her drug tacking activities, her violence towards staff and members of the public, her verbal aggression were not properly evaluated as to how and what should the most appropriate care and therapeutic response be for her care.

The accommodation arrangements provided for T were chaotic and created their own frenzy of activity that diverted social work responses and reaction towards the practical requirements at the expense of the less obvious but no less important therapeutic needs. T needed supported, stable living arrangements with experienced staff supported by relevant expertise. The response provided met some of her needs some of the time and at times provided none of her needs.

It is recognised that T was one of about twenty children who at the time had similar care needs. However, using existing knowledge and pooling skills that were available could have significantly supplemented the shortfall in expertise that emerges from this case. The lack of referral to or getting advice from specialist addiction services and services dealing with prostitution are among the more significant lacunae to emerge.

There were significant investments of time, resources, report writing, liaison and interaction with other services by the Health Board in trying to provide the best care for T, but the delays in providing the type of accommodation recommended within six months of her being admitted to care allied to the resultant multiple accommodation arrangements contributed to a loss of therapeutic focus and integrated professional skills that were required to properly meet T's needs.