LOOKED AFTER?

A FORMAL INVESTIGATION INTO THE LIFE OF A CHILD IN THE CARE OF THE STATE

MAIN REPORT

January 2023

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

VICKY
RONALDO
7
Hollyoaks
RAP
I ♥
COUNTRY

Hello, I am Vicky

I am Vicky* and I am 21 years old. I have been in care since I was 10 months old. I went to live with my Mum, and brother and sisters when I was a baby.

When I was little, I used to like playing outside and swimming and now I like to ride my bike when I can.

Now I like to watch TV and like all the soaps and Hollyoaks and Emmerdale are my favourites. I also like to listen to music and like rap music and country so one minute I like to listen to Eminem and Tupac and then Derek Ryan and Lee Matthews.

I support Manchester United and my favourite player is Cristiano Ronaldo.

I have had a lot of social workers and some of them scared me by telling me that I will be taken away from my Mum. But I also had some very nice social workers who played with me, took me to the swings and cared about me. I think that if my Mum was able to speak out for me, like when I was bullied at school, things may have been different. I think my Mum should have got the right support to get me through what I was feeling.

Nothing is being done for me and I have had enough. I am not getting the support I need, though I came to England to get help and I have not got that. I was told it would be only 4 years so why am I still here.

The system hasn't helped me since I was 6 years old. Since my Mum asked to get me help and I'm still not getting the help!

I am going higher up if nothing comes out of my CPAs** and it won't be the manager I will be going to it will be my MPs who will listen to me. Because I am going to get the right support from now on.

I know that you are going to read about my life in this report but all I want is to come home to Northern Ireland and live as close to my Mum as I can because my family is very important to me.

December 2022

* Vicky is not my real name – it is the name I chose to be used in this report.

** (Care programme Approach – review of her care)

Please note: The images used throughout are for visual purposes only and are not of Vicky.

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COMMISSIONER'S FOREWORD

When the 'Commissioner for Children and Young People (NI) Order 2003' was passed, it was widely agreed that the strongest powers were those relating to formal investigation as outlined in Articles 16-22 and Schedule 3 and I would like to welcome you to NICCY's first formal investigation. This report tells the story of 'Vicky' who for most of the last six and a half years has been deprived of her liberty. She has, since July 2018, been in England and her dearest hope is that she can come back home and live close to her family who she loves very dearly. She is not a case and she is not number; she is a young woman whose life could have been very different.

As you read this report you will meet Vicky and hear her story. The NICCY team have worked incredibly hard to make sure that we are telling that story accurately. Like me, you may at times, be left speechless as to how from the start of her life, the needs of this child became one dimensional – accommodation – and continue to be so to this day. Safety and stability are the first steps in wrapping services around a child – not the end goal. It is my strong view that we have provided the evidence that shows clearly that Vicky has been failed at every turn by her legal parent – the Health and Social Care Trust.

When we were alerted to the fact that a child with mental health issues who was in the care of the State, had been in the Juvenile Justice Centre (JJC), on remand for the best part of a year, we had a duty to investigate and to deploy all the powers of the office to try and understand what had happened to her and hold all relevant authorities to account where failings had occurred. We were determined to get it right but were not prepared for the depth or the consistency of failings for a little girl who is now a young woman of 21 years of age.

Whilst the investigation found that most concerns – and therefore adverse findings – belong to the Trust, three other relevant authorities could have done much better. They could have challenged more and focused on the outcomes for Vicky in their own interactions with her. Co-operation and partnership working are key when a child has increasingly complex needs and we did find a lack of co-ordination across systems but we also found a lack of challenge and have been alarmed that no professional seems to have said "this is not good enough" loudly or persistently enough.

I am a proud social worker and am proud of my profession and this report's findings are not that she was primarily failed by social workers. Indeed, Vicky has very fond memories of some

of the workers she has met and believes that they really cared about her. This investigation outlines the failure of the children's social work system in Northern Ireland which, in this case, valued processes over substance. A system which endeavoured to tick boxes in the most perfunctory way without seeking to understand the impact of its actions and inactions on the child. I believe it demonstrates that by trying to focus on compliance with regulations and rules we have reduced the social work profession to a series of administrative tasks, removing professional initiative and judgment.

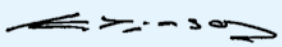
The first standard of conduct for social care workers is 'to protect the rights and promote the interests and wellbeing of service users and carers'[1](NI Social Care Council). I am deeply ashamed of what the children's social care system became during the care of Vicky – paying scant attention to the protection of her rights or best interests. I am also reminded that a system is developed and run by people – politicians, civil servants, social work leaders, managers and others – it is a product of us and we must each reflect on that.

We have made 45 recommendations most of which are about improving the system. The recommendations are based on the adverse findings found throughout the investigation. The Department of Health has commissioned an Independent Review of Children's Social Care Services which has been running simultaneously and we anticipate that there will be some synergy between the two. It is important to point out that Vicky is still in a medium secure hospital without a plan to return to Northern Ireland which must change and we have made three recommendations to reflect this.

This has been a long process and the NICCY team will of course take the learning of this first investigation forward. We have been pleased at the level of co-operation from all the relevant authorities and the respect that they have given my Office and this process. I am also reassured by the level of acceptance regarding the adverse findings but ultimately the test will be on their commitment and effort to meaningfully implement the recommendations.

I am incredibly proud of the NICCY team who have left no stone unturned and worked tirelessly and diligently to get this right which I know we have. I am also grateful to our panel of professionals who have advised us throughout this process.

Finally, to Vicky – you and your family have been very patient with us and have given us your time. I am very sorry that you have been let down so badly by the services who had a responsibility to look after you and meet your needs properly. By letting us share your story you are helping make sure that other children do not go through the same things you did and NICCY will stay by your side for as long as you need them.



Koulla Yiasouma
Northern Ireland Commissioner for Children and Young People

1 https://staging.niscc.info/app/uploads/2020/09/standards-of-conduct-and-practice-for-social-workers-2019.pdf

INTRODUCTION

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This report is the result of the first formal investigation carried out by the Northern Ireland Commissioner for Children and Young People (NICCY) in accordance with the Commissioner for Children and Young People (NI) Order 2003 (2003 Order) establishing the Office.[2] Under the 2003 Order the Commissioner is tasked with 'safeguarding and promoting the rights and best interests of children and young people in Northern Ireland'[3] and has a range of statutory duties as well as powers which can be exercised in meeting these duties. NICCY's remit includes children and young people up to 18 years of age, or 21, if the young person has a disability or has experience of being in the care of the State. In carrying out her functions, the paramount consideration of the Commissioner is the rights of the child or young person, having particular regard to their wishes and feelings. NICCY is also to have due regard to all relevant provisions of the United Nations Convention on the Rights of the Child (UNCRC).[4]

This investigation was conducted as set out in the terms of reference in adherence to relevant provisions of the 2003 Order[5]. The purpose in initiating this investigation was to ascertain all relevant circumstances which led to the young person at the centre of it being held on remand for a protracted period (longer than 290 days); to identify any breaches of her rights; ascertain why there remained ambiguity surrounding her learning disability including a lack of referral to appropriate services and professionals; and to make recommendations where necessary – in compliance with the Commissioner's principal aim and statutory duties. It became evident in conducting the initial collation of evidence that the span of Vicky's[6] life and the actions and decisions of relevant authorities throughout her lifetime were pertinent to the investigation.

The methodology followed is as set out in the relevant section of this report.

The substantive chapters in this report show how systemic failings and breaches of Vicky's rights, at the various stages of her life, eventually resulted in her being placed out of Northern Ireland. From the outset of her life, planning for Vicky's care was not based on her best interests. Instead, there was a lack of appropriate response by the relevant authorities and a failure to develop 'tailored' support structures and services to effectively meet her needs as corporate parents. The approach appeared framed by how Vicky could 'fit into' existing processes and structures rather than focusing more on meeting her specific needs. This was to continue throughout her life, the result being that Vicky has not enjoyed the same opportunities for development (personal, emotional, or educational) as would be expected. Vicky should have had her rights upheld and respected. However, as set out, the evidence shows where these rights have been breached.

As she grew older there was a repeated failure to both fully understand and meet her needs on the part of the relevant authorities. Subsequent decisions led to increasingly difficult situations for her until it appears she became so traumatised that the agencies responsible for keeping her safe and healthy were unable to do so. Vicky was a young person whose voice was her frustrated reactions to circumstances outside her control or ability.

The most recent outcome of these decisions for Vicky has been separation from the only family she has ever known, as well as her community.

2 https://www.legislation.gov.uk/nisi/2003/439/contents/made

3 Ibid Art 6(1).

4 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child Accessed 11th January 2023

5 Ibid Art's 6(3)(b), 7(2), 7(3), 8(3), 12(1)(a)(b), 3(4), 12(1), 16(1)(c), 16(4)(b), 16(9), 18, 19, 20(1), 20(2).

6 The Young Person at the centre of this investigation chose the name 'Vicky' for the purposes of this report.

This is a profound upheaval for any young person and particularly so in her case. It is unclear as yet whether the relevant authorities within Northern Ireland have, after several years, developed bespoke care and living arrangements for Vicky.

The report sets out NICCY's adverse findings at the various stages of Vicky's life, followed by recommendations that have been categorised under the following:

- Failings of the Corporate Parent throughout her life;
- Lack of strategic care planning;
- Lack of early / timely identification of needs and appropriate action;
- Lack of collaboration and information sharing among / between relevant authorities;
- Inadequate SEND support and services;
- Absence of the voice of the Child;
- Not addressing the views of the foster carers;
- Lack of ability to meet all Vicky's needs in secure settings;
- Lack of effective follow up to inspections;
- Deprivation of liberty;
- Extra contractual referral.

There are a total of 45 recommendations contained in this report – it may be that a number of them are incorporated within the Independent Review of Children's Social Care being conducted by Professor Ray Jones – due for publication in 2023. Nonetheless it is NICCY's responsibility to monitor progress on their implementation. The intent behind NICCY's recommendations is that they will inform necessary change in practice. When engaging with the relevant authorities, it has been stressed that this work has focused primarily on highlighting the systemic failings (adverse findings) the young person at the centre of the investigation – 'Vicky' – has experienced, while also highlighting where practice and approaches need to change (NICCY's recommendations).

The recommendations in this report should be read in the context of the Children's Services Co-operation Act (Northern Ireland) Act 2015[7] which places a mandatory obligation on all government departments and children's authorities to work together to deliver on the eight wellbeing outcomes as stated, and in the Northern Ireland Executive's Children and Young People Strategy 2020-2030[8] which recognises the particular vulnerabilities of children who have experience of being in the care of the State.

Section 6 of the Human Rights Act 1998 (HRA) makes it unlawful for a public authority in the United Kingdom to act in a way incompatible with what are known as the 'Convention Rights' i.e. of the European Convention on Human Rights (ECHR).[9] As such the ECHR is directly applicable within Northern Ireland, and breaches of it as referred to in this report are cited as transgressions of rights lawfully enforceable by virtue of the HRA.

Vicky's placement out of this jurisdiction – to England for over four years now – continues to be a cause for concern for NICCY and indeed distress for Vicky, as she has repeatedly stated she wishes to return home to NI. Going forward, it is expected that she will be brought back with the appropriate services and support in place.

Following publication of this report, NICCY's role will be to monitor the implementation of the recommendations – the majority of which aim to prevent the failings experienced by Vicky, to be visited upon others.

7 https://www.legislation.gov.uk/nia/2015/10/contents

8 https://www.northernireland.gov.uk/news/executives-children-and-young-peoples-strategy-published

9 Article 2 to 12 and Article 14 of ECHR; Article 1 to 3 of the First Protocol (ECHR); and Article 13 of the Thirteenth Protocol (ECHR).

METHODOLOGY AND PROCESS

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Article 16 of the 2003 Order empowers the Commissioner to conduct "formal investigations" and further sets out the legal framework.

In accordance under Article 18(3) of the 2003 Order and in order to protect the young person at the centre of the investigation, the name of the young person, details of places, and the names of individuals have been changed or removed.

References to evidence that could identify the individuals involved have been excluded.

For Vicky her foster Mum is her Mum, and in keeping with her wishes we have referred to her as such throughout this report. Similarly, we have referred to Vicky's foster family as her family.

The legislative framework as set out in the 2003 Order determined the processes of the investigation. These processes are set out below.

Commencing and Conducting the Investigation

NICCY received a complaint in January 2018 (in accordance with Article 12(1) of the 2003 Order) that Vicky had, while a Looked After Child (LAC), on the date of the complaint, been held on remand in the JJC for at least 290 days. The complaint noted that this young person has Foetal Alcohol Syndrome (FAS) and an IQ of 56, and that she exhibited self-harming behaviour requiring protective measures while in the JJC.

It appears that while Vicky was in the JJC there remained significant ambiguity as to her learning disability, including a lack of referral to appropriate services and professionals, despite her being held there on remand for a considerable length of time.

Having been made aware of the child's situation, the Commissioner was concerned that the child remained on remand for such a protracted period of time and was equally concerned at the ambiguity surrounding her learning disability.

These concerns gave the Commissioner cause to seek to formally investigate, in accordance with Article 16(1)(c) of the 2003 Order, whether the child's rights had been adversely impacted by the action and/or inaction of any relevant authority and potentially associated systemic failings in relation to the care and other services provided to her as a LAC and the effect it has had on her.

It was determined for the purposes of the investigation that all relevant documentation would be sought, including from all relevant authorities. The best interests of the child were considered by the Commissioner in determining the most appropriate methods by which to conduct the investigation. It was determined that a document review of all necessary documentary evidence, that recorded engagement with the relevant authorities throughout the young person's life, was the most appropriate method by which to conduct the formal investigation. It was determined that, if necessary, evidence sessions would take place with relevant persons and all information would be analysed and a report on the findings of the investigation would be produced with recommendations (Article 18 of the 2003 Order). In accordance with Article 16(5) of the 2003 Order the investigation was conducted in private.

The Investigation Team in NICCY comprised of the Chief Executive and Solicitors from our Legal & Investigations Department with extensive experience in, and knowledge of, the law pertaining to the rights of children and young people including domestic law, policy and practice, and international law relating to children and young people. All are accredited investigative practitioners. The Commissioner also contributed to the investigation as/when appropriate, including drawing on her experience and knowledge as a Social Worker of many years.

Ms Monye Anyadike-Danes, King's Counsel, was appointed as Counsel to the formal investigation to provide legal advice and guidance in respect of legal interpretation, legal process and evidential standards. Ms Anyadike-Danes KC was appointed as she has over 30 years of experience as a lawyer and has an extensive background in public law and inquiry matters.

Collating, Reviewing and Storing the Evidence

In accordance with Article 20(1) of the 2003 Order, the Commissioner requested the supply of all relevant information and the production of documents relevant to the investigation from the relevant authorities and statutory bodies. This was requested at the commencement of the investigation and at various times thereafter in the course of the investigation, when it became apparent that further relevant documentation was necessary.

In response to these requests made in accordance with the Commissioner's statutory powers the relevant authorities and statutory bodies provided relevant evidence. Hardcopy evidence received included social worker notes, records of educational reviews, inter-agency correspondence, medical notes and records, medical opinions, police and related agency reports and file records of residential and custodial care settings.

Documentation was often received in a multitude of files that had been collated chronologically, or thematically, or as a mixture of both. The lack of consistency, the sheer quantity of files, and the potential for overlap meant that the contents of files had to be cross-referred to those of others. This significant time and resource-intensive process was nevertheless necessary to ensure that a complete, accurate, and detailed account of the young person's experience was investigated.

Data protection and retention protocols were devised and applied to provide the requisite security for the evidence received and stored thereafter, and to meet the applicable statutory safeguards.

Impact of COVID-19

Following the declaration of the COVID-19 pandemic in March 2020 and the subsequent government regulations in relation to 'Working from Home', work on the investigation was significantly delayed. In accordance with data protection protocols, files were retained on NICCY premises and stored in a secure key locked investigation cabinet as per the Formal Investigation Data Handling Protocol. Staff working from home were required to access the documents on the premises, which necessitated scheduling specific times. Review and research were thus staggered across a longer period of time than anticipated and this significantly extended the timeframe for completion.

The Appointment and Role of the External Advisers

In undertaking this investigation, to ensure the robustness of recommendations based on evidential documentation, the Commissioner conducted a tendering process for the engagement of a panel of independent professionals appointed on the basis of their experience and expertise.

The Independent Panel comprised of:

- David Gillen: Independent Social Work Consultant.

  David Gillen is a Social Work Consultant with over 40 years of experience. He has extensive knowledge and skills having been employed in a wide range of capacities in this field i.e. as a Social Worker, Residential Social Worker, Deputy Team Leader, Senior Practitioner, Team Leader, and Social Work Service Manager and has practised within statutory Children's Services Social Work since 1979.

- Dr David Foreman: Consultant Child and Adolescent Psychiatrist.

  Dr David Foreman is a Child and Adolescent Psychiatrist with over 40 years of experience. He has substantial skills and knowledge in Evidence-Based Clinical Practice, Clinical Management, and Service Development. He has presented and published extensively in this field.

- Dr Eveline Knight-Jones: Consultant Paediatrician.

  Dr Eveline Knight-Jones is a Consultant Paediatrician in Child Development and Childhood Disability with over 40 years of experience. She specialises in Cerebral Palsy, Autistic Spectrum, Learning Disability, Dyspraxia, ADHD, and children with other developmental conditions, including those who have had Neonatal Intensive Care. She is a Fellow of the Royal College of Paediatrics and Child Health and the British Paediatric Neurology Association. She has published and presented work on Cerebral Palsy and Learning Disabilities.

These external advisors are independent of the relevant authorities in this investigation and each independent professional engaged possesses relevant experience and knowledge of the areas applicable to the investigation. This included expertise in their clinical field, relevant experience in relation to LAC and a detailed knowledge of the case handling and case management roles within the children's care system in Northern Ireland.

The independent advisers were engaged to provide the Commissioner with non-binding advice and guidance throughout the investigation process and to provide their professional opinion and clarification on:

- Relevant topics of research and comment from their areas of expertise;
- Reasonable expectations as to the conduct of the Corporate Parent and other relevant authorities, statutory bodies and public agencies;
- Standards of care given to and the impact upon the young person at the heart of the investigation and report;
- Potential themes emerging throughout the timeline of the young person's life from their relevant areas of expertise;
- Significant events within the life of the young person and potential consequences;
- Guidance on adverse findings.

Reaching Adverse Findings and Making Recommendations

Following evidence gathering, scrutiny and review of evidence and advice from the panel of independent external advisers, it appeared to the Commissioner that there were grounds to make adverse findings and recommendations in relation to the relevant authorities. A schedule of draft adverse findings that identified the evidence supporting the adverse findings was drawn up.

In accordance with Article 16(9) of the 2003 Order, the relevant authorities were notified of the potential for adverse findings being made against them and were each provided with a schedule of the particular draft adverse findings.

Evidence sessions were scheduled with each relevant authority and conducted in private in accordance with Article 16(5) of the 2003 Order. These evidence sessions afforded each relevant authority the opportunity to review the documentation relied upon, to give evidence and to review and challenge the relevant evidence upon which the Commissioner has relied.

Due to the confidential and sensitive nature of the evidence, a protocol for accessing and viewing the evidence at each evidence session was implemented by NICCY, which included setting up a data room within NICCY offices, obtaining details and identification of all relevant authority personnel attending to access

and view the documentation and all personnel attending were required to sign a confidentiality agreement. NICCY legal staff monitored the evidence room at all times.

The relevant authorities were given the opportunity to make representations to challenge or otherwise respond to the draft adverse findings and to provide such further evidence in support of their respective positions they deemed appropriate.

All representations and additional evidence provided by the relevant authorities were subject to further review and consideration and factored into the determination of the final adverse findings. The relevant authorities were notified of the final position.

Publication of the Report of the Formal Investigation

Article 18 of the 2003 Order provides that the Commissioner shall prepare a report on the outcome of the investigation and send it to the relevant authorities. The report may include recommendations as to the actions to be taken by the relevant authority. Article 18(6) of the 2003 Order provides that where a report contains a recommendation as to action to be taken by a relevant authority, it shall be the duty of the authority to consider the recommendation and determine what action (if any) to take in response to the recommendation.

The report was drafted following meticulous consideration of all the evidence. Legal research was carried out to ensure that evidence was appraised in the context of standards and requirements applicable at the time of specific events in Vicky's life.

To ensure that the relevant authorities have every opportunity to comply with their duty under Article 18 (6), the Commissioner has provided them with the opportunity to view the final draft of the report including all the references to the evidence. Due to the confidential and sensitive nature of the evidence, a further protocol for viewing the final draft report was implemented by NICCY ensuring the appropriate handing and protection of the data. In accordance with the protocols developed by NICCY for evidence handling, the published report will not include these references.

ENGAGEMENT WITH VICKY

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Once alerted to Vicky's situation and the decision was made, in principle, to conduct a formal investigation, two members of NICCY's investigation team visited her in the JJC in April 2018. During the visit she was supported by her key worker. The purpose of the investigation was explained to her as making sure that everyone who was supposed to help her was doing so. It was also made clear that NICCY was not responsible for making decisions about her care.

The NICCY staff briefly outlined the process – we would read all the documents and then come back and talk to her and that she did not need to do anything in the meantime.

She was asked if that was OK. Vicky said it was. Her key worker also confirmed with her that she was OK with what had been explained to her.

JJC staff felt that the meeting had gone well but it was unclear how much Vicky had absorbed as she was so unwell. However, there was no suggestion that she did not have capacity to understand and engage.

There was no further direct contact with her until November 2019 when the Commissioner wrote to her to explain the investigation and inform her that she would be visiting the following week to chat and get her thoughts on her situation. It was made clear that the visit would not go ahead if Vicky did not want it. The visit did proceed and went well. She appeared sad in her demeanour and responded to questions, but she did not initiate any topics of conversation. The Commissioner explained the investigation and that it was the first of its kind. Vicky understood questions and was able to talk about her life in the broadest terms and that her dearest wish was to return home to NI. When asked about what she wanted from the investigation she stated that she had three questions:

- "Why was I taken into care?"
- "What were my parents like when they were young?" and
- "When can I go home?"

It was explained that we may not get answers to all her questions.

There was little contact with her for most of 2020 due to the pandemic. The Commissioner met with her remotely (video or telephone calls) on at least five occasions between November 2020 and September 2021, some of which were initiated by Vicky. There wasn't significant discussion on the investigation, just brief updates.

In October 2021, the Commissioner visited Vicky to discuss the investigation. There was a discussion about how the report would look and they agreed on the front cover etc. The Commissioner did not discuss the detail of the investigation but did explain that it was believed that the Trust could have done better. She also asked about court proceedings and it was explained that she should speak to her solicitor about this. The name Vicky was agreed on for use in the report.

Contact was sporadic during 2022 until October when the Commissioner had a phone call with her. Whilst clearly a lot was happening for Vicky and in the ward where she was staying, she did engage in conversation. The Commissioner gave a few more details on the findings of the investigation and also explained about the 'Independent Review of Children's Social Care' and how it was hoped that this would be a vehicle for system improvement. Vicky was sceptical.

The Commissioner visited Vicky at the beginning of December 2022. Prior to seeing Vicky, it was confirmed to the Commissioner by staff that she had capacity to understand and engage. Vicky was animated and was able to both initiate and engage in the conversation. She had prepared questions concerning the investigation report and its dissemination:

- "Who is going to be able to access the article*?" (eg people in England or Ireland?)
- "When I move back to Ireland what support will I get?" (eg "if people find out it's me or ask me questions etc...")
- "Will there be a picture of me in the article? Will people know it's me?"
- "Can I get a copy of the article?"

Each were responded to in turn. On the final question it was explained that the Commissioner would return in early/mid January with a copy of the report to go through it. Vicky talked about her childhood and her relationship with social services and education as well as her fears of being taken away from her Mum. The Commissioner explained that these were some of the issues that would be discussed in the report. As with all engagements Vicky's primary concern was that a plan to get her home to NI is agreed.

** Vicky is referring to the formal investigation report*

THE ROLE OF THE CORPORATE PARENT

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The role of the Corporate Parent, i.e. those with parental responsibility for children who are in the care of the State, has been a central 'theme' throughout the life of Vicky and is, as stated elsewhere in this report, fundamental to the entire approach in how the State 'cares for' our children when the need to do so arises. The Children (Northern Ireland) Order 1995 (1995 Order)[10] sets out the roles and responsibilities of Social Care Bodies in such circumstances.

A child in the care of a Health and Social Care Trust is deemed to be 'looked after' by that Trust. In such circumstances the Trust is the Corporate Parent, whose legal duties and responsibilities are contained in the 1995 Order. Corporate Parents should provide children who are looked after with the kind of support that any good parent would give to their children. According to the 1995 Order:

'"parental responsibility" means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child.'[11]

It has been evident in conducting this investigation, that acting *'in loco parentis'*, i.e. in the place of a parent, has not always been the approach taken by the relevant authority/ authorities. Neither has adherence to the five guiding principles[12] on which the 1995 Order rests, been consistently evident.

It is also the duty of the Corporate Parent to monitor the foster child's progress and placement which includes ensuring the foster carer is being fully supported and guided. The high standard of management and practice in planning, monitoring and resourcing noted as necessary for children who are 'looked after' was not maintained. Rather, as is detailed in subsequent sections, the Corporate Parent failed to uphold minimum standards in foster care[13] in a consistent or structured manner.

NI Ministers of the Departments of Health and Education issued the strategy for children who are 'looked after' in 2020/1: *'A Life Deserved: "Caring" for Children and Young People in Northern Ireland'.*[14] The strategy defines the role of the Corporate Parent as follows:

'When a child or young person becomes 'looked after' by a HSC Trust, the HSC Trust becomes the 'Corporate Parent' of that child or young person ... As Corporate Parent, a HSC Trust is responsible for safeguarding the child and promoting his or her wellbeing and welfare. ***This means that the Trust as a corporate entity must have the same goals for the child or young person as a parent and act for the child or young person as a parent would be reasonably expected to act*** *(our emphasis). The HSC Trust assumes moral as well as legal responsibility for enabling 'looked after' children and young people in its care to experience happy and fulfilling lives'.*[15]

10 https://www.legislation.gov.uk/nisi/1995/755/contents/made

11 https://www.legislation.gov.uk/nisi/1995/755/article/6/made

12 The '5 Ps' i.e. the child's welfare as the paramount consideration, parental responsibility, partnerships among families and the government, prevention, and protection.

13 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192705/NMS_Fostering_Services.pdf

14 https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-lac-strategy.pdf

15 https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-lac-strategy.pdf

In this investigation the failure to effectively act as the Corporate Parent – individually and collectively on the part of relevant authorities – is a recurrent issue at various stages of Vicky's life.

It is also pertinent to note that in their foreword both departmental Ministers state they are committed to working together to deliver on the commitments made to care-experienced children and young people:

'We are determined to create the conditions to provide a system of care and education that nurtures them, acts in their best interests at all times and secures the best possible outcomes for them to increase their chances of a happy and successful adult life. We particularly welcome the commitment by other government departments and statutory partners to be part of the corporate family who will support us in our endeavours.'[16]

It is important to note that Vicky is, at time of writing, still out of Northern Ireland in a facility in England.

16 https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-lac-strategy.pdf

CHAPTER 1
POST BIRTH PERIOD (AGED 0 – 2)

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

Planning

1.1 Vicky was born in hospital in July 2001, approximately nine weeks premature. It was a traumatic birth with a breech delivery. Vicky suffered birth asphyxia and a brain haemorrhage was noted in an ultrasound performed in the first four days of her life.

1.2 Vicky's birth mother had experienced difficulties with pregnancy in the past, suffered trauma within her immediate family network, and had ongoing problems with both physical and mental health. An Education Welfare Officer (EWO) had referred Vicky's birth mother to social services in April 2000 due to a range of concerns, including the well-being of her other children and the condition of the family home. Concerns were subsequently raised regarding the emotional and educational needs of other children in the family and their welfare. In early 2001 Vicky's older maternal half-siblings were placed on the Child Protection Register (CPR) under the category of potential neglect. This was a family which before the birth of Vicky had a history of significant involvement by social services due to fears for the well-being of children within the household.

1.3 A medical assessment of Vicky's birth mother while she was pregnant with Vicky concluded that she had chronic anxiety and she was advised to stop taking diazepam while pregnant. She showed inconsistency in taking prescribed medication and in abstaining from the misuse of other substances. Vicky's birth father had a history of his own difficulties, including mental health. The presentation of both parents suggested that the family environment may not be stable for the care of a new-born.

1.4 Practice in Northern Ireland at that time was for a pre-birth risk assessment conference to be convened by statutory agencies when there were indications that parental health, lifestyle, decision making, or other circumstances posed a feasible risk to the well-being of the expected child. The purpose of such a conference is preventative and to provide a forum where information, both historical and current, can be gathered and analysed. In addition, suitable professionals are made aware of circumstances and asked for a professional opinion. Advice and other strategies arising from these meetings are intended to prevent or at least minimise harm.

1.5 The Children (Northern Ireland) Order 1995 (1995 Order) at Article 66 creates an obligation on the part of Health and Social Care Trusts to investigate when a child within its area is likely to suffer harm. The Children (Northern Ireland) Order 1995 Guidance and Regulations (Guidance) in place at the time[17] noted the importance in this regard of 'whether a child is suffering or likely to suffer' significant harm. The same Guidance explicitly noted the possibility of risks to unborn children and directed:

'where there are concerns about risk to an unborn child, social services should be informed and normal child protection procedures will apply.'[18]

17 Children (Northern Ireland) Order 1995 Guidance and Regulations (Guidance), Vol. 6, para 2.2.

18 Guidance, Vol 6, para 6.26.

1.6 Evidence reviewed did not show that social services substantively engaged with Vicky's birth mother regarding her pregnancy or confirm that she was following medical advice at that time. Given the number of significant concerns regarding the circumstances of Vicky's birth mother, consideration could have been given by social services to undertaking a pre-birth risk assessment.

