



A statement based on an investigation of complaints that the Health Service Executive did not provide appropriate care for a young person.

(In accordance with Section 8 of the Ombudsman for Children Act, 2002)

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Ombudsman for Children's Office

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Introduction

In June 2007 a mother of a 14 year old boy who died by suicide following the issue of a secure care order made a complaint to the Ombudsman for Children's Office (OCO). The mother was unhappy with how the Health Service Executive (HSE) handled the care of her son since 2005.

The investigation was based on two complaints. The first complaint relates to the services provided by the Health Service Executive Child and Adolescent Mental Health Services (CAMHS). The second complaint relates to the circumstances around the handling of her son's care by the Health Service Executive Child Care and Social Work Service. Having undertaken a preliminary examination under Section 8 of the Ombudsman for Children Act, 2002 (the Act), the Ombudsman for Children determined that this matter warranted further investigation pursuant to section 10(1)(a)(ii) and section 13(2) of the Act. This investigation has now been completed and a statement outlining the results of the investigation has been sent to the complainant, the HSE, the Minister for Children and the Independent Review Group on Child Deaths.

The complaints

The mother and her family engaged with the HSE Child and Adolescent Mental Health Services (CAMHS) and the Social Work Department of the HSE in September 2005 to deal with the problems she and her husband were having in parenting her son. The parents received services from both of these departments from September 2005 until December 2006 at which time the young person took his own life. The mother feels that the response of the staff of both departments was inadequate and contributed to the untimely death of her son.

In her statements of complaints to the Ombudsman for Children's Office the young person's mother stated that:

- (a) there was a lack of assessment of the young person's mental health by the CAMHS; a failure by CAMHS to take seriously concerns expressed by the family in September 2006; the acceptance of cancellation of appointments with CAMHS by the young person without parental approval; contact of young person by CAMHS by mobile phone without parental involvement; and failure by CAMHS to contact young person and parents following disclosure of abuse;
- (b) the young person had not been permitted to remain in secure care long enough to address his problems and that the step-down arrangements had been changed at the last minute thereby undermining his effort in getting a normal life. His care arrangements were informal and he was informed that he was returning to secure care despite being suicidal; and
- (c) the management of the young person's disclosure of sexual abuse was inappropriate.

At the time of making her complaint to the OCO the mother also complained about the actions of An Garda Síochána. It was explained that the part of the complaint pertaining to the Gardai's involvement could not be dealt with by this office; however the Garda Ombudsman could deal with this aspect of the complaint. It was agreed with the complainant that the documentation would be sent to the Garda Síochána Ombudsman Commission. This was done in August 2007.

The investigation

The Ombudsman for Children's Office provides an independent, impartial complaints handling service. The office aims to carry out investigations and make recommendations which are fair and constructive for both parties. In the context of an investigation, the Office is neither an adversary to the public body nor advocate to the child.

In August 2007, an investigation was initiated by the OCO, as per Section 8 of the Act. The principal concerns arising from the preliminary examination were:

- whether there was any forward planning regarding supports/diagnosis during this time;
- if, in the light of his vulnerability, were adequate supports/services provided for the young person; and
- the management of the disclosure by the young person of an allegation of sexual abuse.

A preliminary meeting was held with the parents of the child to clarify the concerns. Files were then obtained from all the HSE services involved with the young person. These were reviewed and following this review, interviews were arranged with personnel who had been involved with the family. In addition interviews were conducted with personnel who were not directly involved but who took key decisions about the provision of services to the young person. A summary report regarding the Social Work Service offered to the young person and his family compiled by the HSE Child Care and Social Work Department in June 2009 on the case and a Significant Incident Systems Review into the death of the young person produced by Health Care Quality Systems in August 2009 were also reviewed.

Conclusions and Findings

Following the conclusion of this investigation, pursuant to section 13(3) of the Ombudsman for Children Act, 2002, this Office found that the administrative actions of the Health Service Executive come within the ambit of Section 8 of the Act. Specifically:

- a) Section 8(a) have adversely affected the young person at the centre of this complaint.
- b) Section 8(b)(iv) and section 8(vi) have been based on erroneous or incomplete information (see numbers 5,6,9) and based on an undesirable administrative practice (see numbers 1-4,7,8,10,11,12,13,14).