1.7 A pre-birth risk assessment that identified risks could have led to a pre-birth conference. This could have provided an opportunity for relevant agencies to assess the potential impact upon Vicky of circumstances within the home, to seek to address any issues early, consider the need for ongoing monitoring, and to create a contingency plan in the event of potential or actual risk to her care and well-being (including possible agency intervention by recourse to the courts). This multi-agency conference would also consider the social history and what steps Vicky's birth mother could take to reduce risk to Vicky, develop a multi-discipline care plan, outline what services Vicky might need, and determine whether Vicky's name should be added to the CPR at birth. It would have provided an opportunity to record matters and create a reference point for later referral in the event of continuing concerns for child safety and wellbeing. It could have given an opportunity for a comprehensive assessment to determine any further action, including deciding if further meetings were needed upon birth. The possibility of residential assessments of Vicky's birth mother could have been considered, together with the possibility of a voluntary care placement. Such a meeting could have created an opportunity to pre-empt any impact upon Vicky at birth, signalled a need for preparing to include the new-born on the CPR and/or applying for an Emergency Protection Order. None of this happened.

1.8 Given the presentation of Vicky's birth mother and circumstances within the extended birth family before and during the antenatal period, there was a reasonably foreseeable risk of harm to Vicky after birth. It is therefore striking that no such multi-disciplinary meeting occurred. Consideration could have been given to the merits of undertaking a pre-birth risk assessment to assist professionals in highlighting the level of risk after Vicky was born. When parents present with chronic substance misuse, risk assessment procedures should be deployed before the child is born. Failure to hold such a meeting lies with senior management within the Health and Social Care Trust. If they were not aware of the case, responsibility would fall to the Principal Social Worker.

1.9 Records show that soon after Vicky was born, decisions for her immediate care required reference to antenatal information. In July 2001 a social worker attending to Vicky sought confirmation from social services in her birth mother's locality, to ascertain if they knew her. She did so because the midwife was concerned about the level of prescribed medication Vicky's birth mother was taking. This information was important for Vicky's clinical presentation. Had a pre-birth meeting occurred and been followed by continuing engagement, it could have rendered some of this information readily available. Lack of clarity for postnatal and antenatal circumstances was commented upon with notable frequency in later years.

Adverse Finding 1.1: Failure to convene a pre-birth risk assessment conference

- A pre-birth conference would have provided an opportunity to assess the potential impact upon Vicky of circumstances within the family home; to seek to address any issues early; consider the need for ongoing monitoring; and to contingency plan in the event of potential or actual risk to her care and wellbeing once born.
- Given that Vicky's siblings were on the CPR, a pre-birth risk assessment should have taken place to ensure there was no likelihood she suffered harm. Not doing so meant that there had been no statutory assessment, no recommendations and a lack of forward planning to determine how to best meet Vicky's needs.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 66, The Children (NI) Order 1995;
- Paragraph 2.2, Volume 6, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 3.4, Volume 6, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 6.26, Volume 6, The Children (NI) Order 1995, Guidance and Regulations.

Child in Need

1.10 The 1995 Order sets out 'children in need' by referring to children who are:

> *'unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision ... of services by an authority.'*[19]

This is 'deliberately wide, to reinforce the emphasis on preventative support and service'.[20] The 1995 Order confirms that 'every authority shall take reasonable steps to identify the extent to which there are children in need within the authority's area'.[21] Authorities also have a general duty to 'safeguard and promote the welfare of children within its area who are in need'.[22] In assessing the needs of a child, Health and Social Care Trusts must consider circumstances within families and requirements intrinsic to the child.[23] An assessment of need could lead to a package of services.[24] Forward assessment of Vicky for this was hindered by the lack of a pre-birth conference.

1.11 Vicky should have been treated as a 'child in need' as soon as she was born. Had Vicky been so treated, that in turn would have activated Article 18 of the 1995 Order whereby there is a 'general duty of authority to provide social care for children in need, their families, and others'.

19 Children (Northern Ireland) Order 1995 (1995 Order), Article 17.

20 Guidance, Vol. 2, para 2.4.

21 1995 Order, Schedule 2, para 1.

22 1995 Order, Article 18; Guidance, Vol. 2, para 2.4.

23 Guidance, Vol. 2, para 2.5.

24 Guidance, Vol. 2, para 2.6.

1.12 A reactive rather than proactive forward planning approach continued in the postnatal period, despite the care needs Vicky quickly displayed. This reactive manner manifested in the delay on the part of Foyle Health and Social Care Trust (Foyle Trust) to treat her as a 'child in need' as defined within the 1995 Order, in acquiring Parental Responsibility (PR) for her and in how they exercised PR once it was acquired. At this time Vicky was within the remit of the Foyle Trust.

1.13 The day after she was born Vicky was moved to another hospital for specialist medical treatment because she was experiencing seizures, jerking, and was screaming. Vicky's needs were thereafter assessed as so complex that two social workers were assigned. One social worker was unsure whether a pre-birth conference had been held, suggesting a lack of access to full and thorough information.

1.14 In July 2001 clinicians were discussing the possibility of Vicky having 'floppy baby' syndrome. Clinical opinion was that following discharge from hospital Vicky would be a 'high risk' baby, needing regular medical reviews and may be irritable. There was speculation as to whether her birth mother could cope. Vicky's presentation meant that within less than four weeks of birth a CT scan was proposed.

1.15 In the fortnight following Vicky's birth the presentation of her birth parents during visits to hospital was described by staff as shaky, with Vicky's birth mother noted as having glazed eyes. Vicky's name was added to the CPR after a Child Protection Case Conference, held in late July 2001. As part of this CPR process, professionals expressed concerns regarding Vicky's birth mother including her lifestyle choices, relationships involving domestic violence, misuse of alcohol and/or drugs, not acknowledging (or understanding) concerns expressed by social services, a lack of ability to effect change in her life and seek appropriate help to do so and dependency on prescribed medication and illicit substances.

1.16 In August 2001 clinicians queried whether Vicky was experiencing withdrawal from prescribed medication and/or alcohol and there was clinical consideration of whether she had suffered a brain injury. Toxicology tests had already confirmed the presence of benzodiazepines and barbiturates. In August and September 2001, Vicky's birth mother was not attending appointments with drug services.

1.17 Vicky continued to have difficulty with feeding and required regular attention from hospital ward staff in this regard. Tube feeding was a significant feature of Vicky's care while she was in hospital and a point of ongoing clinical discussion and monitoring at this time. Feeding remained an ongoing problem after Vicky was discharged from hospital.

1.18 Visits from the birth family were inconsistent and the presentation of Vicky's birth mother was, in October 2001, noted by a clinician as being very anxious, tremulous, and otherwise disengaged. She did not appear to understand the significance of Vicky's feeding needs. The same clinician later commented that they had suggested that someone in the birth family learn feeding techniques because feeding was the only reason Vicky was being kept in hospital. The clinician stated that nobody from the birth family came forward to do so. The lack of consistent engagement from the birth family, and Vicky not being a 'Looked After Child' created ambiguity

as to when, how, and by whom PR was being exercised. This in turn raises questions as to how she was being cared for other than clinically, specifically what stimulation and emotional warmth she was being given. Those needs seem to have been forgotten.

1.19 Articles 17 and 18 of the 1995 Order impose statutory obligations on social services to safeguard and promote the welfare of children who are in need, in a way consistent with children being raised by their families. There is no indication that Vicky was, in the first instance, considered to be a 'child in need' or that these statutory issues were actively considered. Who had responsibility for Vicky's care, to what extent, and how delivery of such was being ensured was unclear. The extent to which statutory agencies sought to clarify this uncertainty is also unclear. For Vicky, as well as other children in similar positions, the responsibility of Health and Social Care Trusts and how they in turn perceive their role in such matters needs to be confirmed.

1.20 At a case conference in November 2001 a social worker told Vicky's birth mother that if there was an attempt to remove Vicky from hospital a Care Order would be sought. Despite recognising the potential need of recourse to such significant measures, the social workers appeared focused on stopping Vicky's birth mother from exercising her decision-making authority with no attempt to fill the gap in decision-making this created. This was a reactive, containment focused approach lacking in long-term planning. Social workers did seek to emphasise to Vicky's birth mother that the more they understood her life, the more able they would be to make decisions, which showed the gap in contemporaneous decision-making. Social workers also highlighted a lack of information on the use of drugs.

1.21 Almost four months after Vicky had been born, social workers were still trying to develop a knowledge base that could have been started at a pre-birth conference. While they were aware that Vicky could not be cared for by her birth mother, they did not seem to understand the reasons why or the extent of her needs. There is no indication that they were making any progress in identifying what services she might need, despite this information already being within their reach (further details below). If they knew that Vicky was a 'child in need,' they did not seem to understand why or how that might be catered for. Failures to fully and properly consider Vicky as a 'child in need' raise questions regarding the efficacy of communication between relevant professionals. If communication was happening, then senior figures need to explain their responses and reasoning.

Looked After Child

1.22 The above noted commentary of the November case conference becomes significant when considering the background. Vicky was, in the opinion of clinicians, medically ready for discharge from hospital and they were hopeful that she would do so in August 2001. Correspondence between professionals in December 2001 noted clinical opinion that Vicky could have left the hospital in August but there was insufficient certainty that her feeding needs could be met.

1.23 Barnardo's had been asked by social services to complete a parenting capacity assessment and commented that by the end of September 2001 medical staff were keeping Vicky in hospital for nutrition. The report considered that the birth mother had been advised on numerous occasions that a hospital was

not a healthy environment for Vicky due to the risk of developing an infection, and that she was not receiving the individual care and attention a baby of that age needed to thrive.

1.24 In contrast to 'best interests' principles, instead of being a place for medical treatment the hospital was 'home' for Vicky. The hospital remained Vicky's 'home' for a further seven months. Three-to-four months after Vicky had been born, there was still a lack of progress in meeting her basic need of feeding. The failure to take proactive measures in response to the inability of birth family to meet basic care needs (nutrition) resulted in an overstay in hospital. There was also a failing in social services who only grasped the reality of this situation several months after medical staff did.

1.25 There was no sign that the Trust were substantively considering how or when Vicky might be placed in the care of her birth family, with kinship carers, or away from the birth family. These possibilities should have been considered when it was realised that Vicky could not go home with her birth mother and should have been in consideration at a LAC Review meeting no later than three months after birth. A LAC Review meeting is a regular (statutorily required) meeting that brings together people and professionals involved with the care of a LAC to discuss care arrangements.

1.26 As of 14th December 2001, Altnagelvin Hospital Trust was accommodating Vicky in accordance with Article 21(1) of the 1995 Order. This Article obliges statutory authorities to provide accommodation to 'children in need'. Vicky had clearly already been a 'child in need' when she was in hospital for no medical reason and could not be released to the care of her birth family. This did not seem to have been understood earlier by all relevant social work staff.

1.27 The reasoning presented for this continuing stay in hospital merits attention. In a 'Statement of Facts' dated 5th December 2002, it was noted that as at 14th December 2001, Vicky could have been discharged earlier had a suitable placement been available, namely with a carer who was prepared and able to cope with Vicky's particular needs, including tube-feeding. These clinical opinions were now some months old and there was a delay in action.

1.28 Furthermore, correspondence between social workers on 16th January 2002 noted that a consultant paediatrician had stated at a 'Professionals' Meeting' the day before that Vicky was languishing in a hospital ward full of infections and her immediate need was to be discharged from hospital and placed with a suitable carer. Vicky's birth mother's insufficient action in facilitating her discharge home, was considered an indication of insufficient care and attention to the baby's needs and so the birth mother was not considered a suitable carer. These fears of a risk of infection in hospital were also several months old. The same paediatrician is noted in this correspondence as having commented that Vicky had been ready for discharge since September 2001, but that this information had not been shared at the subsequent Initial Child Protection case conference in November 2001.

1.29 In the first instance this calls into question the efficacy of information sharing between professionals, and what pro-active attempts were taken by social workers to source relevant information. It also raises the question of what social workers thought was the reason for Vicky remaining in hospital, if they did

not know that it was mainly to ensure her nutritional needs were met. Seemingly Vicky was in hospital for a prolonged period without social workers knowing why. Social workers should have been explicitly seeking clarity on the reason for her prolonged stay. In the absence of relevant knowledge, social workers were making decisions without knowing what Vicky's needs were, or what the end goal of those decisions could be.

1.30 Vicky was in hospital for longer than clinically necessary and suitable care plans were not being explored, because the Foyle Trust did not understand from August 2001 until January 2002 what her care needs were. This becomes further difficult to reconcile against correspondence sent by the above noted consultant paediatrician to a social worker dated 16th December 2001 (seemingly received on 18th December 2001) in which the clinician advises the social worker that Vicky's birth mother had been told in October 2001 that the only reason Vicky was being kept in hospital was for feeding.

1.31 This perpetuated the ambiguity of how and when PR would be exercised, and by whom. Vicky's birth mother was the only person to legally have this role, but her own presentation was a cause of concern. In the absence of even an Interim Care Order the Foyle Trust could not exercise PR either. As such, there was no realistic attempt to implement Guidance applicable at the time which noted that 'the purpose of planning is to safeguard and promote the child's welfare'.[25] According to the Guidance: implementation of such would entail assessing need; determining the objective to be met; appraising options; designating who will complete resulting tasks; and setting a timescale. There is no indication that this approach was meaningfully used as a framework for case management. This gains significance when considering that by the end of December 2001, clinical opinion was that Vicky's appearance was suggestive of foetal alcohol syndrome (FAS).

1.32 In January 2002 a 'referral for foster care profile' was shared between professionals. Discussions between social workers indicate that an approach had been made to the Fostering Unit before Christmas 2001, but that the above noted profile had not been shared with all relevant professionals. This had seemingly been done without having already or concurrently considered a kinship placement.

1.33 A suitable foster placement appeared to have been identified in March 2002, but the prospective carers withdrew. In the absence of a contingency plan Vicky remained in hospital. At a case conference the same month there was recognition by social workers of the urgency of finding a placement, as it had already been deemed that Vicky did not need to be in hospital. There was also a report of clinical comment that Vicky needed to be part of a family and that there had been no change in her earlier medical prognosis. In April 2002, genetic testing was conducted and found that Vicky showed signs compatible with exposure to foetal teratogens in pregnancy.

1.34 In April 2002, the Foyle Trust was granted an Interim Care Order. In accordance with Article 50 of the 1995 Order, Care Orders can only be made if the court is satisfied that a child is suffering, or is likely to suffer, significant

25 Guidance, Vol. 3, para 2.18.

harm. That can include by way of impairment of health or development. Yet there had been no significant change in Vicky's circumstances in April 2002. Vicky should have been taken into care as soon as it was realised that her birth mother could not meet her needs. Not only were the Foyle Trust late in realising when that had been quantified, they were also late in reacting to it.

1.35 Nine months after Vicky had been born, the Foyle Trust were now acting as her Corporate Parent. Delay in seeking this authority occurred despite circumstances within the birth family preventing a release from hospital more than six months earlier. While paying due regard to the 'no order' principle (whereby the court should not make an order unless doing so is better for the subject child than to not do so), there was nonetheless substantial delay in securing a Care Order and identifying a home for Vicky. The absence of adequate preparation and development of a plan post-birth had resulted in an unjustifiable delay by the Foyle Trust in becoming Vicky's Corporate Parent. These circumstances carried with them a breach of Vicky's Article 6 UNCRC rights in respect of maximum development of a child. They also infringed on her Article 5 ECHR right to liberty and security, as well as her Article 8 ECHR right to family life, including in the form of placement in a suitable home.

1.36 The antenatal and post-birth periods were a crucial time to take precautionary measures. This was a critical stage of development and protection, yet Vicky's life began with multiple, substantive, and prolonged breaches of rights and standard practices. The Foyle Trust do not appear to have recognised the risks, occurrence, or potential impact of these. If they did, it was not reflected in remedial action or further decision making. These circumstances should have led to an earlier application for a Care Order and the delay in acquiring that status delayed the care planning they attempted.

Adverse Finding 1.2: Delay in explicitly confirming Vicky as a 'child in need', including through delay in becoming her Corporate Parent.

- Vicky's family circumstances, together with what was required to adequately care for her, meant she satisfied the statutory criteria for a 'child in need' as soon as she was born. There was delay in the Foyle Trust treating Vicky as a 'child in need'.
- Vicky was allowed to be in hospital for longer than clinically necessary and suitable care plans were not being explored. There was a general lack of planning in this regard as well as for discharge. At the same time, social workers do not seem to have been querying whether the length of time Vicky was in hospital was necessary or harmful.
- There was delay in the Foyle Trust acquiring Parental Responsibility (PR).
- In the absence of even an Interim Care Order, the Foyle Trust could not otherwise exercise PR.
- The absence of adequate preparation and development of a plan for post-birth resulted in an unjustifiable delay by the Foyle Trust in becoming Vicky's Corporate Parent.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 17, The Children (NI) Order 1995;
- Article 18, The Children (NI) Order 1995;
- Article 21, The Children (NI) Order 1995;
- Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children

(NI) Order 1995, Guidance and Regulations;

- Article 6, United Nations Convention on the Rights of the Child;[26]
- Article 5, European Convention on Human Rights;
- Article 8, European Convention on Human Rights.

Long-term Stability

1.37 The acquisition of PR did not immediately result in the Foyle Trust finding a suitable home for Vicky. During court proceedings in April 2002, maternal relatives approached social workers at court to advise they could care for Vicky but did not engage with agencies thereafter. There is no indication that social services had otherwise sought confirmation of suitable carers from within family networks. One week after the Interim Care Order was granted, Vicky's matter was transferred to the High Court (which is usually done due to complexity).

1.38 This raises a question of why it had not been submitted to judicial process at an earlier stage. If statutory agencies were not aware that the matter was so complex that it would require that level of court attention, they could not have been fully aware of the depth and range of issues therein. If they did have such awareness, an explanation is needed as to why an application to court had not been made sooner.

1.39 In April 2002 the Foyle Trust received advice which emphasised the significance of a situation and that if Vicky caught an infection as a result of remaining in hospital, the Trust would in part be responsible in light of its statutory obligations. It also reiterated Vicky's entitlement to be in a family home and that the Trust had to demonstrate that it had used all reasonable efforts to find a suitable placement.

1.40 Further advice had been received by the time a LAC Review meeting was held on 1st May 2002, where it was noted that while Vicky's case had been categorised as a child protection matter, she should have been treated as a LAC once the Consultant stated she could be discharged. It was apparent from this comment that basic elements of file classification and management were not understood by social services staff directly working with Vicky. At the same meeting there was comment that Vicky would be in care for the foreseeable future.

1.41 A memorandum of discussions between social workers dated 8th May 2002 recorded that while a number of foster placements had been explored, none of these came to fruition and this was recorded as a matter of deep concern. It is apparent from these comments that despite (now) being aware of the importance of finding a home for Vicky, the mechanisms the Foyle Trust had in place to find one were not working.

1.42 In May 2002 a foster placement was confirmed, some ten months after Vicky had been born. There was little evidence that alternative options including within another Health and Social Care Trust, fostering through a private agency, or through specific recruitment were effectively explored. There was no concurrent planning. In consequence Vicky's rights under Article 27 of the

26 The UNCRC has been ratified by 196 countries including the United Kingdom (UK), however it is not yet incorporated into UK law. For this reason, it is used by NICCY as an interpretational guide. Where possible, breaches of the ECHR will be referred to, which is incorporated into UK law by virtue of Section 6 of The Human Rights Act 1998.

1995 Order to accommodation and maintenance were not upheld.

1.43 Effective concurrent planning from the outset could have entailed a process of confirming whether a kinship placement was achievable while also seeking to match Vicky with approved foster carers already listed on relevant registers. No reason has ever been presented to explain why the process of finding a kinship or foster carer took so long. The lack of direction in how this was done was echoed in later processes regarding adoption. The significance of this should be viewed in the context of the views expressed within advice received by WHSCT in April 2002.

1.44 Vicky went to live with her Mum on 20th May 2002. The prolonged stay Vicky had in hospital meant she had no specific, significant person to attach to in the early months of life. At a LAC Review meeting of 28th June 2002 there was comment of a dramatic improvement in the emotional and physical presentation of Vicky since entering her foster home. There is no indication of how the style of care she had been receiving before might not have encouraged her to flourish. That this was not discussed further is indicative of a lack of any basic plan to consider if remedial therapeutic action was needed upon release from hospital.

1.45 In June 2002 the Foyle Trust confirmed they were engaged in concurrent care planning which included the possibilities of rehabilitation to family care or adoption. In August 2002, more than a year after Vicky had been born, the Foyle Trust received a parenting capacity report in respect of Vicky's birth mother (further details below). A diagnosis of Foetal Insult Syndrome (FIS) was confirmed in the same month. Also in that month a clinical report confirmed that since leaving hospital improvement in Vicky's social skills had been quite marked, but that she would be extremely lucky to progress normally developmentally.

1.46 On 3rd October 2002 the Trust Adoption Panel confirmed that adoption would be the most suitable option for Vicky. This was agreed at a LAC Review in the same month. Having already made the decision to adopt, the Foyle Trust in early November 2002 wrote to other Health and Social Care Trusts in Northern Ireland and other organisations asking if they could identify prospective adopters. Despite no prospective adoptive parent(s) being found the Foyle Trust made an application to court for a Freeing Order in December 2002 to give permission for Vicky to be adopted. In the same month they repeated their requests of November 2002 to other agencies to help find an adoptive home – none having yet been found. No other strategy to find an adoptive home had been devised, despite those already tried not working. There appears to be no structure or even basic plan as to how the core issue of finding an adoptive home would be completed and how that would progress in relation to the application to court.

1.47 A recognition of the need to provide protection for Vicky is evident. However, the process by which this was sought appears to lack planning and foresight. As court proceedings progressed it became apparent that the Guardian ad litem (GAL), whilst agreeing that Vicky's needs would be best met through adoption, believed that the absence of a prospective family rendered the application to court premature.

1.48 In their report to the court for January 2003 the GAL noted that their own recent professional experience of 'special needs' cases made them very cautious about proceeding with a freeing application before a prospective placement was identified. The GAL was worried by the possible delay incurred in this process of trawls and advertising for adoption.

1.49 The GAL otherwise saw contradiction in how the Foyle Trust were factoring in the paternal birth family. The GAL noted that the Foyle Trust had advised (verbally) that they were not ruling out assessment of a paternal aunt as a carer if paternity was confirmed. However, in their statement to the court the Foyle Trust asserted no such assessment had been done because there was no contact from paternal family. As an independent voice for Vicky in these proceedings, the GAL was having difficulty understanding what rationale the Foyle Trust were applying, highlighting that the plan was not clear or understandable.

1.50 Vicky's birth father had not been joined to proceedings until January 2003, when DNA confirmed paternity. This was 18 months after Vicky had been born. Until this time Vicky's birth father was legally unable to participate in judicial processes of significant impact to her life and this delay is unexplained. Whilst the impact of having her birth father involved at an earlier stage cannot be known, this highlights a common thread throughout management of Vicky's case – delay. Waiting until so late into proceedings to consider the paternal family was an unnecessary extension of the time taken to look for a home for Vicky. Delay in confirming paternity, not joining Vicky's birth father to court proceedings until January 2003 and not considering potential paternal family carers was a breach of Vicky's Article 8 ECHR right to a family life.

1.51 The GAL did form a clear opinion that the written care plan appeared very singular in its purpose and statements and did not consider the viability of birth family placement. The trust was focused on predetermined options, without wider consideration of other possibilities. They also noted that it lacked contingency arrangements if adoption did not happen (even though the adoption panel identified that as a possibility). The GAL also commented that while the current foster placement was not seen as permanent there was no immediately available alternative. At the same time the GAL thought the foster placement should not have been easily discounted by the Foyle Trust, as Vicky's Mum had advised she could provide permanency.

1.52 Delay was accompanied by a lack of information sharing. At least one agency approached for help in finding an adoption placement advised in January 2003 that they were not able to do so, and that the same agency had not known that Vicky had FAS. Not making this information known created an inevitable risk that processes of trying to find adoptive parents would not target and identify most suitable candidates, would add to the time needed, and heightened the risk that the process would fail.

1.53 In agreement with the GAL, the court was not satisfied that statutory tests for the likelihood of an adoption placement being found were met or that there was sufficient contingency planning. As a result the Foyle Trust explored the possibility of a placement with a paternal aunt, which was found not to be feasible. The duty to promote upbringing within the

family was implemented after adoption proceedings began, highlighting a reactive approach.[27] This delayed a process that potentially could have drawn upon information in concurrent planning at a much earlier stage. It cannot be known what the outcome would have been. Vicky may have had a chance of a stable kinship placement.

1.54 The opinions, findings and conclusions of professionals in support of the freeing order application appear to have been based on information that was consistent with patterns of behaviour established within the broader family before Vicky had been born. The Foyle Trust had been aware of those patterns of behaviour at the time her birth mother was pregnant with Vicky. Resulting concerns were (eventually), in the view of the Foyle Trust, sufficient to justify retaining a clinical expert to draft a parenting capacity assessment.

1.55 In February 2003, Vicky's Mum confirmed a willingness to give permanent care but not to adopt. Instead of trying to further develop adoption planning, in March 2003 the Foyle Trust advised the court that it was no longer pursuing this option. How and why this decision was arrived at is unknown. The strategy and long-term goal of the Corporate Parent in making this decision is not confirmed. Nor is it known what learnings they sought to apply from the earlier haphazard process. It is impossible to know if adopters could have been found with more effort. What is known is that that no further work was done to do so, removing any chance of finding such a home. By April 2003 care planning was drafted in favour of long-term fostering. This was a missed opportunity to ensure maximum stimulation and stability through a confirmed life-long family.

1.56 There is no clear rationale as to why (or how) a 'best interests' decision to adopt was made in the absence of approved parents, or for the failure to engage in advance with Vicky's court appointed independent voice – the GAL.

1.57 The speedy decision in favour of long-term fostering, and the choice of placement, suggests that this was out of expediency rather than the application of the 'welfare checklist' criteria of Article 3 of the 1995 Order. This haphazard approach was inconsistent and not in the best interest of Vicky. A more robust approach should have been taken to locate suitable adopters via other Health and Social Care Trusts or by specific recruitment. It is therefore apparent that Vicky's right to a family life under the UNCRC and ECHR on Human Rights had been breached.

1.58 Viable care options, with scope to be achieved within a reasonable timescale, should have been presented to the court. Indeed, in the face of GAL and court criticism of the Foyle Trust's planning, it might have been purposeful to adjourn matters to facilitate more robust measures to locate a permanent placement for Vicky. The Foyle Trust do not appear to have sought to do so.

1.59 It is regrettable that having rushed ahead with an unrealistic scheme for adoption, the Foyle Trust then ceased to look for a permanent home for Vicky, consigning her instead to continuous uncertainty. This

27 Guidance, Vol. 1, para 9.2.

was despite the Foyle Trust being made explicitly aware, in November 2002, of the heightened importance of the home environment for Vicky, as further medical opinion advised that if Vicky was to reach her full developmental potential it was essential that she receive maximum stimulation and stability in her environment.

1.60 There was an overarching lack of cohesive planning by the Foyle Trust in the exercise of PR and in seeking to protect and promote Vicky's best interests. Instead of methodically developing a feasible, sustainable resolution to ensure best outcomes in the long term, they relied upon immediately available options, which they explored by formulaic means. Knowing that Vicky had substantial needs, the Corporate Parent put her in a placement without being certain that those needs could be met. The responsibility for the outcome of such thereafter always rests with the Corporate Parent.

1.61 The parenting capacity report (completed in August 2002) confirmed that Vicky could not be placed in the care of her birth family. That should have made long-term permanency a crucial aspect of protective planning by the Foyle Trust. While foster care is a beneficial and rewarding experience for many children and young people who otherwise lack a stable home, it nonetheless (by definition) inevitably lacks the permanency of adoption, which should have been available for such a young child. Delay in obtaining the parenting capacity assessment was a contravention of Vicky's Article 23 UNCRC and Article 14 ECHR rights to security, which was dependent upon the outcome of the report.

Securing a foster home

1.62 As noted above, a foster home was finally confirmed in May 2002. Vicky's foster Mum had been approved by the Foyle Trust as a carer in 1989, had fostered in the past, and had other foster children in her care when she was confirmed as foster Mum for Vicky (herein after referred to as Vicky's Mum). In 2000 she had indicated a willingness to care for a child with a disability but does not seem to have been approached in respect of Vicky until shortly before May 2002. The information provided suggests that this foster carer was the only available placement at the time. The complex nature of Vicky's needs, the health difficulties of the foster carer, the fact that two long-term foster children were already in the home and that there was limited space to accommodate a third child suggests that this placement was not a good match.

1.63 Guidance in place at the time affirmed that in approving applicant foster carers the

'unambiguous duty of the responsible authority is to find and approve the most suitable foster parents for children who need family placement'.[28]

This level of regard should apply not simply when somebody first wishes to become a foster parent, but also to when a child is placed with them. The same Guidance also noted there should be consideration of the 'opportunities for development'[29] within the home. This is to extend to 'the capacity to provide

28 Guidance, Vol. 3. para 4.15

29 Guidance, Vol. 3, para 4.29.

educational support... Consideration should also be given to... ability to cope with the challenge of providing any necessary support to a child with special educational needs.' [30] Expediency rather than the paramountcy of Vicky's best interests, as a ten-month-old baby, appear to have been the main motivation.

1.64 In anticipation of Vicky coming into her care, her Mum was trained in the tube feeding necessary for Vicky's day-to-day care. There is no indication that the Corporate Parent at this time factored in applicable guidance which confirmed that fostering 'is a skilled task requiring training and support'[31] and that this was heightened by Vicky's already known circumstances. Nor did that lead to consideration of guidance that following approval of a foster carer 'the social worker and foster parent should agree on the preparation and training needed, both before a child is placed and in the longer term'.[32] Guidance also factored in the possibility of underlying health conditions, which had already been confirmed for Vicky. The Guidance noted that in such an instance there 'should be a clear understanding of the support which the responsible authority has to provide if circumstances of this kind arise'[33], with the possibility of specialised training being given.[34] There is no sign that any of this was considered by the Corporate Parent in this instance.

1.65 As early as June 2002, a LAC Review meeting described this foster placement as short-term. Perhaps that is also why there is no indication that the importance of future and potentially revised training and support needs for the foster carer was being considered in accordance with the Guidance.[35] This was a continuing breach of Vicky's already noted rights to security, development, and family life.

1.66 While Vicky's Mum did confirm her willingness to provide long-term fostering, she declined the option of being an adoptive parent. There is no indication of how (or why) the Corporate Parent contented themselves that Vicky would have received the security she needed. It is reasonable to conclude that they had been motivated to take action that suited in the immediacy, and once they had done so, lost any sense of urgency. Accommodation in the short-term was the priority, and once satisfied was viewed, by default, as the long-term solution. This continuing breach of Vicky's rights to security, development, and family life was in the process of becoming embedded.

1.67 The confirmation of this placement did not include structuring with an added layer of monitoring and support, with a view to appraising suitability and developing its strength. There was no parallel contingency plan in the event of the arrangement not succeeding. There is nothing within the documentation that suggests any of these issues or possibilities were considered by the Foyle Trust, despite how the placement emerged to begin with and the realistic potential for it to not succeed.

30 Guidance, Vol. 3, para 4.30.
31 Guidance, Vol. 3, para 4.1.
32 Guidance, Vol. 3, para 4.52.
33 Guidance, Vol. 3, para 4.54.
34 Guidance, Vol. 3, para 4.55.
35 Guidance, Vol. 3, paras 4.52 – 4.58.

1.68 As time progressed the extent of Vicky's needs were more explicitly commented upon by medical professionals. Medical opinion as of November 2002 is noted above and emphasised Vicky's need for stability and stimulation in her home environment. Such opinion continued to develop and in September 2003, a Consultant Paediatrician with substantive involvement in Vicky's care to date, commented that she may have considerable learning problems in the future.

1.69 In any event, training should have been in accordance with the 'UK National Standards for Foster Care' (National Standards)[36] as published in 1999. This should have been considered particularly important when long-term fostering was confirmed as the core means of long-term care planning. Planning should have been with full consideration of Vicky's needs, in a placement best suited to them, including with regard to disability, development, health, and future education.[37] Foster care is to be in placements that can uphold, safeguard and promote welfare.[38] Foster care agreements are meant to forward plan with consideration of support and training to be given to foster carers.[39] The 'primary duty of a Trust is to safeguard and promote the welfare of a child who is looked after'.[40]

1.70 However, there does not appear to have been any consideration of how Vicky's Mum would be able address these issues (long-term) in the context of the above noted clinical opinions. When the placement began she was taught tube feeding and then deemed suitable. No further training beyond tube feeding seems to have happened. Issues of training discussed in respect of the start of the foster placement (as above) do not appear to have been returned to. This may have been because when it started the placement was considered short-term. When it became long-term, issues that should have been considered for long-term viability were no longer in focus, because the placement was now of considerable duration due to the failure of the adoption process.

1.71 If the Corporate Parent was not worried by this because they saw the placement as short-term, then that means they were content for a potentially sub-standard placement in the immediacy. If the placement was regarded as having the possibility of being long-term then the Corporate Parent were, at this early stage accepting that it would mean Vicky would be in a setting lacking the level of care capacity she explicitly needed.

1.72 Article 27 of the 1995 Order obliges statutory authorities to accommodate children in their care. Despite having Parental Responsibility for Vicky the Corporate Parent was not meeting this basic care need. Vicky's Article 8 ECHR rights to a family life were breached given the placement was proceeding on the basis of placement not being assuredly permanent. Article 14 ECHR, which forbids discrimination on the basis of disability, was also breached. Vicky's care throughout this time was

36 UK National Standards for Foster Care Available (UK Foster Standards), National Foster Carers Association. (ISBN 1 897869 26 6).

37 Guidance, Vol. 3, paras 2.19 and 5.3.

38 The Foster Placement (Children) Regulations (Northern Ireland) 1996 (Foster Regulations, 1996), Reg 5.

39 Foster Regulations, 1996, Schedule 2, para 1.

40 Guidance, Vol. 3, para 2.4.

characterised by a lack of long-term planning or even thinking. Significant actions to be taken with regard to her care followed no discernible plan. Statutory instruction and related guidance with regard to kinship care, foster care, and basic consideration of developmental needs seem to have been forgotten as 'planning' stumbled from one poorly planned and ill-informed option to another.

Adverse Finding 1.3: Lack of planning for Vicky

- As the independent voice for Vicky in Court proceedings, the GAL was having difficulty understanding what rationale the Foyle Trust were applying. This should have been apparent.
- With regard to possible adoption, the GAL considered that the written care plan appeared very singular in its purpose and statements i.e. there was limited consideration of alternative placements.
- After the adoption proceedings were withdrawn, a swift and seemingly final decision was made in favour of long-term fostering, suggesting that this was out of expediency rather than the application of the 'welfare checklist' criteria;
- There was no parallel contingency plan in the event of the placement not succeeding.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Paragraph 2.4, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.1, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.3, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Regulation 5, The Foster Placement (Children) Regulations (Northern Ireland) 1996;
- Regulation 3, Arrangements for Placement of Children (General) Regulations 1991;
- Article 6, United Nations Convention on the Rights of the Child;
- Article 20, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 8, European Convention on Human Rights;
- Article 14, European Convention on Human Rights.

Contact Between Services

1.73 Records indicate inconsistent access by relevant parties to Vicky's social services case file(s). This lack of partnership between relevant agencies may have been a contributing factor in regards to why a pre-birth conference had not been held. In the absence of appropriate interagency information sharing, professionals working within distinct disciplines could not develop awareness of broader issues within Vicky's birth family. In the event of weak interagency regulatory culture, should the need for pre-birth planning assessment originate outside the everyday scope of the social workers involved, the likelihood of arranging one would be reduced.

1.74 This also raises a question of the extent to which social workers were aware of information being gathered in the course of Vicky's ongoing medical treatment. Records clearly note a lack of committed engagement from her birth family, which does not appear to have prompted haste by statutory authorities to seek a Care Order and take firm steps towards long-term planning.

1.75 There was clearly a problem with information sharing between relevant professionals and/or agencies. Whether this was a systemic problem or arose within specific circumstances is not clear. Also uncertain is whether insufficient information sharing emerged from a lack of interagency cooperation or if it created a lack of interagency cooperation. It is possible that more proactive efforts to ensure that all professionals were fully informed were not being taken, because in a dynamic where people were not aware of wider issues they did not disseminate information they had and which might be relevant to others. The limited sharing of information could have resulted in limited responses from agencies, which in turn limited further information sharing. What is clear is that there are signs that information was not being shared and/or the significance of it not being understood and subsequently responded to. In such circumstances it is hard to see how the Corporate Parent would, internally, ensure how they could uphold Article 26 of the 1995 Order, which creates an obligation to safeguard the interests of LAC. It is also hard to see how they could ever seek to rely on Article 46 of the 1995 Order.

1.76 The paucity of interdisciplinary and multiagency partnership appeared very early and would prove to be an ongoing and significant issue for Vicky in that Article 26 of the 1995 Order creates an obligation upon every authority looking after a child to safeguard their interests. Article 3 of the 1995 Order carries the 'welfare checklist' issues which are to be considered. In the absence of effective information recording and sharing neither of these can be effectively upheld. This was not a problem that gradually emerged; it was present from the start of her life and remains so until the present day.

Adverse Finding 1.4: Absence of a partnership approach within the Corporate Parent

- Insufficient collaboration and inconsistent access by relevant parties within the Corporate Parent to Vicky's social services case files;
- Information was not shared, resulting in other agencies not knowing to get involved and co-operate. It also resulted in the significance of the information not being fully understood and subsequently responded to.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 46, The Children (NI) Order 1995;
- Paragraph 2.79, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.80, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Regulation 8, Arrangements for Placement of Children (General) Regulations 1991.

NICCY recommends that the relevant authority/ies:

R1 Review procedures and practice for co-ordination between health and social care staff within and across HSCTs to ensure that vulnerable prospective parents who may present a risk to expectant children are identified and engaged with, to prevent harm and promote the welfare of the child.

R2 Ensure timely identification of 'children in need' and the planning and implementation of an action plan at relevant stages.

R3 Ensure that there are systems in place for data collation and information and that they are available for relevant professionals to access when required.

R4 Develop and implement policy and guidance that ensures consistent monitoring and reporting to senior Trust officials and regulatory authorities in the event of a delayed hospital discharge due to lack of availability of accommodation and care in the community.

R5 Monitor and record adherence to the welfare check list prior to a decision being made with regards to the application of formal orders and initiation of court proceedings.

R6 Ensure the provision of appropriate short-notice options for newborn and young babies.

CHAPTER 2
EARLY CHILDHOOD (AGED 2 – 9)

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

Supervision and Support for Foster Placement

2.1 In the early years of the foster placement there were concerns about Mum's ability to meet Vicky's needs. Vicky's Mum did not adhere to professional advice for Vicky's developmental needs, such as the health visitor's advice about night-time feeding or social work advice on sleeping arrangements. Additionally, she did not report accidents or significant incidents as she was required to and she did not attend all foster carer training.

2.2 Her lack of attendance at training seems to be a consistent theme throughout the lifespan of the placement, as it is noted as far back as 2003 when the Health Visitor mentions a reluctance to accept advice, up to 2016 when a LAC Review notes that Vicky's Mum continued to refuse training.

2.3 Difficulties with the relationship between the Corporate Parent and Vicky's Mum were firmly established in the early years of the placement. Records from April 2005 note conversations between social workers and Vicky's Mum when discussing behavioural management and toilet training. It was apparent that the Mum believed she was being "dictated" to. In conjunction, social workers sought to diffuse disagreements with Vicky's Mum by acknowledging positive aspects of her care. This shows a fractious relationship which social workers were struggling to manage, without a long-term strategy. It should be noted however, that there is evidence that Vicky's Mum did attend some training, as a 2006 Foster Homes and Assessment Panel noted she attended FAS training and found it "beneficial".

2.4 Issues regarding Vicky's sleeping arrangements were also persistent throughout her early years. At a LAC Review in October 2006 it was decided that further discussions were needed regarding Vicky sharing a room with her Mum. In November 2006 social workers were also expressing concern regarding Vicky sleeping in her Mum's bed or bedroom, with the significance of this in accordance with 'UK National Standards for Foster Care' (National Standards) being noted.[1] The National Standards were first published in 1999 by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care. They were part of several initiatives at that time that aimed to improve the quality and delivery of children's services. They are based upon best practice and current research findings and became the framework by which foster care practice was measured.

2.5 Ongoing arrangements in the home were not consistent with the National Standards, which were (and are) directly applicable and are to be followed by all involved in the foster care system. Social service case workers should have been monitoring adherence to these standards, together with the supervising social worker (sometimes referred to as the 'foster carer social worker'). All relevant staff would have knowledge of the National Standards and it should have been highlighted to the foster child's social worker if it became obvious, that they were unfamiliar with them. Instances of serious breaches should be raised immediately and cannot wait until monthly supervision meetings to be reported. None of this occurred in this case.

2.6 When the issue of Vicky sleeping in Mum's bed was raised with her Mum, she did not comply with the social worker's requests to effect changes in these arrangements. Under section 6.3 of the National Standards, which discusses

safe and positive environments, it is directed that 'each child placed has his or her own bed and accommodation arrangements which reflect the child's assessed need for privacy and space.'[41]

2.7 A letter from the family placement social worker to the LAC Social Worker in January 2007 confirmed that the sleeping arrangements at that time did not meet the assessed need for privacy and space, but were assessed as being the best that Vicky's Mum could manage. This was after Vicky's Mum offered to sleep in the living room to give Vicky her own room, an offer that was declined by the Corporate Parent. The family placement social worker had suggested that Vicky could share a room with a fourteen-year-old foster sister, instead of with her Mum. This was rejected by her Mum without challenge from the social worker. It was left to be discussed at the next LAC Review. At the subsequent LAC Review in May 2007, the Corporate Parent commented on the inappropriate sleeping arrangements and stated that it had not been possible to find a solution. There is no note of what attempts had been made to find a solution that followed the National Standards. There is no indication that social workers explicitly identified why this persisted or if they thought it was because Vicky needed this night-time routine for comfort and if social workers sought ways to compensate.

2.8 The above wording suggests that the situation was the outcome of the housing in which the family were living. The number of bedrooms and resulting sleeping arrangements would have been within the knowledge of the Corporate Parent when the placement was approved. If the home did not meet the National Standards, the onus was on the Corporate Parent to ensure accommodation provision was suitable for the family. If the accommodation was not suitable and breached these standards, available options included a change of accommodation to one that was suitable to Vicky's needs or a move to a more suitable placement. Neither occurred in this case. There is no indication of any plan by the Corporate Parent to address the issue.

2.9 The situation improved somewhat by October 2007 when an older foster sibling in the family moved away and Vicky began using their bedroom. However, when the foster sibling returned home, Vicky moved back into her Mum's bedroom. This lack of a room and bed of her own may have affected Vicky's sense of stability and sense of belonging. Article 23 UNCRC states that a child should enjoy a life which promotes self-reliance and this was not being experienced by Vicky whilst she slept in her Mum's bedroom.

2.10 It is also the duty of the Corporate Parent to continually monitor the foster child's progress and how this is supported by the foster carer. If it becomes apparent that a foster carer is not following advice and there is evidence that a child is not thriving then the Corporate Parent should seriously consider how to improve matters. There is no sign of a consistent, structured approach to doing so within this home.

2.11 Taking action when there is evidence a child is not thriving is consistent (and motivated by) the 'best interests principle' underpinning child and young people legislation. There is a duty to supervise and monitor the foster placement which

41 UK Foster Standards.

includes ensuring that the foster carer is being fully supported and guided.[42] Section 16 of the National Standards outline placements are to be reviewed annually and Article 25 UNCRC states that every child has a right to periodic review of their placement. A regular review of Vicky's Mum's approach to caring, sleeping arrangements and a proactive response from agencies would have benefited Vicky. It does not appear from the body of documents disclosed to date that these required annual reviews took place and the LAC Reviews were the only basis for review of the foster placement. If concerns were highlighted at an earlier stage, then other options, both internal and external, to include other Northern Ireland Health and Social Care Trusts and including the options in the previous paragraph, could have been considered before the attachment that was undoubtedly formed in this case was developed.

2.12 It was reported by a paediatrician when Vicky was one year old that, due to a high risk of future neuro-developmental problems, it was essential that she (Vicky) received maximum stimulation and stability in her environment. This paediatric comment was also explicit confirmation of Vicky having high needs and should have been a prompt to ensuring supervision of the placement. While the Corporate Parent might not have understood all matters arising from FAS, it should have considered this a prompt to inform itself as fully as it could of the nature of the condition in general, as well as its specific effects upon Vicky. Such clinical comment should result in the Corporate Parent engaging in detailed supervision, monitoring, and resulting guidance of and for the placement.

Adverse Finding 2.1: Lack of adequate supervision and support of foster placement

- Vicky's foster placement fell short of the minimum standards required of foster care e.g. with regards to training of her Mum and sleeping arrangements within the foster home;
- There is insufficient evidence of attempts to find a solution to these problems even though they were known to the Corporate Parent;
- Instead of Vicky's evident needs resulting in the enforcement of National Standards for Foster Care, the Corporate Parent failed to uphold them;
- The Corporate Parent had a duty to supervise and monitor the foster placement, which included ensuring Vicky's Mum was being fully supported and guided. The Corporate Parent failed to do that, and was therefore not in a position to ensure that the placement functioned in her best interests;
- The mechanisms to supervise and monitor the placement, that were meant to ensure standards were met, were not being heeded.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 3.3, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.27, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;

42 UK Foster Standards, Section 14.

- Paragraph 5.1, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Schedule 2(1), The Foster Placement (Children) Regulations (Northern Ireland) 1996;
- Regulation 5, The Review of Children's Cases Regulations (Northern Ireland) 1996;
- Paragraph 5, Schedule 2, The Review of Children's Cases Regulations (Northern Ireland) 1996;
- Paragraph 7, Schedule 2, The Review of Children's Cases Regulations (Northern Ireland) 1996;
- Section 6.1, UK National Standards for Foster Care 1999;
- Section 6.3, UK National Standards for Foster Care 1999;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 8 European Convention on Human Rights.

Interagency Working

2.13 In August 2005, when Vicky was four years old, she was assessed by an educational psychologist in preparation for her Statement of Special Educational Needs (Statement). The psychologist concluded that Vicky's concentration and attention span was variable and that she had below average ability. A Statement was in place when she began nursery in 2005 and there is a requirement to hold a special educational needs (SEN) review every year. A SEN Review is intended to consider the ongoing suitability of a Statement.

2.14 The Statement of 2005 assessed Vicky to be of below average ability and not on the expected developmental trajectory for a child of her age. This was consistent with clinical opinion. Vicky's birth mother was suspected of having thyrotoxicosis during pregnancy, which has been associated with intellectual disability in offspring. Although this association had been rare, the possibility of such was known at the time Vicky was born. While evidence suggested that people with FAS had increased incidence of behavioural difficulties, the chances of adverse outcomes were reduced when they were raised in supportive, stable environments. There should therefore have been even greater emphasis on partnership between all agencies who were involved in Vicky's life, particularly social services and education. It was in Vicky's best interests that information be acquired from relevant sources, with resulting advocacy and planning in response.

2.15 However, advice and information was either not accorded significance, not properly considered, or otherwise not applied. For example, medical advice at the SEN Review of 2005 explicitly noted that Vicky had complex underlying medical history which included prematurity, fetal insult syndrome and developmental delay. Psychiatric advice for this review assessed Vicky's ability as falling into the low-average range. Parental advice for the same review noted that Vicky lacked concentration and made reference to unsettling behaviour. There was also explicit parental reference to FAS and a request that professionals working with Vicky be aware and read up on the condition. This appears to be an attempt by Vicky's Mum to place clinically diagnosed needs at the forefront of discussion and planning in order to get best possible outcomes for her child. Thus, an array of people with direct and daily involvement with Vicky were all clearly articulating to the Education Authority (in a manner that the Corporate Parent should have been fully aware of) that she had high needs requiring significant input. This however

was not reflected in the level of support within her Statement.

2.16 That was the beginning of a pattern whereby at the SEN Review of 2006 the headmaster of Vicky's school advised that she needed significant one-to-one support at all times. At the SEN Review of 2007 there was explicit comment from her Mum that Vicky needed more time with a classroom assistant. She repeated this at the SEN Review of 2009. There were thus repeated efforts at a school and home level – by parties who could be expected to have a detailed knowledge of Vicky's presentation – to highlight her needs. However, there appeared to be no corresponding effort by the Corporate Parent to promote such a view. Despite all the above clear representations, Vicky's level of classroom assistant support remained at 12.5 hours weekly. Documentation submitted by her school for the SEN Review of 2009 noted that in 2008 she had 15 hours weekly (possibly because of input directly from social services). At the same review her Mum asked that this be 25 hours weekly. That request was repeated in 2010, when provision was still 15 hours weekly. There is no indication that the Corporate Parent gave any consideration to appealing against the contents of the Statement, that they advised Vicky's Mum about how to do so, or that there was any discussion as to who (whether the Corporate Parent or her Mum) would make such an appeal.

2.17 There should have been interagency cooperation in these SEN Reviews; but it would appear that this did not happen. For example, it was striking that Vicky's medical information was not routinely used in SEN Reviews but indeed sought separately. The result was that the SEN Review panel had no direct information from medical professionals caring for Vicky on a regular basis, such as her GP notes or her medical records.

2.18 The Corporate Parent should have ensured that the SEN Review panel had the relevant medical information to allow them a complete picture of the background of her home environment, her medical history and an assessment of her developmental issues. This would have meant that the review panel and the agencies involved would have been better informed, with the most up to date information about Vicky, at the relevant time. The piecemeal sharing of information between agencies was not conducive to shared decision making in her best interests and resulted in some agencies making decisions about her life and care without all the relevant information.

2.19 The SEN framework requires discussion between reporting professionals, like discussions in LAC Reviews. However, LAC Reviews are mandated within the LAC system and the SEN Reviews are for education. Regardless of the different systems, both are required to have regards to every aspect of the child's life, so the LAC Review should consider educational needs and similarly SEN Reviews should factor in the child's home life.

2.20 While there are similar processes for preparing, submitting, and collating reports in these two systems, there was no evidence of a culture of collaborative working, as demonstrated by the response to Vicky's circumstances, across the agencies to enable all recorded information to be used in parallel. Partnership across all agencies was crucial for a child such as Vicky, a 'Looked After Child,' who had been diagnosed with FAS and where there were concerns about the foster

placement. Ultimately it is the duty of the Corporate Parent, with whom Parental Responsibility lies, to ensure all agencies are working in partnership for the benefit of the child.

2.21 While agencies were following their own policies, they showed evidence of a 'tick-box' culture in relation to interagency co-operation. The process of reporting by each agency seems to have been the focus, as opposed to the outcomes for the child, and agencies did not then engage to consider their reports in relation to each other. A consideration of other agencies reports could have highlighted findings or raised other agencies' concerns. These various reports and reviews were seemingly viewed in isolation and there was no detailed consideration of trends.

Adverse Finding 2.2: Lack of strategic sharing and use of information collated so as to inform decisions regarding care.

- Given that medical advice had been clear in noting, at an early stage, that Vicky would have developmental difficulties, there should have been an emphasis on partnership between social services and education;
- Whilst Vicky's Mum and clinicians referred to FAS, the Corporate Parent did not take steps to act upon this;
- The piecemeal sharing and referral to information was not conducive to shared decision making and it resulted in some agencies making decisions without the relevant information;
- There was a failure to work collaboratively across agencies to enable all recorded information to be used in parallel to effectively meet the needs of the child;
- Insufficient gathering, interrogation, and use of information, meant that Vicky's needs were not being properly identified and planned for;
- There was a failure to adequately and effectively factor in and explore Vicky's already known difficulties. They were not explored or assessed to inform planning and decision making of social care and education, whether separately or jointly.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 46, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.34, Volume 3, The Children (NI) Order 1995, Guidance and Regulations.

Nursery and Primary School

2.22 Issues of concern continued throughout Vicky's time at nursery and primary school. Poor attendance at nursery is recorded from March 2006 until the end of the school year. The poor attendance was continuous and unexplained. Her absences increased at age five, from March 2007 to the end of the school year. If a parent is unable to ensure that their child attends school, it is the duty of the Education Authority (EA) to investigate the reason and provide support, particularly when there are underlying issues such as in Vicky's situation. Where a child is a LAC, then the Trust, as the legal parent, has a duty to ensure that the child receives effective education.

2.23 When the attendance of any student falls below 85%, then the school's EWO becomes involved. The school notifies the Foster Carer, and the onus is on the

Foster Carer to inform the relevant Trust about attendance issues. It is unclear from the documentation that NICCY has seen whether the failure in this instance was the school not informing Vicky's Mum or Vicky's Mum not informing the Corporate Parent. In any event the Corporate Parent should have been proactively addressing attendance issues. Given the multidisciplinary nature of LAC Review meetings, issues around school attendance should have come to the attention of the Corporate Parent at least as regularly as such meetings were held.

2.24 In LAC Reviews across 2006 and 2007, there were very positive comments in relation to Vicky and her education. Regarding nursery, she is reported to have settled well and has made good progress. Later in Primary 1 she was doing extremely well in school and was enjoying her time there. There was at this time also further comment that Vicky continued to share a bedroom with her Mum. By Primary 2 she had made an excellent start to the year. This does not chime with an increasing absence from school and suggests that no attempt was made to see a wider range of issues, including those that might have suggested difficulties at home. In failing to have a school representative attending at or a comprehensive report available at LAC Reviews, the issue of attendance was missed in the LAC process.

2.25 By February 2010, Vicky's development was not at the expected level for a child of nearly eight years of age. An Educational Psychologist, when preparing a report for the annual SEN Review, concluded that Vicky's cognitive development, verbal comprehension, perceptual reasoning, memory and processing speed abilities were all below average as were her educational scores and she had problems with concentration and visual impairment. These findings should have prompted more focused attention to Vicky's needs and to consider how they should be responded to. The need to do so had already been confirmed by the above noted medical advice noting that Vicky would have significant needs throughout her life.

2.26 Documentation prepared for the purpose of a SEN Review in 2010 showed that Vicky experienced significant problems at home with no corresponding difficulty at school. Vicky's behaviour seemingly changed depending on her environment. Whilst this is not unusual, there should have been greater effort by the Corporate Parent to understand the cause and where Vicky herself felt there might have been issues.

Adverse Finding 2.3: Failure to effectively consider Vicky's voice and wishes.

- There is little evidence that the necessary effort was made to ensure Vicky's voice and her behaviour were being either heard or considered by the Corporate Parent. Nor was consideration given to how her behaviour was influenced by the environment that she was placed in.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26(2), The Children (NI) Order 1995;
- Article 26(3), The Children (NI) Order 1995;
- Paragraph 2.44, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 12, United Nations Convention on the Rights of the Child.

2.27 Despite the responsibility held by the Corporate Parent it is evident that in SEN Reviews Vicky's Mum was the main advocate for Vicky, especially when she felt statutory authorities were not doing enough. Even though Vicky's declining behaviour, which included temper tantrums, were noted at the 2010 SEN Review, there was little sign of help from the Corporate Parent in relation to behavioural problems. In 2010 correspondence from the Corporate Parent to the EA noted that a psychologist would become involved in due course.

2.28 This raises the question as to the role of the Corporate Parent and the action they should have taken to address Vicky's continuing poor attendance, or her reported developmental delay. The Corporate Parent, as a good parent, should have attended all meetings in connection with their child's development, which naturally includes education. This is particularly so when that child is not on the expected developmental trajectory. This duty requires partnership between all agencies involved in that child's life such as social services and their school. It was in Vicky's best interests for all relevant authorities to acquire information from relevant sources including her Mum, teacher, classroom assistant and Vicky herself at the earliest stage of decline so that relevant measures could be put in place.

Adverse Finding 2.4: Trust's failure to discharge its responsibility as Vicky's Corporate Parent

- The Corporate Parent failed to fully inform itself of issues central to the basic parenting decisions for any child;
- There appeared to have been no urgency to provide necessary intervention and services to Vicky when she and her Mum required them;
- The Corporate Parent did not attend all necessary meetings in relation to Vicky's welfare and development as 'looked after child;'
- The Corporate Parent, as the party with Parental Responsibility, did not allow itself to fully perform its own statutory role.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26(1), The Children (NI) Order 1995;
- Article 46, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations.

NICCY recommends that the relevant authority/ies :

R7 Develop and implement policy and guidance that ensures effective training, support and supervision of foster carers specifically for children with complex needs. Such guidance should be monitored to ensure compliance.

R8 Ensure that the Corporate Parent effectively understands how different systems work and discharges their role as the advocate for the child with all other authorities, particularly education. They must persist when proposals are not in the best interests of the child.

R9 A child must never be threatened with removal from their home unless it is the only option to keep the child or others safe. Proper records must be kept of such decisions.

R10 Ensure that the Corporate Parent makes concerted efforts to understand the causes of a child's behaviour by engaging with them directly and responding appropriately.

R11 Ensure that all relevant assessments (eg LAC Review) take into account a child's education and well-being and where this information is not readily available is requested.

R12 Ensure considered and appropriate responses are given when responding to a child's distressed behaviour and records are kept and monitored accordingly.

CHAPTER 3
SCHOOL YEARS (AGED 10 – 15)

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

A Promising Start

3.1 In the SEN Review of 2010 Vicky's Mum had noted that Vicky had some difficulties with confidence. She thought that Vicky felt frustrated in school and became disinterested in the repetitive tasks she was being given. Vicky's Mum also felt that Vicky needed goals and targets. She wanted a softer approach to be taken, and for teachers to specifically discuss Vicky's circumstances when changing class. She also noted that she wanted teachers to research FAS and understand its impact upon Vicky. Within her comments Vicky's Mum also sought clarification of the role of at least one specific professional who was engaged with Vicky. This is highly significant as later behavioural management plans could be perceived as punitive and strict.

3.2 Social worker comment at the same review was that Vicky's outbursts were becoming increasingly more aggressive and frequent. There were also concerns as to her sleeping and eating pattern and a referral had been made to a community paediatrician. Vicky was described as struggling with this stage of her development. The Statement that was issued in consequence of this review noted that Vicky was unhappy at school and frustrated by the work. Her cognitive profile was described as 'spikey.'

3.3 However, a school report of June 2011 raised no significant difficulties and at the SEN Review of the same year her Mum is recorded as having thought Vicky had had her best year at school. Contributions in 2012 showed that Vicky's Mum thought no progress was being made, and the school thought she was very well-behaved. Vicky had difficulties which, while certainly not solved, appeared to be manageable. It is not known if this was in response to targeted input by educational professionals, or by coping mechanisms developed by Vicky, or a mix of both. What is clear though is that Vicky was doing well in school and that a formal education environment was not seen as negatively effecting her behaviour.

3.4 An educational psychologist gave an updated report in November 2012. At that time Vicky was receiving treatment with LAC Therapeutic Services due to FAS. The educational psychologist described Vicky's presentation during the assessment as engaging, very kind, and co-operative throughout. However, the report also noted that Vicky was showing a variable profile of cognitive skills, therefore a full-scale IQ score would not be valid. However, it was concluded that cognitive functioning was broadly within a below average range. The report further noted that Vicky had difficulty with sustained attention/ concentration, and that she responded well to clear boundaries, consistent routines, and well-defined frameworks for learning. Vicky was noted as enjoying being given specific responsibilities and had additional needs in relation to social understanding and maturity.