The reasons for this are as follows:

1. Appointments with the CAMHS team were offered to the young person following his discharge from secure care through his community care social worker and without parental involvement. There is a record of these in the minutes of a strategy meeting held in October 2006 but no clarity if they were given formally to the young person and his mother. There is an indication in the CAMHS information supplied to the OCO that the social worker was to pass these dates to the staff in a residential home.
2. The young person did not attend any of these appointments but his parents were not informed on each occasion.
3. Contact with the young person by mobile phone appears to have taken place without parental approval or liaison on all occasions.
4. There was a requirement of the social work team to identify an onward placement prior to admission to secure care. This implies that a placement would be always available at the end of the placement in secure care for 3-6 months. It is also predicated on the assumption that the treatment and care the young person receives while in the secure placement will have

- little or no impact on his needs and there will be no requirement to explore other options.
5. The absence of a placement plan for his stay in secure care meant that his onward placement was not reviewed systematically.
 6. Insufficient attention was paid to the clearly expressed views of the young person about his onward placement and the views of his mother about his readiness to leave secure care.
 7. The young person was admitted to the care of the HSE on a voluntary basis on three occasions. His mother signed the forms prepared by the HSE but never received copies of these and little information about the process.
 8. The young person remained in the care of a family over whom there were some concerns without having this placement assessed.
 9. The explicit comment by the young person that he would hang himself if forced to return to secure care was not addressed comprehensively.
 10. There was a delay in informing his mother of the disclosure of sexual abuse.
 11. The young person was interviewed on his own about his allegations of sexual abuse without parental consent or involvement.
 12. Contact was made with the alleged abuser without ensuring that the young person was safe.
 13. The HSE failed to implement the national guidelines on child protection *Children First*.
 14. There was a lack of clarity about the purposes of different meetings, i.e. case conferences, strategy meetings and children in care meetings and the sharing of important information with other disciplines and agencies.
 15. The HSE allocated a very complex case to a community care social worker who had only been in the social work department for three weeks.
 16. There was an absence of intensive supervision and support for newly recruited social workers.

Child Death Review Mechanism

The Ombudsman for Children has previously recommended that a standing child death review mechanism be established in Ireland in order to ensure that such deaths are examined in a systematic way, in line with international best practice. The Ombudsman for Children produced an options paper in February 2009 setting out the different approaches adopted to the examination of child death in other jurisdictions, which was submitted to the Minister for Children and Youth Affairs and to the Oireachtas Committee on Health and Children for their consideration.

In July 2009, the Government undertook to put in place a mechanism for examining the deaths of children in care and in detention in the context of implementing the recommendations contained in the report of the Commission to Inquire into Child Abuse. It is hoped that consideration will be given to the Ombudsman for Children options paper in framing this new mechanism and that it will observe international best practice in the examination of child death.

It should also be borne in mind that Ireland's obligations under international human rights law are relevant to this question. Article 6 of the UN Convention on the Rights of the Child (UNCRC) requires States Parties to recognise the inherent right to life of every child and ensure to the maximum extent possible the survival and development of the child. In its General Guidelines for periodic reports, the UN Committee on the Rights of the Child – the panel of experts charged with monitoring states' compliance with the Convention - has indicated that States Parties should include information on the registration of the deaths of children, the causes of death and, where appropriate, the investigation of and reporting on such deaths. The Committee views such a system of reporting and investigation as having a preventive purpose and regards it as an element of children's right to life under Article 6 of the UN Convention on the Rights of the Child. Indeed, when Ireland's most recent periodic report was examined by the

UN Committee in September 2006, the State's delegation was specifically asked to provide information on Ireland's policy for investigating the deaths of children, and on provisions to monitor the State's direct or indirect responsibility for such deaths.

Articles 3 and 20 of the UNCRC are also relevant to the issues which arise in this case. Article 3 requires States to ensure that:

- In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration;
- States Parties should ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures; and
- States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 20 goes on to deal directly with the situation of children in alternative care and states that a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. The UN Guidelines on the Alternative Care of Children (endorsed by the General Assembly of the United Nations on 20th November 2009) set out in greater detail what states' obligations under Article 20 entail.

Recommendations

This Ombudsman for Children makes the following recommendations. Some of these are specific to the services offered to the young person and some are of a general nature.

It must be acknowledged that the CAMHS and the Child Care and Social Work Department made considerable efforts to engage with the young person who was engaging in very high risk behaviours and on many occasions was beyond the control and influence of his parents and wider family and the professional staff who were attempting to support and care for him. The following recommendations are about their processes for engagement with young people.

The CAMHS to improve procedures by implementing the following recommendations:

1. Parents should be fully informed of appointments made by the CAMHS team with children and young people receiving services.
2. When young people do not attend appointments parents (and where appropriate social workers) should be advised as soon as possible after the failed appointment.
3. Guidelines should be drawn up with regard to service provider's contact with young people via mobile phone.