3.5 In preparation for her move to post-primary school there was a scheduled annual review of Vicky's Statement in May 2013. This review noted issues such as her vulnerability and innocence in comparison to peers. Her cognitive ability was considered as broadly being within a below average range, and she was considered socially immature. The review also noted that Vicky needed a well-planned and structured transition between schools. Her prospective post-primary school was involved in this process, and they noted the importance of Vicky having adult support in this life event. Her amended Statement referred to Vicky as having sensory impairment.

However it is worrying that her learning difficulties were not presented as an area of concern given the assessment of six months earlier. Not noting this renders it something that was not to be directly considered within planning and provision. That in turn means that potentially relevant services, strategies, and other help might not have been contemplated.

3.6 An annual review meeting of Vicky's Statement occurred in March 2014. A pro forma review form was completed for this. Within this was a question asking whether the pupil had made satisfactory progress towards achieving the targets set out in the Education Plan during the past year. The option of 'Yes' was selected. There was a question asking if there were any significant new needs not recorded on the Statement. The option of 'No' was selected. These replies were not further quantified because the formulaic structure of asking for 'Yes' or 'No' answers does not give scope for input of further detail, which by default creates a limitation in reporting. This reduces the utility of such a review, and potentially renders it (even inadvertently) misleading for anyone seeking to use it as an indication of the success of interventions or strategies.

3.7 Contribution from Vicky's Mum referred to her as having settled well into school and that this was a credit to all the teachers who have taken time to understand Vicky. The school advised that Vicky had formed positive relationships with staff: her confidence was improving (although this remained an ongoing issue); she responded well to help from her Learning Support Assistant; she took part in classroom activities; she focused on tasks and was good at completing them; she was keen to do her best and was punctual. Vicky was described as shy and helpful and generally as having had an extremely positive start to post-primary education. There was encouragement that she should have more faith in herself. Vicky expressed a goal of becoming a hairdresser. Vicky had seemingly made a positive move to post-primary school. This is a significant event in the life of any young person but the school appears to have raised no issues of concern for Vicky at this time.

3.8 Social workers, acting for and on behalf of the Corporate Parent, do not appear to have attended the relevant meetings for this review. Their absence meant they could not be fully informed of all matters and therefore the Corporate Parent was unlikely to be properly informed. Not attending meant they could not advocate on Vicky's behalf if needed. This not only limited the Corporate Parent's exercise of Parental Responsibility and their ability to plan for their own role, but it left a vulnerable carer to advocate on Vicky's behalf alone.

Deterioration

3.9 In June 2014 there was an altercation between Vicky (then almost 13 years old) and another student at school. Her Mum believed this impacted upon relationships between Vicky and her peers, despite the school reporting that such relationships were good. Nevertheless, Vicky was reluctant to return to school in September 2014.

3.10 Her family (herein after referred to as family) were recorded as commenting in August 2014 that Vicky had needed support for the past two/three years but this had not been given. The family were disappointed that CAMHS had not been available to Vicky. At the start of September 2014, a member of the family believed Vicky was removing herself from the company of other people

to stop herself from hurting them. If this interpretation was correct, it raises two issues. The first is a significant decline in Vicky's emotional and mental well-being together with her sense of place within family and other circles. Secondly, it means she was trying to lessen the chances of harmful interactions, and was doing so in the only way that she could in the absence of targeted help – isolating herself. No young person should find themselves in this position. There is no evidence of her Corporate Parent seeking to identify the extent of Vicky's insight into her own behaviour and its triggers and attempting to engage with her about it. This would have provided an opportunity to do so on a significant issue.

3.11 Vicky was also showing anxiety regarding the start of a new academic year. She self-harmed on Friday 5th September 2014 and on that day a referral was made for a place on the 'Time Out' programme, but none were available. Four days later a social worker noted that Vicky's Mum was losing support from her extended family as a consequence of Vicky's behaviour and it was apparent that Mum was experiencing significant distress. When Vicky was advised later in September that a respite foster carer was being sought her behaviour became violent and she later refused to attend a 'Time Out' placement away from her Mum. Vicky was refusing to attend medical appointments, as well as school, and a referral was made to CAMHS. There appears to be little recognition of the impact of telling an already anxious child that they may be removed from the only parent that they have known.

3.12 Many of the events were recorded in an 'Understanding the Needs of Children in Northern Ireland' (UNOCINI) report completed in December 2014 and thus known to social workers, who also made referrals to a family support panel and LAC Therapeutic Services. The UNOCINI recorded that Vicky seemed to have a lot of issues at this time around her life story and family history. It also recorded that she had not offered a valid reason for not attending school. With regards to Vicky's Mum, the UNOCINI noted that at times she appeared exhausted and emotionally drained. There was no significant comment as to how these issues could be substantively and quantifiably addressed or the impact upon Vicky minimised.

3.13 In December it was noted that there was no concern with her behaviour when she attended school (attendance in the academic year to date had been inconsistent). There was consideration that discussions of a school move may have been causing disruptive behaviour at home. LAC Review minutes of the same month noted that Vicky's Mum had been asking for an assessment of Vicky for some considerable time to rule out the possibility of pre-existing conditions. There is no indication that this was done. Given that historically Vicky had, for the most part, showed no signs of difficulty at school, it is not clear why more such investigation was not done.

3.14 In January 2015 Vicky alleged that somebody within her Mum's extended family had hit her. This was investigated and no action found necessary but it led to real, difficulties within the wider family network, including a loss of practical support for her Mum from some relatives. Taken in conjunction with the increased anxiety Vicky was experiencing, the incident of self-harm, Vicky's refusal to attend appointments and inconsistent school attendance, this could have been a catalyst for a substantial review of Vicky's circumstances. However,

the opportunity to examine the causes of heightened behaviour and seek to identify remedial action was not taken.

3.15 By the time of the LAC Review in May 2015 Vicky was presenting with, or otherwise had, a range of issues. These included confusion regarding her birth family; school refusal and aggressive behaviour resulting in her Mum asking for police attendance on four occasions. She could present as aggressive if upset, and work was being undertaken with her on the issue of jealousy. Her Mum noted that no support from the Corporate Parent had been given to Vicky to help her attend the LAC Review and express her own views. In accordance with the Guidance there should have been such help to allow for a structured, coordinated approach.[43]

3.16 The minutes of one of these meetings noted that a social worker had been involved since October 2014 due to assaults on Vicky's Mum, who commented that Vicky struggled to move on from past situations. The start of life story work was noted by a social worker as resulting in Vicky hitting her Mum (this had not been explicitly noted at the LAC Review). It was also recorded that she needed 1-to-1 tuition, which was to be a short-term measure.

3.17 It was noted that since October 2014 Vicky's Mum advised that Vicky was starting arguments at home and had assaulted her. Vicky's Mum had asked for police assistance four times. Details of these events are unclear. The lack of recorded further substantive discussion of this at the meeting is striking as it should have been a significant source of concern. A risk management meeting would have been an opportunity to discuss what was happening with Vicky. It is unclear whether such a meeting did happen. In any event, no effective strategy for addressing these difficulties emerged.

3.18 At this time Vicky's Mum advised that she was receiving less support from her extended family and that Vicky had stopped attending medical appointments because she (Vicky's Mum) had been stopped from going with her. The potential impact of this on Vicky's health suggests a breach of her rights to healthcare. There is no indication of a partnership approach between the Corporate Parent or Vicky's Mum in remedying this.

3.19 Vicky's school Special Educational Needs Coordinator (SENCo) advised there were no difficulties at school when Vicky attended. Vicky's attendance was noted to be 6% and whilst the reason could not be confirmed, it was noted that she had anxiety and attachment issues. She had attended some after-school clubs but lost interest in them. She was noted as spending a lot of time outside doing physical activity, which may have been part of her mood regulation. The possibility of 1-to-1 tuition was mentioned as a means of avoiding Vicky needing to attend a special school.

3.20 In contrast, enquiries were being made in December 2014 by an EWO to find a placement in a special school due to requests by social services. The documentation also described the mainstream school which Vicky was attending as appropriate and noted that the problem was not at school even though she rarely attended.

43 Guidance, Vol. 3, para 3.8.

3.21 There is no explanation of why movement to a special school was proposed when feedback from mainstream education was so positive. This raises further questions as to whether the Corporate Parent was insistent on difficulties being viewed in a purely educational rather than home life setting. This proposed school move was not giving paramountcy to Vicky's well-being in an overarching sense. This proposal seems to be part of an overall inability of the Corporate Parent at this time to address a basic aspect of Vicky's needs and well-being.

3.22 Not only could the Corporate Parent not ensure her participation within formal education, they also could not decide on a consistent approach to find another means to ensure that she received an effective education. As her Corporate Parent, they were legally obliged to do. Vicky was a young person experiencing trauma and the Corporate Parent's reaction seems to have included countenancing further disruption in her educational environment as a means of addressing this, despite the education environment itself not being regarded as problematic. The strategy in this approach is not apparent.

3.23 The SEN Review of 2015 contained a detailed chronology of efforts encouraging Vicky to return to school, including home visits, with priority noted as being to invest in her Mum to support Vicky's placement. While the importance of the home dynamic was central, what is not clear is how the home and education dynamic was to be balanced.

3.24 At the SEN Review meeting of 2015 the Corporate Parent asserted that due to FAS Vicky interprets and processes information differently from other children and as a result needed information broken down into simpler terms and to get reassurance. There were comments that Vicky did not cope well with changes in routine and experienced a lot of stress and/or anxiety which could affect her mood. She was also described as lacking social skills and struggling with not having her birth mother in her life. Her Mum raised a query of whether Vicky might have autism.

3.25 In June 2015 there were further discussions where Mum spoke of Vicky's difficulties. At a meeting attended by Vicky's Mum, social services, educational professionals, and EWO it was considered that Vicky wanted to go to school but experienced some kind of barrier, possibly separation anxiety. She was noted as experiencing suicidal ideation, which had not been referred to in the minutes of the LAC Review of May 2015, despite being referenced in the UNOCINI report available for that meeting.

3.26 The need for life story work with Vicky had already been identified and was further discussed at the LAC Review of May 2015, but (in contravention of the Guidance) social workers did not seem to have the contact details for her birth family nor was there any plan to obtain the same.[44] There was also concern that Mum would thwart efforts to progress this work. This had implications for the potential therapeutic impact of having a stronger sense of her background and in addition a failure to uphold Vicky's rights to a sense of identity.

44 Guidance, Vol. 3, para 2.79.

3.27 Records show that Mum was querying ongoing work with Vicky by Barnardo's, which was providing safer choices service in response to identified CSE risks. It was also noted that there had been open disagreement between Mum and a social worker, resulting in heated discussions with regard to aspects of Vicky's care. While there was recognition that the placement continued to remain fragile, the support of the Specialist Fostering Service was assessed to be working well.

3.28 Eleven years after the foster placement had started there was still an unsettled relationship between Mum and social workers. Mum did not understand, or was generally not agreeable, to some aspects of professional input. This suggests a lack of effective communication, guidance, support, understanding, responsibility, or a combination of all of these.

3.29 This lack of partnership should have been resolved much earlier, and responsibility for doing so rested with the Corporate Parent. It also suggests that the Corporate Parent allowed itself to be hindered in the exercise of its Parental Responsibility and took insufficient measures to progress the work that Vicky needed to fully access education and a stable family life. It is clear that difficulties within this home were endemic and inherent in day-to-day life. Responses lacked a coherent, consistent strategy. Meanwhile, the deterioration appeared to be persistent and escalating.

Adverse Finding 3.1: Lack of adequate supervision of Vicky's foster placement

- The Parental Responsibility role was being performed by Vicky's Mum largely alone and, given the long-standing issues with her training, the Corporate Parent should have been vigilant in its duty to supervise, support and monitor;
- In the absence of that, which would have provided the basis for a deeper understanding when Vicky's behaviour began to decline, the response of the Corporate Parent was largely to aim for immediate containment;
- Supervision of the placement was not escalated to the necessary levels by the Corporate Parent to meet the needs of the evolving situation;
- The Corporate Parent permitted, even after 11 years of Vicky's foster placement, an unsettled relationship between her Mum and the social workers, indicating a failure by the Corporate Parent in effective communication, guidance, support, understanding of responsibility, or some combination of all of these;
- Actions by the Corporate Parent at this time appear intended to satisfy minimum requirements to acknowledge matters, without substantively addressing them.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 66, The Children (NI) Order 1995;
- Paragraph 4, Schedule 2, The Children (NI) Order 1995;
- Article 45, The Education and Libraries (Northern Ireland) Order 1986;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;

- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.44, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.79, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 3.11, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.54, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.55, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.1, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.3, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.20, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.3, Co-operating to Safeguard Children, May 2003;[45]
- Article 8, United Nations Convention on the Rights of the Child;
- Article 12, United Nations Convention on the Rights of the Child;
- Article 8, European Convention on Human Rights.

This Adverse Finding is a continuation of that of 2.1 within Chapter 2, showing ongoing thematic consistency of some of the shortcomings within Vicky's care, and that lessons were not being learned (or applied) by the Corporate Parent.

Home Life Collapse

3.30 In spite of Mum's difficulties in managing 13-year-old Vicky's behaviour it is apparent from education records that the Corporate Parent recognised the loving relationship that Vicky experienced in her home. This should have been more reason for the Corporate Parent to seek to improve the situation it the home. In view of the observed lack of routine, it is of concern that the comments of the educational psychologist in November 2012 that Vicky responded well to structure and consistency were not considered and acted on and that the appropriate support was not made available to Vicky's Mum to support her to encourage the structure and consistency in the home that Vicky required.

3.31 There was thus a dynamic whereby professionals were noting that Vicky's behaviour was better within particular dynamics, that was then (it appears) not being effectively applied, while at the same time Vicky's difficult presentation was not improving. It cannot be said conclusively what application of professional interpretations might have achieved. However, in the lack of a consistent application of such advice it is impossible to know whether Vicky might have benefited from the structure and routine that might have been created. This is an issue of a failure to work in partnership by liaising with relevant authorities, including education, to inform overall decision making.

3.32 Difficulties within the home necessitated input from the Specialist Fostering Service. There is no indication of how this improved matters. Behavioural problems continued despite ongoing therapeutic work and additional

45 This replaced the original Volume 6 of The Children (NI) Order 1995, Guidance and Regulations.

support from social services. It would, therefore, be reasonable to expect the Corporate Parent to further investigate whether the behaviour was a symptom of an underlying cause. However, discussions around this appeared to be a recitation of issues rather than any review, assessment, or planning. This suggests that the Corporate Parent set a high threshold of concerns before any meaningful planning was undertaken, which is contrary to the best interests of the child.

3.33 In the care plan arising from the LAC Review of May 2015 it was noted that:

- Mum would continue to ensure Vicky attended all medical appointments;
- An alternative form of education was to be found if Vicky continued to refuse to attend school (with no indication of what that could be);
- Mum was to continue to facilitate contact with Vicky's birth family to help promote her sense of identity;
- Mum was to attend training.

3.34 This care plan was a formulaic listing of intended activities and their aspirational outcomes. There was no detailed plan or timescale nor any discussion concerning overcoming previous barriers such as Mum not attending training. Again, there is no reference to the need for routine and clear boundaries. Nor was there any sense of collaboration or co-operation between relevant authorities. Acknowledging the possibility that the placement may deteriorate, the LAC Review minutes noted that a contingency plan was needed in the case of the placement continuing to break down. This would require identification of a suitable alternative, which could initially function in a befriending capacity, in turn preventing pursuit of an inappropriate placement in the event of an emergency breakdown.

3.35 Again, there appears to be no indication that this resulted in measures to either prevent breakdown or tangible contingency planning. This was a failure to ensure that Vicky, as a young person with additional needs, had her rights to a full and decent life upheld.

3.36 The same minutes of the LAC Review recorded no concerns with the foster placement and noted that it was meeting all of Vicky's immediate and emotional needs.

3.37 It is remarkable that a LAC Review meeting can include two such contradictory standpoints. It raises the possibility that relevant professionals, in the knowledge that Mum was struggling, considered this a good enough standard for Vicky's care. Also, in all the above, there was no sustained endeavour on the part of professionals involved to fully substantiate directly with Vicky what she considered her difficulties or needs to be.

3.38 At an annual review meeting of Vicky's Statement in July 2015 parental advice was given by the Corporate Parent. The same contribution asserted (as noted above) that, due to FAS Vicky could interpret and process information differently from other young people her age and as a result needed information broken down into simpler terms and to get reassurance. There were comments that Vicky did not cope well with changes in routine and experienced a lot of stress and/or anxiety which could affect her mood. This was another acknowledgment of FAS without also developing a corresponding FAS specific strategy.

3.39 Further comment from another social worker was also submitted. It was not dated but was included with the documentation sent to NICCY in respect of the 2015 SEN Review. It referred to Vicky as having both FAS and 'global developmental delay.' The same social worker stated that due to behavioural issues with Vicky in July 2014 an offer of social services managed respite was offered to her Mum, who refused it. There is no explicit discussion of this refusal, other than to note that Vicky's Mum struggled with the separation. Respite did, however, occur by way of Vicky staying with her Mum's daughter. When Vicky returned to her Mum in August 2014 tensions resumed, including self-harm by Vicky. Her Mum was described as needing a lot of input from social services at this time.

3.40 Social worker comments described Mum as potentially having difficulty regulating her own emotions and therefore unable to regulate Vicky. Indeed, children learn emotional regulation from parental models, and as a result excessive parental dysregulation can lead to both behavioural and emotional disorders in children. Mum also expressed frustration when Vicky refused to attend school. Evidence suggests that problems with conduct and oppositionality in children typically reflect excess family discordance, so these symptoms also provide evidence for parental emotional dysregulation in the home environment.

3.41 An assessment of Mum may have been helpful. Vicky was described as wanting to attend school, but experienced difficulties with structure and routine. Her Mum was considered by this social worker as not putting boundaries on Vicky's behaviour, out of fear of an aggressive response. Following Mum reporting Vicky's behaviour to the police, a risk management meeting could have been convened to discuss the safety and feasibility of the placement; good practice includes how to protect a carer.

3.42 The Corporate Parent were advised by Vicky's GP that there were no concerns as to Vicky's mental health, but they did recommend that she have an educational psychologist assessment to determine if she fell within Learning Disability remit. There is no indication that such an assessment took place. Correspondence of July 2015 from an educational psychologist advised that the previously submitted assessment of November 2012 remained appropriate.

3.43 If the request was for an updated IQ score, then it may be reasonable for professionals to conclude that a further test was not needed if no other issue was considered relevant. The main failure regarding IQ assessment was not cumulating all tests over time. However, if a report was being requested to advise on how to re-engage Vicky with school, then refusal was unreasonable given that the causes of non-attendance at school were of importance.

3.44 There is also no explanation of why a young person described as having global development delay had not been previously considered as falling within the scope of Learning Disability provisions. This indicates, at the very least, an ongoing lack of effective partnership between the Corporate Parent, School and the ELB.

3.45 The SEN Reviews of 2014 and 2015 and accompanying documentation recorded the first signs of psychiatric symptomology outside the home. This, and the dramatic contrast between contemporaneous advice from home and school, does not appear to have been

noted by professionals directly involved. It is also questionable why social workers involved with Vicky at this time considered that such matters should be reviewed within a SEN process instead of by way of referral to a child psychiatrist.

Education

3.46 Correspondence dated 30th July 2015 advising of the outcome of the most recent review of Vicky's Statement confirmed that the EA were satisfied that Statement objectives continued to be met in the existing school placement. This means the EA considered that enrolment in a school where Vicky had almost no attendance, resulting in effectively no implementation of her Statement, was sufficient.

3.47 This correspondence was the type of standard template letter sent when no issues had been found during an SEN Review. If this letter was sent because the recent review was found not to have raised significant difficulties, then that is profoundly concerning because the reality was quite the opposite. If it was sent because the EA did not know how to otherwise report on Vicky's current situation then it suggests that they were tied by procedures, or hindered by a lack of suitable processes, that stopped them from engaging transparently and purposively. In either case a child or young person in Vicky's circumstances was unlikely to see any improvement in educational provision.

3.48 There is no indication that the Corporate Parent recognised this anomaly or raised any issue. They did not give paramountcy to Vicky's education. This stance was consistent with their approach of noting difficulties while not suggesting solutions. Where there was refusal to go to school then options such as home tuition and a structured Personal Education Plan should have been considered. The position taken by the EA regarding Vicky's Statement should have been a prompt for social workers to give detailed consideration to the possibility that, if difficulties with school attendance were not educational, they may have had another cause.

3.49 Vicky had a right to a proper opportunity to development to her fullest potential, yet the Corporate Parent sought to address issues that appeared to originate within the home by moving her to a special school. This was despite consistent feedback from educational and other relevant professionals that Vicky was coping well in her mainstream school setting when she attended, which she rarely did.

3.50 Further failure occurred when the Corporate Parent did not appeal against the Statement. A Statement based on strategies that had proved to be ineffective for almost a year was clearly not suitable, but this was not challenged. If the reason for this was because the Corporate Parent considered that the EA could not address difficulties with Vicky's education, that in turn poses the question of who the Corporate Parent believed had that responsibility. It should be noted that paragraph 2.31 of Volume 3 of the Guidance confirms that 'looked after children' have the same rights as all children to education' and that 'responsible authorities have the responsibility of acting as good parents in relation to a child's education'.

Adverse Finding 3.2: Lack of effective partnership between agencies and/or quantifiable beneficial outcomes for Vicky.

- An educational psychologist completed a report in 2012 noting Vicky's significant learning difficulties but, whilst this was used

for the purposes of SEN Review, there is no evidence that the Corporate Parent considered it had wider significance for Vicky;

- The Corporate Parent appeared to look at issues in isolation rather than take a holistic approach to Vicky's circumstances to ensure there was 'joined up thinking' and she received the intervention and support required;
- The Corporate Parent's failure to ensure there was appropriate communication and coordination between agencies led to inconsistent conclusions and action;
- While the EA was aiming to reintegrate Vicky into formal education there was no indication of how this was to be achieved, including what further assessments (other than that of an educational psychologist) would be sourced or factored into this. This was both a lack of partnership and strategic thinking;
- Information received from the EA indicates contact between EA and the Corporate Parent was ineffectual and did not lead to any meaningful improvement in her educational provision. It points to a lack of partnership and strategic thinking regarding her education.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 66, The Children (NI) Order 1995;
- Paragraph 4, Schedule 2, The Children (NI) Order 1995;
- Article 45, The Education and Libraries (Northern Ireland) Order 1986.

Downward Spiral

3.51 Notes of a SEN meeting which occurred in August 2015 refer to strenuous efforts being made to get Vicky to return to school, and concern was expressed at the lack of progress. They also noted that Vicky's Mum expressed no concerns during the summer, with no aggressive or violent behaviour reported. The notes suggested that the Education Other than at School service (EOTAS) had been misrepresented by the EWO. It is unclear what this precisely meant, however it is followed by further comment which reads as though there had been a mistaken assumption that this would continue to be available.

3.52 No more specific detail was given, but it appears as though Vicky's access to EOTAS had not been properly understood or portrayed. Discussion of the referral and approval process suggested Vicky may not have been able to access this service and that different education agencies had very different views as to service accessibility and/or availability. This was a failure to work in partnership to give paramountcy to Vicky's well-being.

3.53 It is clear that resources and frameworks available to professionals at this meeting were insufficient for fulfilling Vicky's educational needs. There was no clear comment as to why this had not been addressed during the earlier SEN Review meeting. It is notable that there was discussion that the nature of and availability of service provision has been misunderstood. When in September 2015 the possibility of tuition was being further investigated this was impeded by a need to be discussed by a panel. Why this had not been raised at the SEN Review was not mentioned, showing a failure to properly plan.

3.54 It is apparent from correspondence that there was a lack of clarity in this regard and educational welfare staff experienced difficulties in getting

confirmation from social workers on where matters stood. Correspondence in the same month from EOTAS service to the Education Welfare Service (EWS) showed considerable confusion between Vicky's mainstream school, EOTAS, and EWS as to what services Vicky could or could not be referred to, including reference to the school SENCo being extremely surprised by the suggestion that tuition would continue. EWS had suggested that a referral for tuition be made, but the school were described as having no intention to make a referral for such because they perceived the problem to be 'one of school refusal' and they claimed that the tuition service did not work with 'school refusers.'

3.55 At a meeting one week before the noted correspondence the same SENCo was recorded by an EWO as being surprised that no tuition would be offered during the school term. In response the EWO noted that EOTAS could not offer tuition while Vicky remained enrolled in her existing school.

3.56 In addition to confusion as to what services (and when) Vicky was eligible for, it appears that in order to access a basic level of education there was an insistence that Vicky's access to full-time, mainstream schooling needed to be conclusively sacrificed. The hope of long-term provision in a school setting – which professionals consistently stated could meet Vicky's needs – would thus need to be abandoned for the sake of a possible short-term remedy. There was no discussion of how this could be resolved or at least improved.

Adverse Finding 3.3: Failure to ensure that Vicky was receiving an effective education.

- By May 2015 Vicky was patently not receiving a proper education as her school attendance had fallen to 6%;
- Information received from the EA indicates that efforts were made address the root cause of absenteeism, however despite being aware of anxiety issues and that methods of engagement were not working, they made no changes to the 2015 Statement to address these;
- SEN Statements issued did not include any realistic attempt to provide education;
- Neither the EA nor the Corporate Parent were prioritising Vicky as a child deserving of and entitled to education; access to EOTAS was unclear with the professionals directly involved being uncertain of her eligibility or related processes;
- Effective education was not possible without realistic planning. However, EA planning at times seems to pay no attention to the realities of Vicky having been, to all intents and purposes, disengaged from formal education. Statements produced did not realistically address Vicky's SEN;
- The EA do not appear to have sought equal treatment of Vicky (as a 'looked after child') by trying to find a remedy to the limitations placed by Article 55 of the 1995 Order upon the applicability of amenity available by way of Education Supervision Orders. Like all LAC in Northern Ireland, Vicky is excluded from this measure. There is no indication of how the EA have sought to challenge or compensate for this;
- With reference to all of the above, the Corporate Parent failed to challenge the inadequacy of the SEN Statements and in general its efforts to address Vicky's education lacked realistic or suitable focus.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Paragraph 4, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.31, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4, Schedule 2, The Review of Children's Cases Regulations;
- Paragraph 7, Schedule 2, The Review of Children's Cases Regulations;
- Article 45, The Education and Libraries (Northern Ireland) Order 1986;
- Article 18, The Education and Libraries (Northern Ireland) Order 1986;
- Article 23 United Nations Convention on the Rights of the Child;
- Article 28, United Nations Convention on the Rights of the Child;
- Article 29, United Nations Convention on the Rights of the Child;
- Article 2, European Convention on Human Rights Protocol 1.

3.57 In October 2015 Vicky was not attending medical appointments required for assessment processes and consequentially was discharged. Yet a contingency plan (as referred to in the LAC Review of May 2015) does not appear to have been enacted. Social workers should have been directly engaging with Vicky to ask her why she would not go to appointments. This could have helped gain understanding of whether there were underlying reasons for Vicky not going, such as fear on her part. Incentives should have been offered for attendance at such appointments.

3.58 The care plan may not have been the only barrier to progress. In December 2015, correspondence from EA Learning Support Services and Training to professionals involved with Vicky at this time directed that the words 'as required' should be included when requesting advisory support, to ensure the responsibility would fall on schools to request such support rather than on the EA to automatically provide it.

3.59 This indicated that resource provision was to be minimised as much as possible. It also placed an onus on schools to be aware of what provision was available and to explicitly request it, rather than it proactively being made available. The use of 'as required' further implied the need for more assessment and evidentially confirmed need. Such an approach reduces agency expenditure at the cost of less provision for people such as Vicky who may have high needs.

3.60 It is also deeply concerning that the proper language was not used to secure the necessary services for Vicky, and that the statutory body sought to impose this style of barrier to service provision.

Adverse Finding 3.4: Bureaucracy and budgets were allowed to supersede Vicky's best interests.

- The EA appeared to approach Vicky's educational needs by seeking to minimise its obligations towards her by placing an onus on others to explicitly ask for help rather than offering it;
- The EA allowed procedural confusion over EOTAS, in respect of when, how, and why Vicky was / would be able to access educational amenity outside formal school attendance.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 10, The Education and Libraries (Northern Ireland) Order 1986.

Assessments

3.61 In February 2016 records show that Vicky had some tutoring and had progressed well, but further tuition was dependent upon a referral to CAMHS. This requirement was something that a LAC Therapeutic Services clinician already involved with Vicky was unhappy with, as it required discharge from LAC Therapeutic Services before CAMHS could act. Such a requirement would mean that in order for Vicky to have tuition she would need to move from one therapeutic service to another, potentially resulting in a lack of continuity of care.

3.62 CAMHS provided both a consulting and therapeutic service and would not normally have required a referring agency to disengage. However, access to tuition was hindered by putting in place this additional layer of assessment, rather than relying solely on advice from LAC Therapeutic Services. Instead of processes working in the best interests of the young person, the effect was to delay her access to services. It is not clear why input from CAMHS was necessary to access tutorial services, and this could be interpreted as putting in place a barrier to minimise resource outlay by some agencies.

3.63 Whatever the rationale, requiring a young person with SEN to change from one therapeutic service to another before they can access a basic level of education shows a lack of partnership across services. The needs of a bureaucracy were made paramount, instead of young people in need of amenity. This may have arisen from confusion on the part of professionals as to the remit of different services. However, the belief that there was a need for discharge from one service to be able to access another was not explained, and there was no apparent conflict of remit or interest between the two services.

3.64 Confusion regarding supervision of Vicky's well-being and care appears to have been widespread. Social worker documentation of March 2016 noted a fear that Vicky's Mum would not fully inform them of significant events, confirming again the difficulties of relationships between important people in Vicky's life and the limitations upon supervision of the placement.

3.65 More tellingly, the Corporate Parent commented upon the frequency of changes in social worker, amounting to six in a three-year period, with the effect being (as the Corporate Parent saw it) that Vicky did not have anybody to talk to. Her earlier social worker had worked with Vicky and her Mum for five years and had developed a good relationship with Vicky. This change was recognised as a big loss for both Vicky and her Mum. The Corporate Parent further commented that it meant newly allocated social workers did not have all details necessary for interpreting matters.

3.66 The Corporate Parent further commented that Vicky had not been properly attended to for a very long-time; that she had experienced considerable disruption; that there was a fractious relationship between the Corporate Parent and her Mum; that the Corporate Parent did not trust Vicky's Mum; and that relevant staff, central to Vicky's life, did

not have all information needed to do their jobs.

3.67 In April 2016 a consultant child and adolescent psychiatrist wrote (at the request of a LAC Therapeutic Service clinical psychologist) directly to EOTAS describing Vicky as having a depressed mood and high levels of anxiety. This was noted as contributing to her non-attendance at school. This psychiatrist commented that Vicky felt sad and different because of not going to school and this was having an ongoing significant impact on her mood, self-esteem, and confidence. She had tried to go back to school but was unable to due to anxiety, compounding her feelings of failure and contributing to lowered mood and occasional feelings that life was not worth living. It was further noted that her history and presentation was in keeping with school phobia occurring in a vulnerable young person who has experienced trauma in her early life.

3.68 The psychiatrist sought an urgent referral for home tuition, noting the provision of such would be enormously helpful in providing the necessary educational support as well as extremely beneficial to her mental health. They emphasised the importance of improving her mood, reducing anxiety, and building self-esteem and confidence. The letter concluded that in situations of phobia the longer the anxiety inducing situation is avoided the more the anxiety builds up.

3.69 This portrayed a very disturbing presentation which had been developing since before September 2014, when school attendance first became an issue. Despite multiple meetings to discuss that topic no progress had been made. Suggestions to have Vicky reviewed by an educational psychologist had come to nothing. In the aftermath there arose clear clinical opinion which noted that there were substantive mental health problems and they had become self-reinforcing due to historical circumstances. Those were circumstances which had not been properly addressed by the Corporate Parent at multiple earlier opportunities.

3.70 It is further remarkable that part of the purpose of the psychiatrist's letter was to attain home tuition for Vicky because, despite her school refusal since September 2014, there was still no confirmed standard and method of educational provision for her as a SEN student. Her needs were not given paramountcy in this regard.

3.71 Correspondence from Vicky's school in May 2016 noted that, once she entered the school building Vicky was able to follow her timetable and mix with her peers without apparent difficulty. The SENCo also commented that it appeared that the longer this situation had continued there was anxiety about returning to school. While this reinforced that attendance problems arose from outside the school setting, it is still odd that a review document of June 2016 (as signed on behalf of Vicky's school) for the annual SEN review meeting answered 'Yes' to the *pro forma* options as follows:

- 'Do the objectives of the Statement remain appropriate?'
- 'Does the pupil have access to the full NI Curriculum without exemptions or modifications?' (Albeit with the qualification that Vicky was *'not engaging'* and *'not attending school'*).
- 'Is the present placement appropriate to meet the pupil's Special Educational Needs?'

3.72 For the question of 'Is there any reason why the provision should be amended to meet the pupil's needs?' the option of 'No' was selected. It also noted that there were significant new needs not recorded on the Statement and that the EA was reviewing the Statement. No further detail in this regard appeared. It was also recorded that satisfactory progress had not been made in achieving targets within Vicky's Education Plan. Vicky's lack of school attendance was recorded, together with comments of social service supports and educational engagement in respect of that. There does not appear to be any definitive identification of the cause(s) of school refusal.

3.73 The school may have been completing this form based on what limited information they had readily available. If so, this was derived from attendance by Vicky of half a school day out of a possible 183 (as confirmed in documentation collated for this SEN Review). It is deeply concerning that neither the Corporate Parent or the EA questioned the efficacy, purpose, and veracity of such an appraisal. If a child in the care of a birth or adoptive parent was showing such difficulty with formal, structured education the option of an Education Supervision Order could have been considered. 'Looked After Children' such as Vicky however are explicitly excluded from the benefits of this, which include a duty of the supervisor to advise, assist, befriend, give directions, and consider steps that could be taken if directions were not complied with.[46]

3.74 This review relied on the educational psychologist report of 2012 when it clearly would have benefited from a more recent assessment. In an absence of agency partnership there was no apparent referral to the expressed views of the consultant child and adolescent psychiatrist of April 2016 as noted above. If this was not because of a lack of information sharing, then it suggests that educational difficulties were not seen as school (or learning) based. If that was so, these SEN Review meetings seem perfunctory, rather than attempts to improve educational strategies and outcomes for Vicky. Educational professionals were tasked with devising responses within an educational setting to behavioural problems within the home, and to do so without substantive improvement in the home setting. The Corporate Parent either did not see the significance of that, or otherwise did not try to address it.

3.75 The final amended Statement of 27th July 2016 notes that Vicky (now aged 15) had SEN needs, cognitive and unspecified learning difficulties, and other medical conditions and/or syndromes. The option of mental health issues was not selected but use of a trampoline and swing to relieve stress and anxiety was recorded. It was again noted that, due to FAS she could interpret and process information differently. The statement also recognised that she was an anxious child and that her anxiety often presented as a display of challenging behaviour. It also noted that being strict with Vicky did not work.

3.76 This amended Statement is striking in that it moved from attributing Vicky to Moderate Learning Difficulties (MLD) and Social & Emotional Behavioural Difficulties (SEBD) in the Annual Review of 2015 to 'unspecified cognitive difficulties' in 2016, though Vicky's FAS remained identified. MLD is generally understood as being equivalent to mild

46 The 1995 Order, Schedule 4.

intellectual disability (ID) while SEBD can be understood as referring to the educational consequences of mental health difficulties.

3.77 Removing the MLD specification was equivalent to removing an ID diagnosis, implying she no longer had educational needs arising from ID, though some cognitive difficulties remained. Similarly, the removal of the SEBD qualification, without replacing it with one of mental health, suggested Vicky was identified with no such needs. Both these changes to Vicky's assessment were made without Educational Psychology or equivalent Clinical Psychology/CAMHS input.

3.78 The effect of these changes can be seen in the objectives and provisions of the Statement, which were discretionary, general, and with extra staff resourcing subject to dual approval. Having not identified Vicky as meeting the SEBD or mental health criteria, the EA was no longer required to review progress involving these areas. However, these were directly contributing to Vicky's difficulty in accessing her education, and this should have been identified in her Statement. This drafting, which did not fully reflect Vicky's circumstances and needs, thus had very real consequences for Vicky. Assessments that did not factor in the basic realities of her circumstances were meaningless in identifying or catering to her needs.

3.79 Within the above noted Statement, the assessment remained that Vicky's needs and objectives would be best met within a mainstream setting - the school she had not substantively attended since June 2014. How this could be reconciled with the assessment of a consultant child and adolescent psychiatrist in April 2016 was not commented upon. The lack of such discussion adds to a perception of the SEN Review being a stand-alone, formulaic process engaged in because it was necessary, not because it was intended to achieve tangible progress.

Adverse Finding 3.5: Annual SEN Reviews were reduced to a tick box exercise.

- Annual SEN Reviews did not fulfil their intended purpose in ensuring that Vicky received an education in a manner that was appropriate to her needs. Instead the focus was on ensuring that procedure was followed, with the outcome not reflecting on all information submitted or apparent needs of the child. This could be described as a form of 'tick box' exercise;
- That allowed Vicky's Statement of July 2016 to be discussed, viewed, and amended at times without full understanding of terms that were used to describe her needs. Terms such as 'learning difficulties' and 'moderate learning difficulties' were used in circumstances which appear to have been misunderstood, incorrect, or with the significance not being noticed. This renders it difficult in places to understand what exactly the EA considered her presentation and needs to have been. Such inconsistent use of terminology created confusion, causing difficulty in properly responding to her needs.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 16, The Education and Libraries (Northern Ireland) Order 1986.

Advocating for the Child

3.80 Final confirmation correspondence to the Corporate Parent advising of the resulting Statement explicitly noted that there was a right of appeal against its contents. That correspondence noted there was a two-month period in which to lodge such an appeal. Appealing against the Statement may have been an opportunity for the Corporate Parent to ask the EA why a school Vicky was not attending was deemed suitable for her education, or how needs not included within her Statement were to be addressed. There was explicit legislative provision in place allowing for:

'appeal to the Tribunal against the description in the statement of the board's assessment of the child's educational needs, the special educational provision indicated in the statement ...'[47]

There is no indication that the Corporate Parent availed of this to discharge their duty to ensure that Vicky received an efficient full-time education.

3.81 In July 2016 (when Vicky turned 15 years old) there was confirmation that EWS would no longer be involved due to EOTAS being in place. This was another instance of service disengagement albeit one whose value to Vicky's education has been difficult to identify. In August 2016 the EA advised that a Transition Plan had been prepared. The plan included an option of education in a formal setting, or an option of EOTAS and/or tutoring. The plan was structured as if Vicky was fully engaged with day-to-day education. In the section allocated to health and therapy it was reported that as far as was known Vicky was healthy at that time. This was something the Corporate Parent should have been able to advise upon further instead of leaving this so ambiguous. The lack of more clarity suggests the Corporate Parent could not give this information, and that there was no multi-agency discussion to ascertain what that information was or how to obtain it. There was also no reference to therapeutic needs or the effect of this upon education.

3.82 Correspondence from EOTAS staff in September 2016 referred to an imminent move from foster to residential care, of which Vicky was then unaware. This raises several questions including how this planned move was factored into education provision. More significantly it poses the issue of why Vicky was unaware a move was scheduled and that it would happen soon. Given her ongoing presentation (including anxiety) it is concerning that no preparatory work was being done with her for such a momentous transition. This must also inevitably mean that Vicky's own views had not been sought in this matter and she was rendered voiceless in this.

Adverse Finding 3.6: Failure of the authorities to identify Vicky's needs and respond to them in an effective and timely manner.

- In August and September 2014, the family were commenting to the Corporate Parent that Vicky had long needed support but there is no indication of substantive efforts being made by the Corporate Parent to improve circumstances within the foster home;
- Vicky was refusing to attend medical appointments, leaving her at risk of not having her needs identified in the first instance, but just as in the case of her absenteeism from school, there is no evidence that the Corporate Parent

47 The Education (Northern Ireland) Order 1996, Article 18.

attempted to identify the cause or how to address it;

- Corporate Parent responses to issues of worry with Vicky's presentation lacked coordination and did not include substantive effort to learn from Vicky directly;
- Whilst the Corporate Parent did at times note that Vicky did not cope well with change, experienced a lot of stress and anxiety, lacked social skills, and could interpret and process information differently, there is no evidence of the Corporate Parent seeking to explore this further or using the information to try and improve her circumstances;
- The extent of breakdown within Vicky's family home was such that police were repeatedly involved, but there is no evidence of any real discussion of it by the social workers - to either develop an appropriate strategy or escalate matters to more senior levels within the Corporate Parent for input and guidance;
- Throughout this period the Corporate Parent failed to properly investigate the likely significant harm she was experiencing, failed to plan with proper consideration of her needs, or give due regard to her health conditions, including her FAS diagnosis.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 66, the 1995 Order;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.26, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.44, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.79, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.80, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.52, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.54, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.55, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.20, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5, Schedule 2, The Review of Children's Cases Regulations (Northern Ireland) 1996;
- Paragraph 7, Schedule 2, The Review of Children's Cases Regulations (Northern Ireland) 1996;
- Paragraph 1.15, Co-operating to Safeguard Children, May 2003; [48]
- Paragraph 2.3, Co-operating to Safeguard Children, May 2003; [49]
- Article 12, United Nations Convention on the Rights of the Child;
- Article 24, United Nations Convention on the Rights of the Child;
- Article 8, European Convention on Human Rights.

48 This replaced the original Volume 6 of The Children (NI) Order 1995, Guidance and Regulations.

49 This replaced the original Volume 6 of The Children (NI) Order 1995, Guidance and Regulations.

NICCY recommends that the relevant authority/ies :

R13 Develop and implement effective policy and practice to ensure that the views and concerns of foster carers are treated with respect and given due consideration. The Corporate Parent must engage with, record and properly respond to issues raised by foster carers.

R14 Work together to ensure that the child receives an effective education. A Corporate Parent must attend relevant meetings and take cognisance of reports and be held to account (including legally) in the same way as a birth parent when they fail to do so.

R15 Ensure that SEN and LAC Review processes work together (e.g by attending meetings, sharing information, and communicating regularly), so that a shared understanding of the child's circumstances and needs can be developed to improve planning and decision-making.

R16 Develop and implement effective guidance for schools, EA staff and their supervisors to ensure that assessments and reports are informed by the child's circumstances and their impact on their education.

R17 Identify and record tangible actions that should be progressed and monitored when a risk to stability of homelife or if deterioration is identified. Such monitoring should continue until the child experiences sustained safety and stability.

R18 Ensure the views of the child are being actively sought before all formal processes or decisions are made with regards to every aspect of their life. This should include, but not limited to, providing children with support to be active participants in their care, health and education and to understand the reasons that decisions are made.

R19 Ensure that policies, practice and training are implemented and that the named social worker for the child is given time and support to understand the child's life and situation. There should be evidence that this informs the way they work with and advocate for the child and foster family.

R20 Review the role of Educational Welfare Service to consider what further role they may have when a child is known to social services, is looked after or has mental health issues.

R21 Ensure that assessments are undertaken and recorded in a timely manner and that interventions and supports are identified and provided accordingly. If this cannot be the case then reasons must be recorded and an action plan identified.

CHAPTER 4
AWAY FROM HOME (AGED 15 – 17)

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

Sept 2016 – June 2018

4.1 In August 2016 (when Vicky was 15 years old) social care professionals became aware that her Mum was ill and required surgery. A LAC Review took place in late August 2016 and with knowledge of Vicky's Mum's illness, the panel set out a care plan which included a decision that she should remain with her Mum with a high level of support. A contingency plan had been agreed in the event the placement broke down or in case of an emergency. This involved having Vicky's Mum's adult children help care for Vicky and would need to be revisited at intervals. It was noted that the placement required a lot of support and there was mention of an outreach facility being sought.

4.2 An email within the LAC team spoke of a decision to place Vicky in residential care on a shared care basis. Comment was also made that Mum needed to attend training in connection with coping strategies and working with Vicky in a therapeutic way. More robust support measures could have been put in place to support the placement as an alternative to residential care. This would have needed the consent of Mum and could have included a family support worker and/or engagement with Barnardo's, Action for Children, or VOYPIC. Remarkably, this "plan" may not have been intended to have been implemented.

The Children's Residential Home

4.3 On 23 September 2016, a 15-year-old Vicky was admitted to a children's residential home (CRH). This home was operated by WHSCT and was registered with six beds for children with emotional and behavioural difficulties. At a LAC Review on 6th October 2016 it was noted that that Vicky's home situation had been deteriorating for the past two years and that her Mum had no control over Vicky at home. Incidents included Vicky dancing on her Mum's car and staying overnight with a friend of her Mum. Minutes from the meeting indicate Care Planning meetings found that moving to the children's residential home (CRH) was the only but not the best option.

4.4 Documentation also shows that this move was being planned in July 2016. It appears there was a plan to not tell the family (including Vicky) until the day before she would move in. This stands in contrast to Guidance, which sets out that residential care should be 'used in a planned way', and that 'partnership with parents' and 'involvement of children... apply equally to children in residential settings'.[50]

4.5 All of this was despite the need for a contingency plan being identified in 2014, as well as commentary on the need for consistency. In contrast to not telling the family of plans, a UNOCINI of 24th August 2016 explicitly quoted guidance on parenting children with a FASD diagnosis, stating that one of the most important things they could do was to be very consistent in their daily routine, develop a schedule and stick to it. If a change in routine is going to occur, explain this to the child in advance and prepare them for it. The UNOCINI noted that Vicky was initially hyper-vigilant around strangers, and ongoing difficulties within the family home, including comment that her Mum was afraid of maintaining boundaries for the young person, and that she lacked insight into FAS. This again raises the question of what the Corporate Parent had done in the preceding fifteen years to address these issues.

50 Guidance, Vol. 4, para, 1.2.

4.6 Vicky, as a young person with FAS and who had for some time been discussed as potentially having anxiety and difficulties with separation was, with deliberately little warning, placed in a setting that removed her from all the structures of familiarity, comfort, and safety she knew.

4.7 After a few weeks in the CRH, Vicky's relationship with staff deteriorated. She was arrested, reported, or staff requested police presence twelve times between 8th November and 29th December 2016 and eleven times between 8th January and 31st January 2017. Following arrests Vicky was given bail, the conditions of which were unchallenged by the Corporate Parent, despite her cognitive ability and needs. They included:

- Not to make threats of violence or be violent towards staff or young people in any residential home where she resided;
- Not to make threats of violence or be violent towards her Mum;
- To follow house rules in the residential home; and
- Not to abscond from the residential home.

4.8 There developed a pattern whereby police were engaged, bail conditions were set, those bail conditions were then breached, resulting in further police involvement to renew the cycle. The regularity of police involvement as well as the nature of the bail conditions was something that the statutorily required monitoring reports would have noted.[51] This should then prompt discussions between relevant parties, including advocacy. This was especially important given that some of the house rules that Vicky was expected to follow included handing over her mobile telephone and going to bed at specific times. Her failure to comply with these resulted in staff at CRH asking police to attend.

4.9 Police were attending to put Vicky to bed and to take her mobile phone from her. During some instances of police attendance Vicky's behaviour escalated, and restraint and/or handcuffs were used. This would be distressing for any young person, let alone somebody with FAS. It also contradicted Recommendation 24 by Lord Carlile of Berriew QC, which noted that handcuffs should not be used.[52] The potentially traumatic impact to Vicky should be acknowledged.

4.10 This situation also distressed staff charged with Vicky's care. There were instances of staff locking themselves in a room when Vicky's behaviour escalated, with one member of staff describing herself as fearing for her own safety. It should be noted that the Guidance sets out that 'staff must be competent, experienced and qualified for their work'.[53]

4.11 Applying such bail conditions, especially to 'follow house rules,' is unethical and inappropriate with 'looked after' young people, as this can set them up to fail, often leading to them to become criminalised. In relation to Vicky, the nature of bail conditions and the 'breaches' and consequences of their 'breaches' thereof amounted to a breach

51 The Children's Homes Regulations (Northern Ireland) 2005, Regulation 29.

52 The Carlile Inquiry – The independent inquiry into the use of physical restraint, solitary confinement, and forcible strip searching of children in gaols, secure training centres, and local authority secure children's homes. https://howardleague.org/wp-content/uploads/2016/03/Carlile-Report-pdf.pdf)

53 Guidance, Vol. 4, para 2.3.

of Article 6 ECHR standards (being the right to a fair trial). They were draconian conditions that did not take into account Vicky's cognitive capacity, and staff members at the CRH did not appear to have considered mitigating circumstances influencing her behaviour.

4.12 Instead, there was a worrying default position of contacting the police to report a breach of bail for minor misbehaviour. Police should never have been asked to attend. Professionals working with Vicky should have been able to recognise that trauma-based behaviour was being displayed. Requesting police intervention should have been the final and last resort, but unfortunately it became the default reaction.

4.13 The involvement of police was a 'red flag' to Vicky, who responded with a fight, flight, freeze behaviour. Senior management should have been aware of the circumstances of arrests, and the social worker team leader should have been compiling a synopsis of all arrests and bail conditions. The nature of bail conditions should have been noted and raised with the social work manager.

4.14 A good parent would not let criminalisation of their child go unchallenged, nor indeed the use of restraint, or bail conditions which were based upon 'house rules'. However, the Corporate Parent did not challenge those things, and in the process did not 'parent' in the way that it would expect a good parent in the community to do so.

4.15 It is worth considering how a good parent should behave. Good parents are expected to adopt a positive, not negative, dynamic to protect their child, prioritise meeting their needs, and protect them. Indeed, Health and Social Care Trusts expect all parents to behave in that way, and this is the framework through which parenting capacity assessments are done.

4.16 This should be further viewed in the context of the 'Minimum Standards for Children's Homes' issued by the Department of Health in 2014 and operative when Vicky was admitted to the CRH. This sets out a need for proportionate, consistent approaches for managing behaviour, which are explained to and understood by all children and young people and staff. This should not go beyond what would be expected from a reasonable parent. Discipline, including any use of restraint or seclusion, and expected standards of behaviour should be made clear to and understood by children, young people, and parents before admission.[54] It also directs that use of restraint or restriction for managing behaviour be consistent with the Guidance.[55]

4.17 The Guidance outlines that each home, including management staff and team leaders, should ensure that positive child care practices prevail and staff must convey a strong sense of wanting to form constructive relationships with resident children.[56] The same paragraph of the Guidance notes that due to low self-esteem some children may hurt themselves, others, or destroy property. This however 'cannot be allowed to justify low standards of care or a poor living environment. It is up to staff to

54 Department of Health, Minimum Standards for Children's Homes (Children's Homes Standards), 3.12.

55 Children's Homes Standards, 3.13.

56 Guidance, Vol. 4, para 4.1.

create a positive atmosphere in which to care for children.'[57] There is no indication that this was factored into decision making at this time or subsequently.

4.18 Situations such as Vicky's were envisaged by the Guidance, including where it noted 'problems will occur where expectations of behaviour are unrealistic, inconsistent, or where insensitive methods of control are used.'[58] It also explicitly notes that 'a child's age, understanding, and competence can have a bearing on ability to recognise and understand danger whether to himself, other people, or to property.'[59] These directions do not appear to have been considered regarding Vicky.

4.19 The management of Vicky's developing symptomatology within the Social Care and Criminal Justice System had the unintended consequence of exacerbating, rather than alleviating, their deterioration. It is well documented that overly onerous bail conditions such as the one above are often unrealistic or unachievable and therefore more likely to be breached.[60] Having a condition to 'follow house rules' enabled staff to report even minor breaches of the rules which resulted in further arrests. As Vicky became increasingly sensitised to loss of appropriate input, her dread would be increased by the impending risk of arrest, which then increased the potential for disorganised and aggressive behaviour that then led to arrest. The cycle of arrest, incarceration, return, seclusion, and defiance would inexorably drive Vicky's behaviour to escalate.

Adverse Finding 4.1: Lack of effective planning by the Corporate Parent.

- Despite knowledge that her relationship with Vicky's Mum had been deteriorating for the past two years, a 'contingency plan' for Vicky was only in place in August 2016 when Mum became unwell;
- A month later Vicky was placed in the CRH, which was considered to be the only option, notwithstanding that there is no evidence that it was one of the options considered in August 2016 and it was not included in the 'plan';
- The viability of the planning in August is undermined by its abandonment in a matter of weeks. As is the viability of the option of the CRH, as there is no evidence of any proper assessment that led to its selection;
- There was a failure to devise and implement a sustainable plan to provide accommodation outwith the CRH or the JJC or the Secure Children's Home (SCH).

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 72, The Children (NI) Order 1995;
- Paragraph 4, Schedule 2, The Children (NI) Order 1995;
- Paragraph 7, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;

57 Guidance, Vol. 4, para 4.1.

58 Guidance, Vol. 4, para 4.7.

59 Guidance, Vol. 4, para 4.10.

60 The Marshall Report 2014, p.87, The Report of the independent Inquiry into Child Sexual Exploitation in Northern Ireland https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/csereport181114_0.pdf

- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 12, United Nations Convention on the Rights of the Child;
- Article 18, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 8, European Convention on Human Rights.

Therapeutic Interventions

4.20 Referred to previously, all staff that work in children's homes have mandatory training on different types of therapeutic interventions. This helps offer special protection and assistance for children who have experienced trauma and comes in the form of a Regional Therapeutic Model (RTM). Two models were in use, namely the Model of Attachment Practice (MAP) and Therapeutic Crisis Intervention (TCI). The models set out requirements for staff to understand and address underlying behaviour appropriately and according to the child's background or disability.

4.21 All staff interaction/intervention should have been consistent with training and guidance regarding MAP. This should have been in terms of therapeutic interaction and TCI during intervention, and/or managing behaviour. These matters should be reinforced via team meetings, supervision, and refresher training. Strategies that could have been used would have included distracting, engaging, and co-regulation, to assist the child with self-regulation. Restraint should have been a last resort and, if done, been used therapeutically. Police attendance should only have been considered in extreme circumstances and danger.

4.22 Risk management planning should have explicitly noted if, or when, police should be asked to help, and the CRH should have provided guidance on this, which Department of Health and the Social Care Board should have been involved in drafting. There was no indication that the staff actively engaged with police to devise suitable strategies for these issues, and management within the CRH / Trust at senior level should have explored matters further.

4.23 It is unclear to what extent the staff engaged the therapeutic model approach. Emphasis should have been on creating a trauma-informed therapeutic environment for Vicky that was supportive to her needs in order to maximise her wellbeing and development. Staff training on MAP and TCI should have taught them to identify trauma pain-based behaviour and respond therapeutically. With Vicky they did not respond therapeutically, but in a manner that required control, such as contacting police for alleged breaches of bail. This was a stark failure to implement training and policies in place around therapeutic models. There is no indication that her behaviour was seen as trauma based; rather, it was viewed as non-compliance or bad behaviour.

4.24 Vicky's multiple arrests and criminalisation might have been prevented if the Corporate Parent effectively monitored and reviewed occasions when police were requested.

Established governance systems, such as the RTM, were not followed to ensure that her management was conducive to her wellbeing, or if it was appropriate, or if guidance and Vicky's Individual Crisis Management Plan (ICMP) were suitable or being followed.

Adverse Finding 4.2: Regional Therapeutic Model not implemented properly resulting in the unnecessary criminalisation of Vicky.

- The Corporate Parent permitted Vicky to remain in the CRH without developing any plan for an alternative placement, despite it being evident that it was not equipped to respond to her needs;
- MAP and TCI techniques were also not properly applied in the CRH in relation to Vicky. Police were being called to attend during outbursts with frequency, indicating TCI was not being properly applied;
- The CRH interpreted the bail conditions, the catch-all 'abiding by house rules,' as entitling them to call the police for relatively minor breaches by Vicky;
- There is little or no evidence of the WHSCT, as Vicky's Corporate Parent, complying with the RQIA's requirement to develop a social work response to challenging behaviours nor is there any evidence of any medical assessment on the use of restraint as there should have been;
- There is no evidence that the Corporate Parent, in its role as the Health and Social Care Trust with responsibility for the CRH, was seeking to ensure that Vicky's welfare was being properly promoted therein. Nor that staff within the CRH were not properly trained for Vicky's needs. There is also no indication that 'notifiable events' were being properly recorded, reported, acted upon, and improvement sought;
- Despite social workers being aware of Vicky's limited insight and considering her breach of bail conditions to be minor, there is no indication that they tried to limit scope for her continuing criminalisation, or to move her from that setting.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 72, The Children (NI) Order 1995;
- Paragraph 7, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 1.5, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.3, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.1, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.4, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 4.7, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Article 11, The Children's Homes Regulations (Northern Ireland) 2005;
- Article 25, The Children's Homes Regulations (Northern Ireland) 2005;

- Article 29, The Children's Homes Regulations (Northern Ireland) 2005;
- Standard 3.13, Minimum Standards for Children's Homes, April 2014;
- Standard 6.15, Minimum Standards for Children's Homes, April 2014;
- Article 18, United Nations Convention on the Rights of the Child;
- Article 20, United Nations Convention on the Rights of the Child;
- Article 27, United Nations Convention on the Rights of the Child;
- Article 37, United Nations Convention on the Rights of the Child;
- Article 40, United Nations Convention on the Rights of the Child;
- Article 5, European Convention on Human Rights;
- Article 8, European Convention on Human Rights;
- Article 14, European Convention on Human Rights.

RQIA inspection and involvement

4.25 The Regulation and Quality Improvement Authority (RQIA), established under the 'Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003,' is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvement in the quality of those services.[61] The RQIA has powers to require information, entry and inspection of premises. It is responsible for the inspection of children's homes, which should be inspected at least twice a year. Inspectors carry out both unannounced and announced inspections. The RQIA inspects and reports on the following four domains: is care safe?, is care effective?, is care compassionate? and is the service well led? A requirement is an action to be taken by the premises to rectify a fault.

4.26 The CRH fell under the remit of the RQIA and an unannounced inspection took place in January 2017. The inspection was in response to notifications received by RQIA which indicated a high level of police involvement when responding to challenging behaviour by young people accommodated at the home. Police had been called to the home 14 times across December 2016 and January 2017 due to what were described as challenging behaviour of one young person. Due to safeguards applied by RQIA their report does not specifically identify this young person, however commentary in respect of police intervention and medical circumstances indicates this is Vicky.

4.27 The Inspection Report details that a review of the young person's case showed they had an underpinning medical diagnosis and complex needs which required a high level of support from staff. However, social work responses to date had involved an escalation in the use of the PSNI to respond to this young person at critical stages of intervention. Staff also advised that the Trust was revising the effectiveness of the social work plan and therapeutic support in place for this young person.

4.28 The report further noted that physical restraint had been used upon a young person who had a defined medical condition which possibly precluded the use of restraint. This had not been

61 Circular OSS 1/2018 'Role and responsibilities of directors of the Health and Social Care Board and Health and Social Care Trusts for Children in Need, Children in need of protection and Looked After Children', p.8.

assessed by their doctor and the matter required urgent review by the Trust with respect to their management plan.

4.29 The Inspection Report also noted that a UNOCINI assessment was in place and outlined the needs of the young person. Those needs had been recently reviewed through the LAC Review process. Records noted that behaviours of the young person had reached a critical point and the young person required additional support from other services.

4.30 The Report continued that focus seemed to be on managing the environment around the young person, including identifying triggers and trying to work positively with the young person. There was discussion of examples where intervention had successfully de-escalated the situation and helped the young person to manage their emotions. However, the management plan became less clear when discussing how to respond to the young person during an outburst phase as identified within the ICMP.

4.31 The police activity was described as indicating that the use of TCI was either not effective as a form of intervention or was not always being applied effectively in every circumstance.