The Social Work Department to improve practice by implementing the following recommendations in relation to the care of children and young people:

4. The requirement for social workers to identify onward placements prior to admission to secure care should be reviewed by the HSE.
5. All children placed in secure accommodation should have a placement plan in place not later than seven days after placement.
6. The views of young people and their parents about an application for a secure care order, the continuation of a secure care order, or the discharge of a secure care order should be fully documented in relevant files.
7. The HSE should consider giving parents a copy of the forms which they sign when a child is admitted to care together with comprehensive information about the consequences about such a move for the child and their parents.
8. While the HSE states that it is the practice to talk through the process of reception into care with parents, the HSE should also consider giving parents a 'discharge from care form' when a child is returned home together with information on the care provided and future HSE engagement.
9. The HSE should assess the suitability of all living arrangements of children with whom they are working.
10. The HSE should assess on a multidisciplinary basis any threat to self-harm made by a young person to any member of staff.

The Social Work Department to improve practice by implementing the following recommendations in relation to the safeguarding of children and young people:

11. The HSE should fully endorse and implement the guidance contained in *Children First, 2009*.
12. The HSE should fully implement the guidance on interviewing children and should ensure that the involvement of parents is secured at all appropriate times when it is assessed as being in the child's best interests. If it is assessed that it is not in the child's best interest to have the parent involved, the reasons for this needs to be clearly documented on the social work file.
13. The HSE should make arrangements to safeguard children and young people making disclosures of abuse from the alleged abuser.
14. The HSE should implement fully the guidance contained in *Children First 2009* on Corporate Risk Strategy and staff supervision and support.
15. The HSE should review the different types of meetings held in connection with the management of cases of children and young people who have been referred for child protection concerns and who are in the care of the HSE either on a voluntary or compulsory basis.
16. The HSE should develop a set of criteria to govern the allocation of cases to different grades of social workers.
17. The HSE should ensure that staff involved in traumatic events such as the death of a child have appropriate support and counselling arrangements in place for as long as necessary for each individual involved.

POSTSCRIPT

In accordance with Section 13 of the Ombudsman for Children Act, 2002, the Ombudsman for Children's Office gave the HSE the right to reply to the findings and proposed recommendations of the investigation. The Ombudsman for Children's Office considered the comments made in the HSE's response. The finalised statement and its findings and recommendations were accepted by the HSE. Some of these recommendations require action at local level, and others must be dealt with at national level, in particular those which pertain to the Children First National Guidelines, which were the subject of a separate national investigation undertaken by this Office.

Comments by the Ombudsman for Children

The complaint in this case was received by the Ombudsman for Children's Office (OCO) in June of 2007 from the mother of a child who died whilst in State care. The Investigation carried out by my office was completed in July 2010. Given the nature of this complaint it is considered necessary for the public record to explain why this investigation has taken such a long time to complete.

A significant delay was encountered by the Health Services Executive in providing a response to the original statement of complaint, and also in providing the papers necessary for this Office to pursue the preliminary examination. Such papers were only furnished in March 2008. Following notification that the Office was proceeding with a full investigation in August 2008 further difficulties ensued. The HSE informed OCO that it had sought legal advice and that in the interim the HSE staff would not be in a position to furnish any further documentation or attend meetings.

This further resulted in the decision of the HSE to commence High Court proceedings to challenge the power of the Ombudsman for Children to investigate the matter at all. The HSE considered that as matters under investigation had already been the subject of *in camera* proceedings in the High Court, that there were issues of personal, sensitive, confidential or privileged data, documentation or information at issue. It is important to note that the Ombudsman for Children's Office treats all matters under investigation, including the identities of service recipients, complainants, and individuals from whom information is acquired, as confidential, except as far as disclosures may be necessary to enable the OCO to perform the duties of the Office and to support any recommendations resulting from an investigation. Upon receipt of information that by law is confidential or privileged, the OCO maintains the confidentiality of such information and does not further disclose or disseminate the information except as provided by Sections 13 and 16 of the 2002 Act . Investigative records of the office of the OCO are otherwise confidential and are exempt from public disclosure by virtue of Section 16 of the Act.

The High Court proceedings were ultimately determined in November 2009. Only then did the investigation process proceed. These High Court proceedings were costly in terms of both time and resources.

Delay in securing information often deprives it of value, and any delay that OCO faces frustrates the fulfillment of its statutory obligations and the completion of its investigations as quickly and as efficiently as possible. While this Office appreciates that any public body is entitled to some consultation about complex matters, it is nevertheless considered to be unacceptable that an investigation should be delayed to this extent. Not only did this serve to frustrate the work of this Office, it also served to cause further upset for the complainant.

This Office urged the Health Service Executive to continue to highlight within their organisation the procedures for dealing with the Office of the Ombudsman for Children with regard to the investigation of complaints under the Act.