4.32 In relation to the police call outs, RQIA were critical of the lack of managerial oversight. They commented that records noted police call-outs to the home could be to assist with the management of aggressive behaviour and restore order rather than necessarily to make an arrest. They also thought that incident records showed examples where the police were asked by staff not to arrest the young person. The managerial oversight or approval of this course of action was not evident from the records.

4.33 It was also not clear how the plan to involve the police with such frequency had emerged, or what the expectations were of police when they were called to the home. RQIA further noted that the Trust should ensure there was a clear process in place giving guidance for staff about the involvement of police at the home. It was noted that the involvement of police should be subject to greater managerial oversight and scrutiny at a senior level to ensure that it was justified and necessary and proportionate.

4.34 Following its inspection RQIA made two requirements with respect to 'safe care' within the CRH. Firstly, the frequency of police involvement at the home should be reviewed by the Health and Social Care Trust with a view to implementing a planned social work response to the challenging behaviour. Secondly, the medical condition of the young person should be assessed with a view to permitting or prohibiting the use of physical restraint.

4.35 The significance of this should not be underestimated. A regulation and inspection agency had to set out the frequent elements of Vicky's experience to the Corporate Parent. Even though the agency's attendance at the CRH was for – relatively speaking – a small window, they were far more familiar with the details than the Corporate Parent. The Corporate Parent should have remedied these matters already, without needing to be advised to do so. This example of an external agency advising the Corporate Parent is the equivalent of Health and Social Trust social workers directing birth or adoptive parents in the care of children. Except this was a role reversal for the Corporate Parent, who were being advised in how to care for their own child.

4.36 The report also made a requirement with respect to care being effective. The requirement was that the Health and Social Care Trust review both the ICMP for the young person and the application of TCI during episodes of challenging behaviour. There was a requirement made regarding the service being well led. This was that the Health and Social Care Trust should establish systems for increased evaluation and management of police involvement at the home. Within the 'Quality Improvement Plan' (QIP) issued by RQIA remedial action was to be completed no later than 31st March 2017. Those for the specific young person were no later than the end of February 2017.

4.37 Both RQIA and the Corporate Parent knew at the time of the noted report that there were issues of concern regarding ongoing care and conditions within the CRH. However, the pattern of police involvement continued. From 24th January 2017 onwards Vicky experienced multiple arrests, was remanded to a JJC, and then returned to the CRH. On many occasions the originating offence was a breach of bail and when police arrived Vicky then committed further offences as a 'fight or flight' reaction kicked in. RQIA did not do a follow-up inspection until September 2017, and their report did not appear to expedite the finding, by the Corporate Parent, of a more suitable setting for Vicky. Given the significance of what was found during inspection by RQIA, and the timeframe they set out for remedial action, it is striking that so much time was allowed to pass. This delay was a breach of statutory provisions.

4.38 The pattern of police involvement that developed, involving subsequent arrests and being remanded in custody, clearly had profound negative implications for Vicky's emotional and mental health wellbeing. It continued until March 2017. A GP record from February 2017 outlined that the CRH requested information on how a particular hold and/or restraint would impact on Vicky's asthma. The staff of the CRH had put in place TCI which included a form of hold/restraint. Given all staff would have had RTM training these TCI techniques should have been used effectively from Vicky's admission to de-escalate challenging behaviour, but they were only in use from January 2017. The GP also noted, after speaking with staff, the pattern of Vicky being sent to the juvenile court after every incident, and then subsequently spending time in the JJC. That staff and clinicians were aware of the repeated cycle of incident, arrest, remand, and bail but did not successfully act to stop it raises many concerns.

Adverse Finding 4.3: RQIA's failure to follow-up their recommendations in relation to Vicky or to conduct further inspections.

- It is clear from the records that there were multiple notifiable events occurring within the CRH;
- It is also clear from the records of the RQIA's reports of its unannounced inspections of the CRH, especially that of January 2017, that the RQIA recognised the issues that Vicky was facing and made clear recommendations on care, assessment, and staffing;
- The circumstances and duration of unsuitable treatment of Vicky while in CRH were not effectively monitored;
- Accordingly, the RQIA should have used it powers to conduct a further inspection of the CRH in February 2017 to ensure

that their recommendations had been addressed but instead it did not carry out an unannounced inspection until September 2017, by which time Vicky was being regularly moved between secure care and the JJC.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Regulation 29, The Children's Home Regulations (Northern Ireland) 2005;
- Article 35, The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Paragraph 3, Schedule 1, The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Juvenile Justice Centre

4.39 During the period from 23rd January 2017 to 28th June 2018, Vicky (aged 15-16 years old) had ten admissions to the JJC, the sole custodial facility for children in Northern Ireland. Her stays ranged from between one day to 135 days. In total, she spent 408 days of a period of 521 days (78.3%) in the JJC, all on PACE or remand, never as a sentenced offender. Her offences consisted of assault, resisting arrest, breach of bail, disorderly behaviour and threatening to destroy property. During most of her time in the JJC Vicky had been granted bail but a lack of suitable accommodation meant that she was unable to perfect it.

4.40 Whilst at the JJC Vicky spent approximately 80 days in single separation and some form of force was used against her on over 20 occasions, most of which were in an attempt to stop her self-harming. There were multiple attempts at self-harm which mainly consisted of swallowing items.

4.41 During her first few admissions in early 2017, Vicky's general health was good and she was involved in education and activities at the JJC. A Youth Justice Agency (YJA) assessment stated that she had good levels of self-worth, however there were comments made that she was confused about her life story and that she craved attention from her Mum. The outcome of CAMHS assessments for Autism Spectrum Disorder (ASD) and IQ were outstanding around this time. In February 2017, it was recorded that Vicky's Mum believed Vicky's offending escalated due to the CRH.

4.42 During her fourth admission, it is concerning that within a pro forma LAC Review document, the Corporate Parent marked a box confirming that all tasks identified in the care plan were being undertaken in this placement. They also marked a box confirming that the placement could be described as 'stable.'

4.43 In February 2017 a social worker was aware that that the court had directed the Corporate Parent to find more suitable accommodation to meet Vicky's complex needs and in turn reduce the need for police involvement and further JJC admissions. It should be noted that the court advised the Corporate Parent of the need for other accommodation, not the other way around. The Corporate Parent was also made aware that community paediatric opinion was that Vicky was much too vulnerable for JJC.

4.44 In April 2017 clinical opinion was that Vicky's presentation was more in keeping with somebody who had a learning disability.

4.45 It was clear by Spring 2017 that there was a risk of regular admissions to the JJC, but despite the court's direction Vicky ended up back in custody and this admission would be for 77 days, finishing on 8th June 2017.

4.46 There were on-going discussions regarding securing alternative and affordable accommodation for Vicky and her Mum and in June 2017 they went to a new residential setting. However, following a serious assault on a family support worker, Vicky returned to the JJC later that month.

4.47 By June 2017 a Child Psychiatrist stated that Vicky did not have a mental health issue but still suggested that a complete reassessment (including bloods and EEG) be undertaken. These tests were completed and found to be all clear. There was agreement that Vicky did not meet the criteria for mental health or learning disability but a recommendation was made that she needed extensive support.

4.48 For some time (November 2016 – June 2017) educational professionals struggled to get information from social workers within the Corporate Parent, and the JJC and YJA had difficulty in getting a copy of her Statement. This raises the question of why the Corporate Parent did not provide a copy upon admission to the JJC.

4.49 There were a range of e-mail communications between July and September in which the Corporate Parent enquired as to further clinical assessments. During these exchanges staff at the JJC appear to have become quite frustrated regarding the fragmented approach to Vicky's care and her prolonged stay there. In an email of 25th July 2017 the Corporate Parent recognised that the JJC was not appropriate for Vicky and accepted the need for a sustainable plan that did not include a return to her Mum as any plan involving living with her Mum was unlikely to succeed. JJC records of the same month show that single separation had been used for Vicky in response to disruptive behaviours at night, such as playing loud music and inciting other people. While guidance clearly defined the purposes and boundaries of seclusion as not being for punishment, this principle was not being followed in a manner that would be expected in such a facility.

4.50 A psychological assessment was completed of Vicky in July 2017 to assess cognitive ability, together with social, emotional, and behavioural presentation. During the assessment Vicky commented that she had asked for counselling four years ago because she believed she was deteriorating but nobody had helped her. She also commented that she had asked again but still nothing was done. Her intelligence level was found to be well below average, a full-scale IQ of 56, and Vicky was assessed to be demonstrating a lower than average self-concept. Her working memory was also well below average and it was noted that individuals with poor working memory may lose track of what they are doing or forget what they are supposed to do.

4.51 The assessment stated that Vicky's behaviour should be interpreted from the perspective of an individual with Foetal Alcohol Spectrum Disorder (FASD), who are likely to be prone to impulsive aggression. With regard to engagement with other people, it was noted that, while Vicky's view of relationships with professionals had become extremely negative, she nevertheless appeared to be open to working with professionals as long as this was done on a partnership

basis and she had input into what was happening. It would be reasonable to expect that such clinical conclusions would form the basis of behavioural and other individual management plans for Vicky thereafter.

4.52 In July 2017 care staff recorded that Vicky was asking why people kept trying to find something wrong with her. At a LAC Review in the same month the chair noted the lack of attendance by professionals from the Corporate Parent. The chair further noted the complexity of the case and the need for more professionals to be present. An assertion was made that social workers were however meeting more with Vicky than was statutorily necessary. This confirmed an approach of referring to action rather than outcome. The important issue was not that Vicky had not been visited, but rather that relevant professionals were needed at decision making meetings. When the JJC tried to contact the Corporate Parent in August 2017 they had considerable difficulty doing so. A member of JJC staff recorded they had struggled to obtain information from social services for a period of ten days.

4.53 At a social work meeting in August 2017 an independent psychological assessment indicated a cognitive age of six or seven years of age. There was also comment from another professional that Vicky worked in a sensory way. There is evidence of continual, and in some cases half-hearted, attempts at assessment. In September 2017 the Corporate Parent noted their intention to develop a 'Signs of Safety Plan' for Vicky and that doing so required some preparatory work before meeting Vicky and her Mum. In the related correspondence it was recognised that this work should have started in July when Vicky went into the JJC, but the author would 'pull' some of it together. However, three days later a further e-mail was sent informing that the professional meeting for Signs of Safety was cancelled as more work needed to be done. This is yet another instance of planning lacking coordination for targeted purposes.

4.54 In other emails in September an advocate on behalf of Vicky sought confirmation of what support would be put in place for her. They also noted that Vicky was very distressed by her situation and did not know what was planned for her. There was explicit comment that people working with Vicky expressed concern that her continuing to remain in the JJC had severely impacted upon her emotional well-being. Correspondence from the same time notes Vicky commenting that if she does not get the right help her mental well being could decline in future.

4.55 On Vicky's eighth admission to the JJC she stayed 135 days; this was her longest admission. At the Initial Planning Meeting on the 6th November 2017 it was suggested that there may be gaps in assessments or some key work that might have been missed. There had been a Neurodisability Assessment in October 2017 but it was decided that no further action was required as other professionals were already involved. At the end of November 2017 an Occupational Therapist believed that some of Vicky's difficulties arose from early childhood trauma and insecure attachment history. This Occupational Therapist believed that Vicky's prolonged stay in hospital for the first ten months of her life, without the usual nurturing from a parent, would have affected brain

development. The Occupational Therapist also believed Vicky was, as a result, in constant 'survival mode' (flitting between fight and freeze) and found it hard to engage in approaches on a cognitive level, forward planning, and working with consequences and rewards. There was further comment that Vicky appeared to be using short-term strategies that gave predictability and safety in order not to feel anxiety.

4.56 At a case review meeting in early December 2017 it was noted that the residential placement was not working for Vicky, so her social worker was looking at an out-of-trust placement, although no decision had been made yet. Also in early December 2017 a family support worker visited Vicky and, in an email, reported that Vicky appeared downhearted and did not want to be in the JJC. Vicky asked him if he knew where she was going to live and replied that he did not. Vicky responded stating that wherever she lived needed to be close to her family for her to feel safe and secure. Vicky had discussions around how she wanted and needed to be part of her family in order to feel safe. Vicky wanted to go home at Christmas for a few hours.

4.57 By the end of 2017 social services accepted that they needed a broader understanding of Vicky's situation and her life story. Her social worker stated in an e-mail that she would attempt to draft a timeline for Vicky's history but envisaged that this would be very difficult as she was unable to locate some earlier files. They also wrote of having to use Google to inform themselves of terminology used in discussion of Vicky's diagnosed conditions. Not only had information not been properly collated and retained but decision makers did not have immediate (or at least easy) access to it. Thus no progress had been made since Vicky was in the CRH and insufficient paramountcy was given to her basic needs.

4.58 By end of December 2017, Vicky had been seen by a clinician who assessed her IQ at 56 and stated that she did not have capacity. Contact was to be made with an external advocacy group in this regard.

4.59 Correspondence between professionals at the end of December 2017 noted an assessment conducted on information from a number of sources, which identified Vicky's IQ as 86. It was hypothesised that the anomaly between this and an earlier rating of 56 arose from the different assessments being used by educational compared to psychology practitioners. It is not clear whether the Corporate Parent sought clarification of this, which would have been relevant for a planning meeting in November 2017 with the YJA. During that meeting there was discussion that an IQ of 86 indicated Vicky did not have a learning disability. There is a question of whether decisions were made on that basis.

4.60 This situation shows that a lingering uncertainty as to what exactly (or perhaps instead the full extent) Vicky's cognitive difficulties and/or diagnosis were. This was of crucial significance for all decision makers in Vicky's life, but somehow the Corporate Parent had not got it clarified. This also raises considerable questions as to partnership between different agencies in the sharing of information, which becomes apparent from correspondence dated January 2018.

Adverse Finding 4.4: Failure to view custody as a last resort.

- It is a fundamental principle in the care of children that the deprivation of a child's liberty must be a last resort, yet this principle was not applied by the Corporate Parent in relation to Vicky;
- Vicky was granted bail but nonetheless, through the failure of her Corporate Parent to find a suitable alternative, she spent 408 days out of 521 in a custodial setting and was deprived of her liberty in secure care for another 32 days meaning that in total Vicky was deprived of her liberty for 84% of that period;
- The Corporate Parent knew of the extent to which Vicky was being deprived of her liberty and the conditions and circumstances in which she was held. This included being in a setting explicitly commented upon as being unsuitable for her, in which she was self-harming, while there was ongoing discussion as to her capacity and learning difficulties.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 37, United Nations Convention on the Rights of the Child;
- Article 3, European Convention on Human Rights;
- Article 8, European Convention on Human Rights.

Communication and Partnership Working

4.61 There was evidence of deterioration in Vicky's mental health at the end of 2017 and beginning of 2018, with increased incidents of self-harm, such as application of ligatures, head banging, and other behaviours. In response special glasses were provided to her and potentially dangerous items of clothing removed. She was also exhibiting sexualised behaviours which were considered to be out of character.

4.62 In January 2018 JJC staff were provided an individual management plan devised under clinical direction. This included purchasing a doll for Vicky, but she was only to be given it when she presented as 'settled'. It is questionable whether sensory deprivation was appropriate, given that Lord Carlile of Berriew QC advised that 'time out' should never be used for more than a few minutes.[62] Later in the same month JJC care staff were advised by a doctor to adhere to an individual management plan that included minimal interaction with Vicky. At the same time, professionals were also noting the possibility of a Judicial Review in respect of Vicky (although it is not clear who was proposing such a course of action).

4.63 In parallel to this was commentary from professionals working directly with Vicky noting that Vicky had poor insight into her rights and legal matters and she had trouble understanding basic questions, never mind bail conditions. It was also commented that a Wechsler Intelligence Scale for Children (WISC) assessment had been performed in May 2017, the results of which were received by JJC staff in November 2017. Reference was made

62 Carlile Report, Recommendation 41, https://howardleague.org/wp-content/uploads/2016/03/Carlile-Report-pdf.pdf

to an IQ of 56 and there was confusion as to how this information had been on file since July with nothing being done. Commentary went further to suggest that the report was almost ignored until Vicky's new '16+' team were asked if they could find the records. The report was described as comprehensive and confirmed an IQ of 56.

4.64 In respect of these matters a psychiatrist was reported as highlighting the detrimental impact of a child as vulnerable and complex as Vicky being involved for so long with a juvenile placement. She was described as having limited understanding of what was happening around her and was beyond the remit of the JJC. There was an assertion that the JJC was at times at a loss as to how to manage Vicky as many of the staff did not have skills or knowledge in relation to her level of learning disability.

4.65 It was explicitly stated that Vicky should not have been in the JJC in the first instance, let alone for almost a year. An experienced member of staff commented that they had previously worked with young people with similar needs to Vicky and they were managed by skilled and trained staff in a specialised environment. The correspondence ended by noting that by 23rd January 2018 Vicky would have spent 289 days in a JJC, while young people committing more serious offences would receive shorter sentences.

4.66 On 18th January 2018 professionals involved with Vicky were party to correspondence discussing that, despite social services having had almost three months to find a placement for her, no progress had been made. There was more comment that Vicky was assessed in July 2017 as having an IQ of 56 and the resulting report was shared with social services, who then had responsibility to arrange appropriate referrals. It was considered by care staff and other professionals working with Vicky that, had this been progressed appropriately, the situation for Vicky would have been considerably different at this point. It was also mentioned that social services had not been attending Vicky's court hearings. This sums up the nature, structure, outcome, and efficacy of the planning which had resulted in Vicky being admitted into the CRH, everything that happened subsequently, and much of what happened after the date the comment was made.

4.67 Also on 18th January 2018 a Consultant Psychiatrist working in the JJC wrote to the Corporate Parent noting that Vicky had been detained in the JJC for far too long. At that point she had been there for approximately 290 days, which was equivalent to a custodial sentence of approximately 18 months – a sentence usually reserved for serious offences. This clinician explicitly expressed concern as to serious difficulties arising if advocacy bodies for children and young people, namely NICCY and the Children's Law Centre, became aware of her situation.

4.68 The Consultant Psychiatrist also referred to the assessment of Vicky's IQ as 56 putting her within the Learning Disability range, and that despite this knowledge, little had happened in relation to a referral. They expressed frustration at the lack of progress and the number of steps required to move her into the care of Learning Disability services and recommended in the strongest terms that Vicky should be moved within the week to a residential unit for young people with a learning disability.

4.69 They noted that the implications of the recent assessment of learning disability and the suggestion of mild cerebral instability identified through an EEG should be addressed and responded to before any decisions were made about an Extra Contractual Referral (ECR) (An ECR being a transfer, upon medical request, of a patient to outside Northern Ireland for assessment or treatment which is not available within Northern Ireland) which could be both inappropriate and extremely costly. They also made clear and explicit comment criticising the length of time that had been taken by agencies to respond to confirmed information, including to perform further assessments. The reply sent by the relevant social worker confirmed that no young person should be in the JJC any longer than necessary.

4.70 It is hard to exaggerate the significance of this. A clinician explicitly stated that:

- Vicky had been detained too long in a custodial setting;
- already confirmed needs had not been attended to after the passing of considerable time;
- the Corporate Parent had allowed unnecessary delay;
- there could be resulting difficulties with relevant agencies; action must be taken immediately; and
- planning to date, including potentially sending Vicky out of Northern Ireland by way of ECR, was being done without reference to all necessary information (with potential waste of public health service resources).

4.71 It is notable that there was such a focus by the Corporate Parent to get Vicky out of Northern Ireland without knowing if that was the right thing for her, or what needs in general any setting she was to be placed in should have regard to.

4.72 The letter from the Consultant Psychiatrist, stating that Vicky needed to be moved from the JJC without any further delay was another 'red flag' that should have prompted a multidisciplinary risk management planning meeting. There should have been weekly meetings with key professionals, involving psychiatric practitioners, social workers, and JJC staff to develop a plan. This should have been requested by senior management regardless of when the next LAC Review meeting was due to be convened. Indeed, Vicky's age and the risks at JJC should have been a prompt to a child protection conference being convened.

4.73 In the absence of Vicky being moved out of the JJC within the week as the Consultant Psychiatrist had urged, and in the absence of any multidisciplinary meetings to progress this recommendation, further correspondence between clinicians a week later confirmed that she should not be in the JJC. This also reflected on the lack of support from the learning disability system for Vicky. There was no explanation of why these supports had not been offered earlier.

Adverse Finding 4.5: Lack of information sharing or partnership between agencies.

- During the 18 months between January 2017 and June 2018 Vicky had ten admissions to the JJC and during that period there are numerous examples of poor communication, collaboration and coordination between the relevant authorities, particularly the Corporate Parent not responding to appeals from the YJA to find alternative accommodation;

- Each of the relevant authorities had a duty to cooperate with each other in the interests of Vicky's well-being;
- The poor communication between agencies and continual confusion regarding her IQ, whether she had a learning disability, and referrals to mental health services, all contributed to the unacceptable delays in the adequate care and treatment of Vicky. At the same time there was seemingly no regard for capacity assessment obtained by Vicky's legal representatives;
- Save for the initial move to the SCH from the JJC, there is no evidence that any of the subsequent moves from the JJC were being carefully planned as was required. Rather evidence shows little continuity of care and minimal communication between agencies;
- The WHSCT, as Vicky's Corporate Parent, did not fulfil its role of ensuring that those responsible for her day-to-day care had the basic knowledge of her needs and, therefore, were able to meet them;
- Multiple professionals were advising that Vicky was vulnerable, and more work needed to be done, but there is no evidence of any response being properly thought through and planned. The severity of this was such that a clinician explicitly advised the Corporate Parent in writing that they (the clinician) expected action to be taken urgently by the Corporate Parent.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 46, The Children (NI) Order 1995;
- Paragraph 2.4, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 1.15, Paragraph 2.3, Co-operating to Safeguard Children, May 2003;
- Article 20, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 8, United Nations Convention on the Rights of the Child;
- Article 14, European Convention on Human Rights.

Somewhere to Live

4.74 Near the end of January 2018 Vicky was assessed by a consultant child and adolescent psychiatrist to formalise a diagnosis of an ID, to further inform placement decisions and determine what therapeutic supports were needed. The report noted concern that she was inappropriately placed in the JJC. The psychiatrist noted that JJC staff thought Vicky was very stressed by uncertainty around her living arrangements and that she stood out among her peer group in the JJC as being much less able and more vulnerable both in terms of her social functioning and intellectual ability. Vicky was described by this psychiatrist as having become increasingly emotionally dysregulated in her adolescence.

4.75 It was further stated that when Vicky was asked what her worries were, the only thing she could think of was where she was going. The psychiatrist reported that a consistent theme throughout

the appointment was Vicky's sense of hopelessness, that everyone had abandoned her, and no one cared about her. When asked to name one person she would take with her to a desert island, Vicky replied that she would go by herself. There had been a significant decline over the previous five years in her cognitive abilities.

4.76 The clinician further noted that the JJC did not appear to be the right setting for Vicky, whose main requirement at that point was for a stable base with tight structures, boundaries and routine in a therapeutic milieu informed by attachment and trauma theory. It was noted that this was unlikely to be achieved outside a secure setting. The psychiatrist commented that while in the JJC, Vicky was mimicking behaviours of other young people and that her difficulties were in keeping with FAS, learning disability, developmental trauma, and emotional dysregulation.

4.77 The assessment stated that Vicky would not meet criteria for detention on grounds of mental illness or severe mental impairment as she had a mild learning disability. She was not clinically considered detainable under 'The Mental Health (Northern Ireland) Order 1986' (MHO (NI) 1986). The report suggested that a bespoke individualised placement might be an option for Vicky, but that it could entail a Declaratory Order if she was not being cared for in an established secure residential setting. The clinician worried how this would be achieved in the time frame necessary to accommodate Vicky.

4.78 The possibility of an ECR was noted. The report concluded by noting that a request would be made for Vicky's name to be added to the Trust's Master Patient Index for Learning Disability Services. There was no indication of why that had not been done earlier.

4.79 Despite earlier clear clinical advice and recommendations that Vicky needed to be in a different setting, and commentary from court as early as February 2017 (before Vicky's presentation had declined as badly as it did) the Corporate Parent had not moved her to such. While clinical advice noted the potential inapplicability of the MHO (NI) 1986, as well as the delay a Declaratory Order might have entailed, neither of these are justification for inactivity. Instead, questions arise as to why statutory authorities had not done more to develop secure residential settings, including for the wider community, in response to the implications of the MHO 1986 and the care needs demonstrated by Vicky's story.

4.80 There is no explanation of why, given her FAS diagnosis from an early age, Vicky had not had access to Learning Disability Services. She only now had access to supports and interventions she might have been eligible for many years earlier. If her access to Learning Disability Services had arisen because a decline in ability, that otherwise raises a question of what impact traumatic experiences had in causing such a decline.

4.81 There appears to have been a lack of partnership and/or collaborative working in terms of her diagnoses and appropriate intervention which might have prevented the deterioration in her situation. The 1995 Order principles of Parental Responsibility, protection, prevention, paramountcy, and partnership had not been adhered to. The 'Children's Services Cooperation Act

(Northern Ireland) 2015' (CSCA 2015), which was put in place to strengthen cooperation between agencies was not being given due attention.

Adverse Finding 4.6: Failure to find alternative accommodation and to plan.

- At this time the Court was directing the Corporate Parent to find more suitable accommodation for Vicky but it was not until January 2018 that the Corporate Parent appears to have made serious efforts to find alternative accommodation for her;
- By this time there are clear signs that Vicky's mental health had deteriorated, which should have caused her Corporate Parent to make strenuous efforts to find alternative accommodation but there is no evidence of it doing so;
- Throughout this period, there are examples of delay and missed opportunities, which amounts to both a failure to plan for a vulnerable child and neglect.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 72, The Children (NI) Order 1995;
- Paragraph 7, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 20, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 28, United Nations Convention on the Rights of the Child;
- Article 37, United Nations Convention on the Rights of the Child;
- Article 40, United Nations Convention on the Rights of the Child;
- Article 5, European Convention on Human Rights;
- Article 6, European Convention on Human Rights;
- Article 8 European Convention on Human Rights.

Care planning

4.82 A Corporate Parent report dated 8th February 2018 for the purposes of updating the court confirmed that Vicky met criteria for secure accommodation, but that no beds were available for her. On the same date as the above update to court, a LAC Review was held which, again, raised concerns that Vicky was inappropriately placed in the JJC. It was also reported that, since Vicky had been admitted to the JJC in October 2017 there had been 37 known incidents in which she had either considered or carried out self-harming behaviours. The problem of a bail address was again identified.

4.83 Such concerns were raised by JJC staff, one of whom noted that the length of time Vicky had spent in the JJC was much longer than any sentence Vicky might receive if convicted for the charges pressed against her. A member of JJC senior management reinforced this point. A senior figure within the JJC had also approached the Corporate Parent to discuss Vicky's circumstances, and a member of JJC staff also raised concerns

regarding Vicky's fitness to plead within the criminal matters brought against her. It was noted that bail had recently been granted – subject to a suitable address being found.

4.84 Two pieces of paperwork were completed for this meeting. One included pro forma layout with 'Yes' or 'No' boxes to confirm if day-to-day needs were being met with regard to health, education, disability, and contact. The 'Yes' box was ticked for all of those issues. There were also options for describing the placement, and that of 'stable' was selected. There had been options for 'fragile' and 'approaching breakdown'.

4.85 Such representations as to the suitability of the placement do not reflect the views of the multiple professionals that had engaged with Vicky over the previous weeks and raise the question of how and why they were accorded. They stand in contrast to other commentary within the documentation for the same LAC Review noting that the court had advised that Vicky needed an appropriate placement. This was an insufficient exercise of Parental Responsibility. It is also notable that staff and management within the JJC, an arm of the YJA, were to all intents and purposes advocating for Vicky in a manner her Corporate Parent was not, and that some of this advocacy was done to that same Corporate Parent.

4.86 The significance of this should be noted, because an agency of the criminal justice system advising the Corporate Parent that Vicky's ongoing issues of living arrangements and capacity needed attention. The criminal justice system was thus advising the Corporate Parent to take action that they (the Corporate Parent) should have already taken.

4.87 In early March 2018 a Restriction of Liberty Panel reviewed and confirmed documentation in respect of the Corporate Parent's application for secure accommodation. Vicky's date of birth was incorrectly noted in this, showing a lack of attention to detail and record keeping. Commentary of Vicky's care plan noted that she needed to be provided with therapeutic support within a contained/secure environment suitable to her complex needs. In the absence of such a facility being readily available, the Corporate Parent would need to be 'creative' in their approach. Vicky was also described as needing education and consistent care with minimal staff change.

4.88 This documentation also described objectives to be achieved during secure placement, including Vicky having an opportunity to increase her insight into her 'risky behaviours' and recommitting to education. It was also noted that Vicky was inappropriately placed within the JJC. In considering her ongoing placement, it was decided that, due to Vicky's behaviours, a placement in the SCH would assist in breaking the cycle and support the transition to a more appropriate placement to meet her very complex needs.

4.89 These comments by decision makers demonstrated a lack of insight into Vicky's situation and background as there was no presented evidence of why everything that had been tried or done to date had not improved her circumstances. There was no corresponding quantification of how the objectives would otherwise be achieved, despite an acknowledgement that what had been tried to date brought no tangible benefit. What was agreed did not constitute a 'plan' but a list of aspirations with no detail of how they might be achieved.

4.90 The same document referred to discussions in October 2017 of placement options. Consideration of various potential options was done in a manner suggesting they were noted simply to explain why they could not be pursued. These included foster care, which was not an option because of her recent behaviour. Residential care was not feasible for the same reasons. None of the private care options that had been considered were feasible. Vicky was not deemed ready for supported living either. Reference to secure accommodation was simply to confirm that Vicky had been assessed as a significant risk to herself and others. There was no discussion of what secure accommodation options had or would be considered.

4.91 When considering potential accommodation options, that of supported living was ruled out because in such a setting Vicky would need a qualified team of professionals and it was stated that this level of support was not available within a supported living environment. There was no discussion of creating a bespoke arrangement tailored specifically for Vicky. Discussion of such an arrangement could have included basic exploratory work of when and where such a setting could be developed, to include the nature of therapeutic work, clinical engagements, education provision, and staffing. This was not suggested. The document did though clearly state that Vicky was inappropriately placed in the JJC.

4.92 Vicky resided at a SCH from 9th March 2018 until 17th March 2018. When the decision is made to place a child in secure accommodation, an exit strategy should be identified. There should also be clarity as to what will be done during that placement to reach the aspired exit. Care planning and exit strategy need to be attuned, because a child should not be in secure accommodation for any longer than necessary. Consideration is needed as to whether a placement would be conducive to well-being and how needs would be met. However, in this instance, the motivation of the proposed placement was that there was no other appropriate place for her to go. At the same time the ambiguity in sharing of information was further apparent when professionals were not sure what information could be shared with Vicky's Mum given her lack of PR.

4.93 Professionals who met less than a week after the Restriction of Liberty panel meeting commented that the current 'goal' within the SCH was to offer safety and 'emotional containment' and that no therapeutic work would be offered until Vicky was in a long-term placement. The same document acknowledged that Vicky had experienced a lot of loss in her life, including recent short-lived placements. There were contemporaneous indications that staff in the SCH had raised a perception of the lack of consequences in place on Vicky's part. This resulted in discussions regarding Vicky's ability to process information and that consequences have little impact. Such information was to be reiterated across the team of staff.

4.94 A query was raised as to whether SCH staff were replicating the one-to-one sessions Vicky had been having in the JJC. This could not be answered, because the relevant professional within the SCH had not been aware of this practice. In correspondence where this was recorded there is also comment that Vicky had asked a psychiatrist involved with her care why she presented and behaved as she did. In a clinical assessment soon

after there was further discussion that a lot of Vicky's behaviours were learnt and that she needed a lot of sensory activities.

4.95 After another youth court attendance, Vicky was remanded to the JJC in mid-March 2018. At a care planning meeting in the following days there was explicit comment that the SCH had difficulty with confinement in compliance with RQIA guidelines. It was noted that the JJC was a custody environment where staff were not trained to manage complex trauma and learning disabilities.

4.96 A clinical psychologist's report obtained in March 2018 noted that Vicky was highly dependent upon the care of adults and fell with an extremely low range in terms of adaptive functioning. Professionals within the SCH compiled a court report to be presented in proceedings scheduled for 29th March 2018. It detailed a substantial list of significant behavioural problems displayed by Vicky since admission to the SCH. The report explicitly advised the court that neither the SCH nor the JJC was an appropriate setting for Vicky. It was highlighted that, at a Care Planning Meeting during 23rd March 2018, it was widely acknowledged that a long-term placement was needed urgently to meet Vicky's therapeutic needs and allow positive progress. The report further remarked that the lack of a suitable placement to date was concerning, and that placing her in the SCH was not in her best interests.

4.97 In key work session notes later in the same month there was record of Vicky asking her keyworker if her (Vicky's) behaviours had got worse. In the same conversation she commented that she didn't see the point in being good sometimes as it didn't get her anywhere; and also asked if she was going to be put in a mental hospital, which was reported as something she had asked in earlier sessions. She described herself as a "nutcase" and again asked why she was like that. Vicky had these fears due to what she had been told by a clinician. In reply she was told that hospital is a place for people who are unwell and was assured that it was ok to feel stressed, overwhelmed and scared and this did not make her a bad person. Visits from professionals were noted as causing her anxiety.

4.98 A Youth Justice Assessment record in late March 2018 noted that Vicky's living arrangements were a significant factor in the risk of further arrest. There were also concerns regarding the amount of time Vicky had spent in the JJC, and the risk of being further traumatised. The JJC was noted as meeting Vicky's most basic needs but not fundamental needs in relation to trauma and learning disability. There was explicit comment that models used in a custody environment did not work with Vicky due to her understanding and vulnerability. There was also comment that Vicky was simply being contained day by day. Her prolonged stay in the JJC was thought to have likely resulted in some degree of institutionalisation.

4.99 In a multidisciplinary meeting on 6th March 2018 concerns were widely shared regarding how long Vicky had been in a secure environment without addressing her long-term therapeutic needs. It is impossible to read the above as anything other than professional comment that relevant agencies did not heed advice received and delayed in acting. The effect was to make matters worse for Vicky. Urgent action was needed and clinicians were explicitly telling the Corporate Parent to take action without delay.

Suitable Options

4.100 When a Secure Accommodation Order application was brought before the court on 29th March 2018 the presiding judge declined to grant it. A later report stated that, at three Care Planning Meetings in March 2018 and April 2018, it was recognised that Vicky urgently required a long-term placement in order to meet her therapeutic needs and allow her to progress to positive outcomes in the future.

4.101 At a care planning meeting during 6th April 2018 it was apparent there remained a lack of clarity as to a potential bail address for Vicky. It was noted that therapeutic work was not being carried out with Vicky in the JJC or the SCH because containing her safely was the main goal until a community placement was identified. Some staff were struggling to cope with Vicky as they were not trained for her needs. It was explicitly noted that there was a shared concern among all professionals that Vicky would be in the SCH or JJC for longer than necessary and that she might be re-traumatised by placement moves.

4.102 There was consideration of whether a new legal team (as appointed by the Corporate Parent) might be needed and whether Vicky had capacity to instruct a solicitor. This meeting also discussed a further meeting scheduled the following week at Corporate Parent director level regarding an appropriate placement. It is unclear if this meeting was held. It can reasonably be concluded that although the Corporate Parent appeared to recognise their responsibility to this child at a senior level that did not result in action that improved her situation.

4.103 Vicky was sent to the SCH again for the period of 19th April 2018 – 12th May 2018. She was readmitted to the JJC in May 2018, by which time there were plans to make bespoke arrangements for her care. These included a plan to give her more space in a residential unit where there were no other young people. However, further assessments were awaited from a Forensic ID Consultant from England. There was also comment from Vicky that her behaviour was caused by being bored.

4.104 File records show that at this time a team leader at the JJC believed Vicky should not return to the JJC and that staff in the SCH should have managed Vicky's behaviours instead of recently asking for help from police. The team leader was also frustrated by bail arrangements and the short timeframe for Vicky's return to the JJC. This record noted that there were concerns raised that Vicky was entering into the same cycle of moving between the JJC, to the SCH and then back to the JJC, and that the JJC could not keep Vicky safer than if she were in the SCH. Apparent from such a comment is how widely perceived was the difficulty of Vicky's circumstances and the significance of her accommodation within the cycles of her presentation.

4.105 Daily records showed that Vicky commented that SCH staff had told her they were tired and needed a break from her. She was also asking questions regarding her care arrangements, angry and frustrated by related uncertainty, and further queried why doctors were frequently attending but were unable to tell her why she was being held or where she was going. A court report in May 2018 made clear that Vicky had been cared for in a secure environment without addressing her long-term therapeutic needs and the author commented that a suitable placement should be identified with haste. On several occasions Vicky had voiced that she did not wish

to remain at the SCH and exhibited frustration around not being able to move forward into a long-term placement. The court report also stated that it was apparent to staff that the lack of a long term placement caused Vicky significant anxiety as she regularly questioned staff around where she would be living following her time at the facility. It was also noted in the report that Vicky's wishes were to live in a house with staff by herself with no other young people present. This shows there can be no question of how widespread these difficulties were, or at least they should have been, known.

Adverse Finding 4.7: Failure to protect Vicky.

- The Trust failed to consider Vicky's situation in the context of her FAS, learning disability and mental health needs. Despite knowledge of these conditions deteriorating, the Corporate Parent failed in their duty to prevent this decline;
- Despite a report from the SCH in March 2018 explicitly advising the court that neither the SCH nor the JJC was an appropriate setting for Vicky, the Corporate Parent failed to take the necessary steps to place Vicky in an environment conducive to her health and well-being;
- The Corporate Parent knew, or should have known, of Vicky's needs and circumstances, yet in March 2018 it considered it appropriate to seek a Secure Accommodation Order to enable her to be placed in the SCH; an application that was subsequently denied by a Judge;
- Despite the apparent widespread acceptance that Vicky's circumstances were in urgent need of remedy, there is no evidence of such a response from the Corporate Parent;
- The evidence suggests the Corporate Parent appeared to recognise its responsibility to Vicky at the highest level, yet it failed to turn those words into actions that progressed her situation.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Paragraph 7, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.4, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 19, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 24, United Nations Convention on the Rights of the Child;
- Article 25, United Nations Convention on the Rights of the Child;
- Article 3, European Convention on Human Rights;
- Article 8, European Convention on Human Rights.

Understanding the Child

4.106 In May 2018 a social worker was recorded as commenting that they believed senior figures within the Corporate Parent were aware of Vicky's case and that they should be attending core group meetings in respect of such. A broad range of professionals in different settings were worried by what was happening. Some were so concerned that they wanted to speak with the judge involved with Vicky's court matters. This indicates a lack of partnership at both an intra-agency level within the Corporate Parent as well as at an interagency level. In the meantime, Vicky was repeatedly being moved between the JJC and the SCH around this time.

4.107 The above matters should have been given more attention by the Assistant Director with responsibility for LAC, who in turn should have been briefing the Director. Consideration could have been given to making the Health and Social Care Board (HSCB) aware of matters, with a possible resulting referral to the Department of Health. There was also a question of what staff within the JJC were doing to bring attention to this situation. While it cannot be definitively confirmed what outcomes from such referrals might have been, the failure of this to take place prevented Vicky from potential benefits had they done so. This could have included more appropriate placement, provision of service, and targeted planning.

4.108 CSCA 2015 was applicable at this time, requiring cooperation amongst public authorities for the well-being of children and young people. Some of the areas which this legislation includes are 'well-being' including physical and mental health, learning and achievement and living in safety with stability. All agencies involved with Vicky's care and accommodation at this time were governed by this legislation. Yet these two agencies continued to work separately.

4.109 In May 2018 the JJC queried with the SCH why they called police (due to self-harm instead of offending behaviour) and were told that this approach had been taken as it had been used the night before and proved effective. When a member of the JJC staff asked whether this could have been resolved without involving police, the relevant person within the SCH refused to be held accountable by a member of staff from another agency. This raises questions of both collaboration and training. After the history and impact of this within the CRH, it is of concern that the Corporate Parent did not raise issues with police involvement in behavioural management.

4.110 The lack of understanding on the part of staff directly involved with Vicky's day-to-day care suggests that the Guidance was not being followed. This sets out that managers:

> *'must ensure that their staff are familiar with the relevant histories of children for whom they have responsibilities. Staff should take this into account in deciding how they respond to a child, and in making judgements about appropriate interventions. This history should be noted in care plans which may include agreed approaches to the control of individual children who present particular behaviour difficulties.'*[63]

4.111 Utilisation of police when methods of RTM were available echoes Vicky's time in the CRH. It is all the more concerning

63 Guidance, Vol. 4, para 4.8.

that this measure was used when it patently failed in the CRH and led to Vicky's long period of accommodation in the JJC and the SCH. The Corporate Parent were aware of the reliance on the police in the CRH and did not take steps to intervene at that time.

4.112 Vicky's experience within the CRH, JJC, and SCH should be considered as part of a single system of care. The repeated use of arrest while Vicky was at the JJC was seamlessly replaced with 'single separation' despite moving to more specialist accommodation at the JJC.

4.113 In middle of June 2018, psychology advice was that Vicky should have more activities. Vicky was at the same time describing herself as being bored and said that sometimes she self-harmed because of that. During the last week of June 2018 staff recorded Vicky's continued deterioration. Again the JJC appeared to have been left by partner agencies to support a very vulnerable young person. There were concerns about an emerging psychosis and about the risk only being manageable in a hospital setting. Attempts were made to ascertain if bespoke nursing care within the JJC would be an option, however they were unable to access nursing support via an agency.

4.114 Much of the difficulty with Vicky being held in custodial settings is that it never seems to have been treated as an option of last resort. Instead, it was used as a de facto care setting for this highly vulnerable young person. Courts respond to alleged law breaking and in doing so can impose bail conditions, while investigating and responding to those matters is ongoing. Responding to those bail conditions, including by way of finding a suitable bail address, was (in this instance) the responsibility of the Corporate Parent.

4.115 Use of custodial environments for residential purposes ran counter to Recommendation 38 of the 2012 Northern Ireland Law Commission's report on bail in criminal proceedings, which states that 'bail legislation should prohibit the detention of children and young person's solely on the grounds of a lack of suitable accommodation.'[64] This though is exactly what was happening to Vicky, because a lack of suitable accommodation meant she stayed in a facility which did not serve her needs and arguably made them worse. Article 37 of the UNCRC directs that a child should not be subject to imprisonment without the possibility of release and depriving the child of their liberty should only be 'used only as a measure of last resort and for the shortest appropriate period of time.' Furthermore, her time on remand at the justice facility breached Article 5 of the ECHR right to liberty and security.

4.116 The JJC did manage Vicky's behaviour however there were still risks, ranging from excessive medication to improper use of isolation. It was very limited in meeting Vicky's mental health needs. The JJC was fundamentally inappropriate for Vicky, and this was indeed recognised by the JJC when they stated that they were simply containing her, as the models they used to manage young people within a custody environment simply did not work with her due to her vulnerability and limited understanding.

4.117 During her prolonged period at the JJC Vicky's attempts at suicide and self-harm increased in November 2017 when she used a TV cable as a ligature.

64 http://www.nilawcommission.gov.uk/32432_-_bail_report_nilc14__2012_.pdf p.108.

She began attaching items around her neck, swallowing items, voicing that she wanted to die and that life was pointless. This resulted in basic comforts such as a mattress and bedding being removed from her room. Instead of wearing her own clothes she was often given anti-ligature clothing. If Vicky did not engage in the morning routine she was not allowed to play music, which she used in a self-soothing way, and the water and electricity supplies in her room would be turned off. She was separated from others throughout the day. Other examples of inhuman or degrading treatment included being kept in a room for forty-five minutes because a member of staff was not available. This amounts to a breach of Article 5 of the ECHR right to liberty and Article 3 prohibition of torture.

Adverse Finding 4.8: Inappropriate care and response to disability, trauma and adverse childhood experience.

- Recognising that their models were not appropriate for Vicky, the JJC pressed the Corporate Parent to have her properly assessed and moved to a place that was appropriate to support her as a young person and could meet her needs;
- By November 2017 Vicky's mental health had deteriorated and her self-harming escalated. The JJC responded by subjecting her to an increasingly sparse regime with electricity and water being cut off for parts of the day, together with most of her items being removed from her room, including at one stage her glasses and items of underwear;
- The JJC did not recognise Vicky's behaviour as a manifestation of her distress and trauma but as attention seeking and staff were advised to have minimal interaction with her outside of formal sessions, amounting to inhumane and degrading treatment.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 72, The Children (NI) Order 1995;
- Paragraph 7, Schedule 2, The Children (NI) Order 1995;
- Paragraph 2.4, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.53, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Section 2, the Children's Services Co-operation Act (Northern Ireland) 2015;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 24, United Nations Convention on the Rights of the Child;
- Article 37, United Nations Convention on the Rights of the Child;
- Article 3, European Convention on Human Rights;
- Article 5, European Convention on Human Rights;
- Article 8, European Convention on Human Rights;
- Article 14, European Convention on Human Rights.

Adverse Finding 4.9: Failure to ensure the voice of the child was not ignored.

- Vicky consistently expressed feelings of loss, abandonment, frustration, and confusion;
- Vicky also clearly expressed her desire to go home, or at least into a community setting, as well as wanting to understand why she was the way she was;
- The evidence records many examples of the JJC succeeding in achieving caring and meaningful interactions with Vicky in which she expresses her views and concerns, but it was her Corporate Parent, not JJC staff, that was in a position to discuss the plans in relation to her future and to put matters in context for her;
- The Corporate Parent should have been able to achieve those kinds of interactions, or in any event to actively seek Vicky's views to enable her voice to be given proper weight or consideration in decisions regarding her care or her future.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Paragraph 2.44, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 12, United Nations Convention of Human Rights.

NICCY recommends that the relevant authority/ies :

R22 Ensure that statutory planning and reviews consider all relevant information including an assessment of the child's mental health and cognitive ability and that there is an understanding of the causes and impact of any changes in behaviours. These should be addressed according to the best interests of the child and not available resources.

R23 Ensure that systems and procedures are in place to have one set of comprehensive records prepared and shared with those responsible for the care of a child.

R24 Ensure that care pathways between different disciplines in health and social care are seamless – there should be a 'no wrong door' approach.

R25 Ensure communication, cooperation and partnership working is effective for all looked after children in the JJC – with weekly contact between the Corporate Parent and the JJC. Similarly, the JJC and SCH should ensure effective communication when children move between the centres.

R26 There must be a continuity of services (eg mental health and social work) which follow the child whether living in the community, residential or secure care, when assessed to be in their best interests.

R27 Ensure that the education, youth justice, health and social care systems agree (in consultation with the child) the care plan and work together to deliver and review it accordingly.

NICCY recommends that the relevant authority/ies :

R28 Trust staff and managers must monitor records to ensure that there is accurate and contemporary information that assists and informs the care of the child across all systems.

R29 Ensure that care planning involves the child or young person and is undertaken in a way that meets the child's assessed needs and cognitive abilities.

R30 Ensure that police attendance and interventions in children's homes are a measure of last resort.

R31 The HSCT must never suggest or agree to bail conditions which are aimed at 'managing' a child or compelling their compliance with care home rules.

R32 Ensure that all residential settings including secure settings adopt an approved holistic and therapeutic approach to children in their care and that staff are supported and trained to implement the approach.

R33 All staff should be properly trained to support young people with additional needs.

R34 RQIA must follow-up and monitor recommendations of inspection reports on a monthly basis when in reference to or arising from a care of a particular child.

R35 Legislation and regulations should be revised so that RQIA has powers to ensure compliance with recommendations.

R36 The law regarding bail must be revised to remove the JJC as a place of safety (removing lack of accommodation as a reason to remand).

R37 The YJA should robustly challenge a Trust if they believe that they are not properly discharging their duty of care to a child. This includes escalating it to Ministerial and Permanent Secretary level if necessary.

R38 When a child is in single separation in the JJC for longer than three days an independent assessor must examine and assess the situation and report to the YJA CEO.

R39 The Assessor should escalate it to the DoJ if they deem that suitable action is not being taken.

R40 No decision to apply levels of sensory and material deprivation in the JJC should be taken without consultation with an independent expert. Such decisions must be taken by the Centre Director.

CHAPTER 5
YOUNG ADULTHOOD (AGED 17 – 20)

NICCY
PROMOTING THE RIGHTS OF CHILDREN & YOUNG PEOPLE

Away from Northern Ireland

5.1 Directions in management plans for Vicky throughout 2017 and 2018 meant that by June 2018 she had been regularly separated from other people for prolonged periods. In June 2018 an entry (by a nurse at the JJC) into the daily observation notes regarding Vicky recorded that she had been virtually confined to her room for eight months. This was described as being due to risk. Confinement of Vicky was therefore a response to behaviours rather than an attempt to identify or meet her needs.

5.2 Vicky's daily circumstances at this time were analogous to those experienced by children and young people in secure accommodation. Article 44 of the 1995 Order defines 'secure accommodation' as 'accommodation provided for the purpose of restricting liberty'. When a secure accommodation order is made in accordance with Article 44, Regulation 6 of 'The Children (Secure Accommodation) Regulations (Northern Ireland) 1996' (Secure Accommodation Regulations) applies. It directs that:

'the maximum period beyond which a child to whom Article 44 applies may not be kept in secure accommodation without the authority of a court is an aggregate of 72 hours (whether or not consecutive) in any period of 28 consecutive days'.

5.3 The Guidance reasserts this.[65] It further sets out that

'restricting the liberty of children is a serious step which must be taken only when there is no appropriate alternative. It must be a "last resort" in the sense that all else must first have been comprehensively considered and rejected – never because no other placement was available at the relevant time, because of inadequacies in staffing ... and never as a form of punishment.'[66]

The Guidance also notes that if a secure placement is considered there must be a clear view of goals to be achieved.[67]

5.4 Although Vicky was only subject to Secure Accommodation Orders for two relatively limited periods of time, 8th March 2018 – 29th March 2018, and 19th April 2018 – 17th May 2018 due to the very restrictive circumstances imposed upon her through 2017 to 2018, she had effectively been living for extended periods of time as though she was subject to one, despite a court not having given the requisite approval. Her liberty was restricted as though she was subject to a Secure Accommodation Order when she was not. This was unauthorised deprivation of liberty. In conjunction, the lack of judicial sanction and oversight meant that she did not have the benefit of Regulations 7 and 8 of Secure Accommodation Regulations, which define (and limit) periods a court may authorise secure accommodation.

5.5 The MHO (NI) 1986, which was applicable at the time, gave explicit legal protection against detaining somebody without quantifiable process and authorisation. There is no indication of what the Corporate Parent did to investigate, challenge, or seek justification for behavioural management plans that so heavily depended upon confinement. Nor do they appear to have sought to develop sustainable alternatives.

65 Guidance, Vol. 4, para 15.9.

66 Guidance, Vol. 4, para 15.5.

67 Guidance, Vol. 1, para 18.1.

Adverse Finding 5.1: Deprivation / unauthorised restriction of Vicky's liberty.

- Vicky was being held in what was, effectively, secure accommodation. This was a restriction of her liberty;
- Guidance noted that restriction of liberty was to be a 'last resort,' but this was being done to Vicky because there was nowhere else to accommodate her. There was never a clear goal to be achieved through confining Vicky, other than simple containment;
- Evidence presented to NICCY does not suggest that there was a specific application to the Court for authorisation of the deprivation of liberty in this case. There is no evidence that deprivation of liberty guidance was considered, or that there was consideration of how to ensure that deprivation of liberty did not arise.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 44, The Children (NI) Order 1995;
- Paragraph 18.1, Volume 1, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 1.5, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 15.5, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 15.9, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Regulation 6, 7 & 8 the Children (Secure Accommodation) Regulations (Northern Ireland) 1996;
- Article 37, United Nations Convention on the Rights of the Child;
- Article 5, European Convention on Human Rights;
- The Carlile Inquiry, The Howard League for Penal Reform, 2006.

More assessments

5.6 Professionals working with Vicky noted a deterioration in her mood in June 2018. Vicky was saying that she should not be in the JJC and that she had been there for too long. She also said her behaviour had deteriorated in the past year and that what she had been doing in the SCH and JJC was because she was unhappy. JJC staff noted Vicky's self-harming may have become a coping mechanism and that Vicky had explained that this had relieved stress. This is a tragic manifestation of Vicky's own voice in response to circumstances she had no control over.

5.7 If staff noticed a deterioration in her presentation then a robust mental health plan should have been considered, as well as consideration of involving mental health professionals and advocacy groups. A support package specifically targeted at her circumstances within the JJC might have been helpful, and weekly risk management meetings would have been the forum to address matters. When any child or young person is placed in secure accommodation there should be clearly noted specific objectives. Full planning should include note of the purpose of secure accommodation; what is being done; the intended conclusion; and mechanisms for achieving goals. Deprivation of liberty should be for no longer than absolutely necessary for the well-being of the child / young person.

5.8 Vicky was a young person who clearly felt lonely and abandoned. Despite her sensory issues she was being detained and isolated for very prolonged periods, which could be expected to exacerbate

matters. The decline in her presentation was simply one of the many indicators that the programme of isolation being used to manage Vicky's behaviours was exacerbating it.

5.9 Vicky was not being protected. Her Corporate Parent had allowed her, as a vulnerable young person, to remain in settings where her health and well-being were deteriorating. The Corporate Parent was not addressing this with the level of urgency warranted.

5.10 The clinician who had assessed Vicky in January 2018 submitted a further report dated 13th June 2018. This was the second report they had given in five months. It reiterated that Vicky was not detainable due to severe mental impairment within the meaning the MHO (NI) 1986, which specifically excluded personality disorder as a detainable mental illness. It also noted that Vicky's self-harming behaviours had been extremely concerning over the previous few months. This clinician also cited a discussion they had in May 2018 with a consultant forensic adolescent learning disability psychiatrist. The latter clinician reportedly commented that Vicky, if moved to England, would be detainable under the Mental Health Act 1983. The latter clinician was cited as having advised that when Vicky reached 18 years of age, she might be more appropriately diagnosed with an Emerging Unstable Personality Disorder.

5.11 This raises questions of whether Vicky's clinical condition in January 2018 was such that it would have been captured by the MHA 1983 and if this was considered at the time. It also raises questions of why, since November 2017 at the latest, there had been no progress in developing secure accommodation settings (as compatible with Northern Irish law) locally.

5.12 The clinician who reported in both January and June 2018 also noted that Vicky asked JJC staff repetitive questions and was highly anxious about her living arrangements. This clinician reported that staff in both the JJC and SCH thought Vicky was unable to appreciate consequences of actions and her violent and self-injurious behaviour was, generally, impulsive and/or opportunistic. Similar to earlier discussion in the previous chapter, it was noted that an assessment from a psychologist based in England had found Vicky's IQ to be 70, whereas it had previously been assessed as 56.

5.13 This divergence was considered as likely to have arisen from fluctuations in Vicky's emotional state, indicating that her ability to understand and process information is significantly impacted on by her level of mental distress at the time. This again raises a question of why nothing had been done since January 2018 to have Vicky placed in a setting where such issues would be less likely aggravated, as well as the effect of the continuing failure to do so.

5.14 This clinician further reported that Vicky felt abandoned and craved a sense of permanency. Her decision making was affected by her emotional state and the fact that she has been assessed by many professionals now but saw no immediate change in her circumstances was compounding her distress and sense of hopelessness. They also repeated a point they had made in their initial report, that the nature of Vicky's emotional difficulties did not lend themselves to a quick solution. Five months had passed since that earlier report with no realistic solution being found.

5.15 The importance of this to Vicky's behaviour, treatment, and decline in presentation since and in the years leading up to this point should not be underestimated. As a vulnerable young person with a learning difficulty, she was placed in circumstances that caused her emotional and mental distress. That this endured for as long as it did, despite the nature and level of comment as to her needs, was a failure in the exercise of Parental Responsibility by the Corporate Parent.

5.16 The consultant forensic adolescent learning disability psychiatrist noted above also produced a report. This assessment considered Vicky's experience in both the JJC and SCH. It was done in anticipation of a possible move of Vicky to a hospital in England. Vicky had previously commented that she was scared of going to England. The resulting advice referred to an IQ of 68 and noted that professionals were having difficulties in identifying and meeting her needs within resources available. The drop in Vicky's IQ has been considered as greater than what could likely be attributed to FAS.

5.17 Vicky was considered unique in the JJC both because of her learning difficulties and gender, the latter limiting her ability to fully access activities within the JJC. Allowing Vicky to remain in such a setting showed a lack of protection by the Corporate Parent. It also raises a question of what was being done to prevent a further decline in her presentation, including with regard to care planning and therapeutic input.

5.18 This same clinician noted that in discussion with JJC staff it was apparent that there were difficulties in identifying Vicky's needs and meeting them with available resources. Staff also commented that they had been traumatised by the level of self-harming Vicky had demonstrated and the impact that such behaviour had on both the risk to her life and the level of intervention that they had needed to exercise.

5.19 This should have prompted immediate, urgent response to ensure that suitably able staff were directly involved with care. It also raises a question of why they were not already in place. The clinician further noted that Vicky presented with anxiety and fear and that there was a clear effect of a history of trauma. All of these circumstances arose whilst Vicky was in the direct care of statutory agencies.

5.20 This clinician further considered that Vicky's specific deficits particularly around communication, comprehension, and expression may previously have been underestimated. They further commented that there may have been a lack of awareness of the impact of her communication and cognitive abilities on her presentation, and that it was possible that all of her difficulties were being ascribed to cognitive impairment, rather than trauma (or vice versa) instead of an appreciation of the cumulative impact of both. Vicky was 16 years old (nearly 17) when this comment was made, had been a 'Looked After Child' for almost her whole life, and had been subject to various assessments since she was a young child. Yet clinical opinion now was that professionals who had had her under direct observation for many months might not have understood the effect on her behaviour of her difficulties with communication and understanding.

5.21 The above clinical comment indicates that, while staff working with Vicky knew of her ID, they did not appreciate how the detailed profile of her abilities

varied. While this knowledge had been available in records, it had not been disseminated in a manner that could be applied by staff directly working with her. This limited understanding of Vicky's needs was a reason she should not have been accepted into the JJC. A better identification of Vicky's needs while in the JJC might have been achieved through use of in-reach specialist staff and appropriate in-house training.

5.22 The above noted clinical comments were matters that the Corporate Parent had known for many years and, despite having that knowledge, it was clear that nobody appeared to really know or properly understand what was happening to Vicky. By the time this clinician was involved matters had already deteriorated much too far. There had been clear signs of difficulties, possibly including capacity, while Vicky had been in the CRH. At this stage commentary should not have been about what people already knew; it should have been targeted at what needed to be done to improve circumstances. Vicky had by now deteriorated very rapidly. There were no clear or apparent endeavours to ascertain Vicky's own views or feelings. Trauma was being missed and there was lack of involvement of advocacy agencies. At the same time, the issue might not have been Vicky's capacity, but the ability of others to understand the meaning and causation of her behaviour.

5.23 It is concerning that such a circumstance could have arisen given that Vicky had, since a baby, been known as likely to experience cognitive difficulties. Combined with the difficulties experienced by those working in secure accommodation in getting a copy of Vicky's Statement, this suggests a severe breakdown in information sharing regarding assessed needs. If this is not the case, it suggests an inability of those who had been working with her directly for many months to understand her circumstances.

5.24 The team involved in the above noted assessment considered that Vicky's presentation was an interplay of communication disorder, cognitive impairment, and disrupted attachment. Significantly, the report went on to state that Vicky's problematic behaviours were currently being reinforced rather than diminished and that the systems in place within both the SCH and the JJC were actually contradicting and conflicting with the management plan that would be necessary.

5.25 This assessment was conducted with little access to Vicky's early developmental history and there was a lack of clarity on the part of assessing professionals as to the form of interventions that had been earlier attempted. There was no explanation for this lack of information, which presumably would have been desirable. Such professionals were nonetheless tasked with identifying potential future pathways for Vicky's care and treatment. (A reason for the scarcity of information was not recorded).

5.26 It is also confirmation that the people with whom Vicky was in day-to-day contact were unable to respond and engage with her as necessary. How she was being treated was not helping her; it was reinforcing negative behaviours which were contrary to appropriate interventions. There should have been meetings by relevant parties, including professionals, to discuss care planning, advocacy, and understanding of Vicky's capacity.

5.27 The clinical assessment was carried out with a view to identifying pathways of care and treatment. It advised that inpatient treatment of some three years in England for therapeutic purposes was now needed. Given Vicky's age (she was now 16, almost 17) this would not be an uninterrupted three years in the same setting; she would instead need to transition to adult services upon reaching 18 years of age. Such planning was possible because Vicky was, in the view of the assessing clinician, detainable under the Mental Health Act 1983 as extant in England. It was considered that initial admission could cause a decline in Vicky's presentation in the short-term, but that would hopefully be balanced by long-term improvement. This clinician was careful to note that the legal compliance of moving Vicky to England was something to be resolved in Northern Ireland.

5.28 It is useful to summarise here briefly that (as noted above) in January 2018 Vicky was not detainable under Northern Irish law and was still not so in June 2018. By that time she was considered detainable under English law, with the caveat that taking her to England needed to be legally compliant. As of June 2018, her clinical presentation did not allow for this, despite having so significantly declined. There is no indication that social services considered how Vicky, or anybody else trapped in this legal limbo, might be catered for. Focus instead seems to have remained on the possibility of sending her to England, which would result in her experiencing initial disruption of being moved. She would have 18 months in one setting, and then, due to reaching 18 years of age, would be moved to another.

5.29 Given the severity of this clinical advice, including the detailed commentary as to the ongoing lack of proper understanding of and meeting of Vicky's needs, it is remarkable that no substantive action was taken in response. This was, at the very least, an issue of child/young person welfare. Yet there was no development (or seemingly discussion) of bespoke care for Vicky in Northern Ireland. Nor was there any apparent care response to some of the specific issues raised by this clinician, such as Vicky's deterioration in consequence of placement transfers and her unresolved separation anxiety regarding her Mum. These were matters within the knowledge of the Corporate Parent, but no remedial response was implemented. This suggests that there was no strategy to develop help for Vicky in Northern Ireland.

5.30 A consultant clinical psychology report was completed by another professional in June 2018. The professional concerned worked within a psychiatric facility in England and was aware of two cognitive assessments of Vicky; that completed in 2012 by an educational psychologist, and a report obtained in July 2017 by solicitors instructed in legal proceedings at that time. They were further aware of two adaptive functioning assessments carried out in January 2018 but had no access to either. This was a concerning omission on the part of those with Parental Responsibility in respect of a young person with Vicky's presentation, who was being brought before the courts on criminal charges. This clinician did not have information regarding Vicky's behavioural history before 2016.

5.31 The resulting report noted that the care team had been advised that they did not have the skills to work with Vicky and that plans might change when teams change over, leading to inconsistency

in management. Vicky's cognitive abilities and adaptive functioning were assessed as falling in the range expected of an individual with global learning disabilities. The report stated that over the last year she had not been provided with a sustained placement or sustained base from which to address the challenges she has presented.

5.32 While noting that Vicky had Global Learning Disabilities, she was described as motivated and on task during assessments conducted by this clinician. There was speculation as to whether a drop in her cognitive function had been contributed to by emotional or behavioural difficulties. Such was Vicky's sense of abandonment at this time that when she was asked who she would take with her to a desert island Vicky could not name anybody.

5.33 The report also recommended a stable long-term placement over years rather than months which could contain the risks that she posed to herself and others and support her in developing more helpful strategies to cope with and manage her emotions. This was the very opposite of what had been happening. It is notable that following this recommendation no substantive action was taken to implement it in a manner compliant with her not satisfying detention conditions of MHO (NI) 1986.

5.34 This was made more important as Vicky was described as being very stressed by the uncertainty around her living arrangements. In the previous few weeks, she had been more settled as she was then being cared for in a separate low stimulus area of the JJC on her own. However, within a week of this comment she was detainable in accordance with the MHO (NI) 1986. This rapid significant decline was in the immediacy of assessment by several clinicians based in England with a view to her being moved there, a possibility about which Vicky (as noted above) had expressed fear.

5.35 Towards the end of June 2018 Vicky was in crisis. Clinical opinion was that immediate psychiatric care was needed. Due to her deteriorating presentation, she was assessed on 27th June 2018 by professionals as meeting the criteria for detention under the MHO (NI) 1986. There was no suitable facility that could safely provide for her therapeutic needs in Northern Ireland, so she was placed in an adult intensive care facility instead.

Adverse Finding 5.2: Failure of the Corporate Parent to advocate on Vicky's behalf

- It was the role of Vicky's Corporate Parent to properly advocate on her behalf and to equip itself with the necessary information to enable it to do so;
- Senior professionals within the JJC considered that the Corporate Parent was not properly advocating on Vicky's behalf and consequently wanted to speak with the Judge presiding over Vicky's court cases
- A social worker within the Corporate Parent commented that senior people within WHSCT should have been more involved with Vicky, including attending meetings;
- Vicky obtained a criminal record due to events that took place while she was placed in unsuitable settings, many of which resulted from her breach of house rules at the CRH, which were part of her bail conditions.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995
- Paragraph 5.20, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 5.21, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 6, European Convention on Human Rights.

Discharged and Someone Else's Problem

5.36 In anticipation of further court proceedings a 'Discharge Summary' was prepared in July 2018 by a consultant forensic psychiatrist working within the Forensic Child and Adolescent Health Service for Northern Ireland. This was within or about a fortnight after the reports in or about June 2018 noted immediately above. Inexplicably, Vicky's recorded date of birth in this report was wrong, again suggesting inattention to basic detail.

5.37 This summary commented that Vicky's involvement with in-reach CAMHS had been inconsistent due to multiple moves between the JJC and the SCH. It should be noted that the two sites are, geographically, very close to each other. Vicky was described as having an extensive history of development and relational trauma. There was also reference to a historic diagnosis of PTSD, together with comment that the impact of her extensive history on her psychological, behavioural and emotional well-being had been profound. A tentative diagnosis of Acute Polymorphic Psychotic Disorder without symptoms of Schizophrenia was noted, together with a need that it should be assessed in hospital though multidisciplinary observation.

5.38 The clinician considered that assessment of Vicky would be rendered less reliable while she was using high dose antipsychotics. However, they also believed that a reduction of medication would be unsafe if not done within medium security and/or seclusion. In their opinion, the limitations in regional facilities meant that reducing levels of medication for the purpose of assessment was unlikely to be achievable within Northern Ireland. They continued that it was in Vicky's best interests that she be admitted as soon as possible to a bed offered to her in medium security in England. This clinician found no evidence to support an organic disorder.

5.39 As of January 2018, Vicky's condition had been outside the remit of the MHO (1983). In the following six months there had been no development of care facilities in Northern Ireland to treat Vicky, so she stayed in settings which professionals explicitly stated were not suited for her. At that same time, her condition was further aggravated to a point where at least one professional came to consider that she needed to be taken out of Northern Ireland for assessment. This raises at least two questions (and indeed possibilities, which are not mutually exclusive):

1. How and why Vicky's clinical condition could be viewed as severe enough to justify her removal from Northern Ireland. This is highly significant given removal of her solved the problem of there being nowhere to place her locally in compliance with the MHO (1983). Confirmation is needed of whether there developed a heavy focus on aspects of Vicky's presentation justifying her removal in preference to developing a care package and amenity to treat her locally. It is notable that within a

period of about one week since the completion of the two reports noted immediately above (one of which carried confirmation of possible placement in England) Vicky was found to satisfy the requirements of detention under MHO 1986 and within less than one further week another report substantiating that was also relied upon. Reponses and reference to those reports were far quicker than to others which showed need for action and planning locally.

2. If Vicky's condition had indeed declined so severely as to necessitate her removal to England, this occurred in circumstances where those responsible for her care already knew of her profound needs and that her placements were entirely detrimental to these needs being met. That carries with it possible responsibility for the aggravation of her condition. Decline was over a period of some six months, with decline being particularly severe in the preceding fortnight.

5.40 It could be queried why the Discharge Summary was written by somebody other than the Resident Medical Officer who would have been most familiar with Vicky. NICCY is not aware of any reason for this. It is also questionable why there was no report from CAMHS, and it is clear that the author of the Discharge Summary emphasised the margin of uncertainty around the suggested diagnosis. The author of the Discharge Summary noted that they had limited records for this purpose despite previous clinical opinions which could have been of use to this clinician in considering a diagnosis. It is difficult to understand why the Discharge Summary did not contain a description of Vicky's mental state or how it changed after her admission to the Psychiatric Intensive Care Unit in June 2018. If there were no significant difficulties or episodes, this would have suggested that these were associated with her stay in the JJC regime, but this clarity is not possible due to the lack of comment on this matter in the discharge summary.

5.41 This may be part of a wider issue as to a lack of understanding of Vicky within the context of the sequence of movements she had been experiencing since entering the CRH, including brief periods back with her family, nights in police custody, and lengthy stays in the SCH and JJC. The effect of this should be considered holistically. Potentially absent from this was a shared understanding by and across all of these settings and the relevant decisions makers either within those settings or outwith, as to the possible interconnectedness of Vicky's experiences.

5.42 The absence of wider background information (across a range of places and issues) when drafting a 'discharge summary' may be indicative of each setting being viewed in a standalone manner, and not as a continuous part of Vicky's evolving presentation. The CRH, SCH, and JJC however can be viewed as part of a single care system as all the placements chiefly concerned themselves with restricting Vicky's behaviour and employed isolation as their primary means of behaviour control. The use of arrest and the custody suite when at the CRH was seamlessly replaced with single separation despite moving to more specialist accommodation at the JJC.

5.43 The main distinction with the CRH was that its seclusion and/or isolation was provided by arrangement with the police, rather than in-house. While being held in these settings there was no indication of a systematic attempt to apply psychiatric

diagnosis to the deterioration in Vicky's behaviour. There was no indication of a completed ADHD assessment, despite this condition being found in 94% of children with FAS. Such condition may have contributed towards Vicky's impulsive behaviour.

5.44 Issues around diagnosis had three effects:

- Possible missing of Borderline Personality Disorder (BPD), and treatment of same, as well as possible treatment of ADHD;
- Consideration of FAS and ID, without BPD, which led both to therapeutic disengagement and frantic attempts to move her on and;
- failure to consider iatrogenic causes for deterioration.

5.45 Records of Vicky's day-today care management show that, by the time she was being assessed by a clinical psychologist in June 2018 she no longer had access to her own clothes, belongings, or companions of her own age. This seems entirely at variance with the spirit of Lord Carlile's recommendations on segregation, and possibly in direct contradiction to his 41st recommendation, which stressed 'time out' should only be for brief periods.[68]

5.46 The conditions in which Vicky was being held at that time were similar to the conditions experienced by prisoners in so-called 'supermax' prisons where psychological consequences such as social withdrawal alternated with acting out behaviour. Such behaviours are also associated with high levels of self-harm and disorganised behaviour of the type demonstrated by Vicky when her move to England was imminent, as well as many occasions before then.

5.47 While Vicky was being held in the above noted settings there was insufficient awareness of the significance of changes in her behaviour. Such changes should have been recognised as simply one of many indicators that the programme of isolation being used to manage Vicky's behaviour was in fact exacerbating it. The effects of Vicky's experiences in all those care settings had been cumulative.

5.48 None of this was explicitly discussed in report documentation prepared. On the same day as the above noted Discharge Summary, a 'Form ECR002' was completed by the Corporate Parent. These were used by the then HSCB when considering an ECR, which result in placements of patients from Northern Ireland into settings elsewhere. The form completed at this time for Vicky commented on the range of options the Corporate Parent explored as potential placements for Vicky (including within the voluntary sector), with most being outside Northern Ireland. In doing so it noted why those settings were not deemed feasible, stating that their existing levels or style of service provision did not fit Vicky's needs. Consideration of a placement within Northern Ireland concluded that no residential facilities immediately within the remit of the Corporate Parent were suitable.

5.49 Vicky's presentation and deterioration during her time in the CRH was cited as indicative of a lack of a suitable setting locally. Using the CRH as a benchmark is hard to understand (or justify) given how unsuitable it had been in the first instance. Relying on this example amounts to both an admission of the failure of that placement as well as reliance on that failure. It also had the effect of hindering

68 Carlile Report, Recommendation 41, https://howardleague.org/wp-content/uploads/2016/03/Carlile-Report-pdf.pdf

the range of options that might otherwise have been considered.

5.50 This was an example, indeed evidence, of the need to develop within Northern Ireland residential amenity for circumstances such as Vicky's. This should have been further emphasised by the conclusion that other residential placements in Northern Ireland were thought to entail as much risk as the CRH. Discussion of bespoke options appear focused on considering a placement with Vicky's Mum (with a staff team around her), and to rule that out because it had previously failed.

5.51 That consideration of bespoke placements went no further than reviving an arrangement already regarded as unsuitable is striking. There was no discussion of adapting a property for Vicky's needs and staffing it with trained care givers as suitable to her condition and presentation. This falls far short of the 'creative' thinking earlier called for by the Restriction of Liberty Panel. Further discussions of local options noted Vicky needed a medium secure setting, which did not exist in Northern Ireland, and that safeguarding of Vicky was a significant priority. There was no discussion of what had been done (or would/could be done) to develop those amenities within Northern Ireland.

5.52 While Vicky's presentation had declined immediately before the Declaratory Order, she had also since 2016 been displaying behaviours potentially harmful to others, and records no later than March 2017 refer to her self-harming. This was the basis on which behavioural management plans were developed throughout that time. The lack of sustainable and effective bespoke planning to address corresponding accommodation issues during the same time, as apparent from the Corporate Parent's own comments when applying for an ECR, show a long-lasting failure to exercise Parental Responsibility in a manner giving paramountcy to Vicky's protection and well-being.

5.53 The ECR document included much discussion of Vicky's historical needs and difficulties. Such information was necessary for the application being made. The range of comment within this is such that it is hard to discern why appropriate responses and interventions were not developed when awareness of those issues arose. The ECR document reads like a list of problems for which no targeted responses had been developed (a recurrent theme throughout her life).

5.54 The historical discussion used tone and phraseology that did not acknowledge this. Instead, there was comment which noted how, since October 2016, Vicky had had a range of placements in an attempt to settle her within the community. This glossed over the inherent limitations of those placements, including with regard to scope for therapeutic intervention. It also failed to acknowledge that living arrangements determined by public agencies had entailed a risk of her being further traumatised. With regard to 'settling' Vicky in the community, this stands in contrast with comment in March 2018 that the models used to manage young people within a custody environment did not work for Vicky due to her limited understanding and vulnerability. She was merely being contained on a daily basis.

5.55 Rather than referring to such issues as recorded in case files, the ECR document reads as though the difficulty was that Vicky could not adapt to the setting, rather than the setting being unsuited to her needs. This is consistent with the lack

of discussion as to why no other amenity had been developed in the meantime, including in response to clinical opinion of January 2018 as referred to above. That same clinical opinion was however cited in support of the ECR application, by noting that in their updated report of June 2018 the drafting clinician had stated in their initial report that Vicky's emotional difficulties did not lend themselves to a quick solution.

5.56 Not mentioned by the Corporate Parent is that the initial report was from five months earlier and that no progress had been made since then in tailoring for needs unlikely to be quickly resolved. This is in further contrast with other commentary in the same ECR application that safeguarding Vicky was a priority, and that the WHSCT was seeking assurance that a placement could provide this alongside meeting her other assessed health, social and educational needs. These priorities, while being used to justify the ECR, had not been treated as justifying the development of a bespoke placement within Northern Ireland over the preceding several months. The failure to address well-established and documented issues was now being used to justify sending Vicky out of Northern Ireland.

5.57 Details of how the ECR would operate were scant. There was reference to clinical comment that Vicky was likely to need secure therapeutic input for at least several years, with graded reintroduction into the community. The ECR was intended to result in a sustained and containing placement; the development of frameworks for her needs and presentation; and multidisciplinary involvement and intervention to improve her own skills. There was to be consideration of trauma work; developing resilience; provision of education; and preparation for transition to adult services. No in-depth details for any of this were given.

5.58 There would be ongoing liaison with local services (which may have meant those within Northern Ireland – it was not explicitly stated) through meetings scheduled in three-month blocks. This was not further quantified. Vicky was to receive weekly statutory visits for first six weeks, and monthly thereafter. There was no discussion of family visits or other contact, other than to note the prices of such was not included in expected costs (see below). There was no consideration of how to maintain her sense of identity and links with her place of origin. A transition plan out of this setting was to be developed before Vicky's eighteenth birthday but no further details of this were discussed and otherwise no exit strategy was mentioned.

5.59 There was no comment as to how Vicky would be brought home to Northern Ireland. There was no comment as to what development of amenity within Northern Ireland could be explored. There was no comment of monitoring how beneficial treatments in England might be applied within Northern Ireland. Costs were noted as being £3,284.60 daily, not including family visits, clothes, toiletries, or leisure activities. There was no consideration of how such an outlay could eventually be reduced by the development of facilities within Northern Ireland. It is NICCY's understanding that when an application for an ECR is made to the HSCB a structured 'exit plan' should be included and that this was particularly relevant for Vicky who was approaching a transition to adult services.

5.60 Also missing from the ECR application was reference to a Youth Justice Assessment for the period of 8th February 2017 – 15th June 2018. A natural place to include such information would have been in the section of the form titled 'Reason for Referral,' and the subsections thereafter of 'The patient's assessed needs' and/or 'Events Leading to Trust Application' [sic]. Some of the issues raised within the Youth Justice Assessment appear in Chapter 4, including the impact of time spent in the JJC; fundamental needs regarding trauma and learning disability were not being met; the risk of re-traumatisation; that models already used do not work for Vicky due to her vulnerability and understanding; that she had not been part of a community for a long time; that she had likely experienced institutionalisation and dependency due to her stay in the JJC; while in the JJC she had been introduced to peers engaged in risky behaviour; she felt unmotivated. These were crucial aspects of Vicky's lived experience at the date of making application for funding to send her out of Northern Ireland.

5.61 It is notable that although Vicky's presentation and clinical needs were central in making application for funding to send her to England, the Corporate Parent did not note some of the most severe (and indeed current) manifestations. It is significant how many of these had arisen when and where the Corporate Parent had allowed Vicky to remain for lengthy periods.

5.62 Not including such commentary within ECR documentation meant discussion of the impact upon Vicky of how she has been treated by the statutory authorities responsible for her did not arise. These are nonetheless critical issues within Vicky's historiography. It must be noted that the most explicit comment on these matters and the effect of such upon Vicky is made not by her Corporate Parent, but by an agency of the criminal justice system.

Adverse Finding 5.3: Failure to provide suitable secure care and accommodation in Northern Ireland.

- There was a lack of effective planning in response to events and advices, resulting in uncoordinated responses;
- Vicky, notwithstanding her challenges, was expected to adapt to the circumstances in which she was placed;
- In January 2018 a Consultant Child and Adolescent Psychiatrist in ID clearly stated that Vicky needed other accommodation - by June 2018 that had not yet been actioned;
- Clinical advice in January 2018 was that Vicky was detainable under English law but not under the Mental Health Order (Northern Ireland) 1986 (MHO 1986). The Corporate Parent did not ensure that Vicky was suitably accommodated, and by June 2018 she had deteriorated and become detainable under MHO 1986;
- Prior to the extra contractual referral (ECR), WHSCT had failed to develop an amenity compliant with the MHO 1986, to obviate the 'need' for an ECR;
- The failure of WHSCT to develop a proper MHO 1986 compliant amenity meant that when Vicky was detained 'for assessment' in June 2018 under the MHO 1986, she had to be placed in an adult intensive care facility because there was nowhere to otherwise accommodate her, notwithstanding that she was still a child;
- There is no evidence that the Corporate Parent gave any proper consideration to providing Vicky with bespoke placements, rather it seems to have focused on trying to revive the foster placement;

- Not developing a suitable setting within Northern Ireland creates a continuing deficit for children and young people who present/will present with high needs.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 27, The Children (NI) Order 1995;
- Article 72, The Children (NI) Order 1995;
- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 1.2, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 9.44, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 9.53, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Regulation 3, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Recommendation 61(c), The Committee on the Rights of the Child.

Extra Contractual Referral – "Why can't I go home?"

5.63 On 9th July 2018 the High Court held that under Article 33 of the 1995 Order Vicky could be removed from Northern Ireland, and it awarded a Declaratory Order to allow deprivation of her liberty. The decline in Vicky's presentation was now so bad that the judiciary authorised extreme steps for her protection. Earlier applications had already been declined on 17th May 2018, 24th May 2018, and 7th June 2018. On 24th May 2018 the court explicitly asked for confirmation that the legal criteria for such an application would be satisfied. This suggests that applications were being made without full quantification.

5.64 Vicky was immediately moved to a medium secure mental health facility in England by way of ECR. This facility was based in England and was where the consultant clinical psychologist worked who had provided the updated report of June 2018. The facility described its remit as treating young people (aged under 18 years) with complex mental health needs (including learning disability) as inpatients in a medium secure setting.

5.65 A LAC Review took place soon after Vicky arrived at her placement in England. Resulting documentation recorded that her last statutory medical examination was in August 2014. Although this LAC Review took place in July 2018 it was signed off in February 2019. She was still on bail at this time and a list of her charges were noted but there was no commentary as to what was being done in that regard. The documentation of this LAC Review, and others conducted while Vicky has been in England, cited an incorrect date of birth for her. This is something her case workers could have been expected to notice.

5.66 LAC documentation at this time noted the recommendations from an earlier review of May 2018, including that the Trust should actively work to develop bespoke living arrangements for Vicky. The note of progress in this regard (as of July 2018) was that this had been considered, but deemed inappropriate. This infers a far more active attempt to develop bespoke options than what appears to have happened. As noted above, service providers (including voluntary) were spoken with, but their existing amenities were not suitable.

5.67 That is not an attempt to develop bespoke arrangements; it is a conclusion that existing arrangements do not work and then not trying to further develop them. This is noted here because as Vicky had been placed on an ECR there was, effectively, a discountenance of exploring bespoke solutions in the true meaning of the term. This is made clear by a further ECR funding application on 26th August 2018, which largely repeated that of a month earlier, and shows there has been no discussion of developing a Northern Ireland based amenity.

5.68 The Corporate Parent, as the referring Trust, had an ongoing and active role in the ECR due to a need for sufficient information to be available for funding applications. After Vicky started the ECR placement there were reviews and updates by way of monitoring of the placement and the Corporate Parent should have provided written reports highlighting progress. This appears to have been happening while Vicky was a LAC, but no information available suggests it has happened since she transferred to adult services.

5.69 At a Care Programme Approach (CPA) meeting in October 2018 it was noted that Vicky's insight into her own needs had increased. Her mood had improved, her medication was reduced and she was having leave outside the facility where she was staying. No evidence of psychosis was observed. With regard to her mental health a clinician commented that symptoms Vicky displayed before transfer to England may have been anxiety in relation to that move. This raises a question of how the fear of being moved to England was factored into assessments of Vicky while in Northern Ireland, including how the outcome of those assessments might have been used to support such a move.

5.70 Further reports continued to note that early attachment and trauma had impacted on her ability to manage emotions and relationships. At a CPA meeting in January 2019 there was discussion that aggression by Vicky resulted from her being unable to express her emotions. However her presentation had continued to improve. She was engaged in education and was considered delightful to teach. Ancillary documentation for this meeting noted Vicky had become better at seeking out staff and explaining what was upsetting her.

5.71 Documentation of this meeting recorded discussion that Vicky had a background of trauma complicated by learning difficulties and communication issues. All of this trauma must have occurred while Vicky was being looked after by the state and were all issues that should have been within the contemporaneous knowledge, consideration, and decision making of her Corporate Parent. Documentation of this meeting further noted that all criminal charges which had been brought against Vicky had been dealt with in relation to time served. Vicky now had confirmed criminal convictions and there is no indication of what steps the Corporate Parent took, as a good parent, to address the issue of a young person with learning difficulties being given a criminal record.

5.72 In March 2019 there was a First-tier Tribunal to consider Vicky's continuing detention in a medium security setting. Vicky did not attend but her instructed representative did. Her clearly expressed wish was to return to Northern Ireland. Discussion as to Vicky's history noted that staff in settings where she had been held in Northern Ireland had been traumatised by her suicide attempts.

5.73 There was clinical comment that Vicky had a mental disorder of Mild to Borderline Learning Difficulties associated with abnormally aggressive and seriously irresponsible behaviour and Mixed Disorder of Conduct and Emotions. The latter of these was considered as being complicated by Vicky's cognitive impairment. There was also clinical comment on the importance of environment in Vicky's treatment due to her need for intensive support in the form of physical structure, procedural, and relational security.

5.74 Given that such comment was being used in proceedings to justify Vicky's continuing detention in England, it raises questions as to why such significant issues had not prompted targeted action while she was in Northern Ireland.

5.75 The tribunal was satisfied that the treatment Vicky needed could not be given in the community and that it had to take place in a hospital setting. They noted that she presented with a pattern of behaviour consistent with a history of complex trauma and disrupted attachment in the developmental period.

5.76 In conjunction, it was noted that in the meantime there has been no apparent practical consideration by the Corporate Parent of how Vicky could be brought home to Northern Ireland. Such practical consideration would have included the development of an amenity to cater for a child or young person who presented with the same level of clinical need as Vicky.

5.77 The changes in Vicky's condition while being treated in England are highly significant. The professionals working with her there commented that her aggression was motivated by communication difficulties. This is remarkable given the lack of clarity as to her learning difficulties and IQ while she was in Northern Ireland. It is also notable that professional opinion (and that of a tribunal) continued to be that trauma and separations contributed to her mental impairment. These were all matters which the Corporate Parent had scope to guard against through effective exercise of Parental Responsibility.

Adverse Finding 5.4: Failure of the Corporate Parent to carry out basic safeguarding / promote welfare.

- The Corporate Parent had not, in the five years from 2012-2017, obtained an updated cognitive assessment despite there being significant decline in Vicky's presentation, and her lifelong diagnosis of FAS;
- The Corporate Parent sought to justify its application for an out of jurisdiction placement for Vicky by reference to clinical reports that emphasised her significant care needs, which were reports it failed to act upon at the time, effectively acknowledging a failure on their own part to discharge their duty of care;
- WHSCT permitted long periods of placement uncertainty and multiple placements in England, which contributed to a decline in Vicky's presentation during that time.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Article 27, The Children (NI) Order 1995;
- Article 72, The Children (NI) Order 1995;

- Paragraph 2.18, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Paragraph 2.19, Volume 3, The Children (NI) Order 1995, Guidance and Regulations.

From Pillar to Post

5.78 A Care Order normally ends when the subject child or young person reaches 18 years of age, which for Vicky was in July 2019. At such a time WHSCT ceased to be the Corporate Parent. WHSCT have confirmed that as of 19th September 2019 Vicky has been within the scope of their 'adult services' and that a social worker therein has case management responsibility.

5.79 In July 2019 there was a 'review of detention' of Vicky. This was a setting where continued detention under mental health legislation was reviewed. In advance, Vicky noted her wish to return to Northern Ireland. Documentation from this review notes that the panel described Vicky as "a very brave young woman." They also recorded that they had not been able to get access during the hearing to the social worker. However, after the hearing the social worker standing in for her colleague did contact the panel and received an update.

5.80 The panel further expressed concern that no arrangements in respect of accommodation in Northern Ireland had been put in place in the event that the outcome of the panel had been to discharge Vicky. They made it clear that a future reviewing panel would expect such a plan to be in place.

5.81 In August 2019 Vicky was moved to a second setting in England as part of her transition to adult services. In its application for funding for this placement the WHSCT relied upon an inspection report dated more than a year before the most recently available appraisal. While both reports were favourable, this is another instance of a lack of attention to detail.

5.82 Vicky continued to be in regular contact with her family. Her Mum would travel often to visit Vicky when she could. Vicky's family raised concerns as to the care she was receiving in this setting. Vicky advised that her placement was not working. She wanted to come home to and be treated in Northern Ireland. The family worried that strategies of behavioural management being used were excessive, that there was insufficient attention being given to her eye care and she did not have access to her glasses, causing her agitation. Family sources described this setting as "toxic" for her and advised that Vicky felt neglected and let down by the state. Vicky was described as a very sad broken young girl crying out for help to get moved back to her own region. She was begging her family to get somebody to help her, because she needed to be moved.

5.83 The family's fears for Vicky's physical well-being continued for a long time further, and they noted, that there was physical treatment Vicky needed but did not receive for several weeks. In 2020 the hospital where Vicky was being treated was placed in 'special measures' following an inspection by the Care Quality Commission (CQC). There were two further inspections in 2021, the second of which found there had been insufficient improvements since the earlier report, so a rating of 'inadequate' was given.

5.84 Issues of concern included:

- Inconsistent recording in patient clinical notes (including of significant events as well as care strategies);
- Insufficient staff, not all staff being fully trained, and use of male staff for intimate observations of female patients;
- Care plans not being adhered to and sometimes being unsuitable for subject patient;
- Safety concerns not always being responded to, including instances of self-harm by patients;
- Risk assessments not being consistently done, the outcomes not always being fully shared and/or being used to inform planning;
- Instances of seclusion not being properly recorded or being used to inform care planning;
- Multi-disciplinary meetings not discussing all issues relevant to specific patients;
- A lack of psychological, speech and language, and therapeutic sessions, together with long in-house waiting lists for such;
- Admission of patients for whom this was not a suitable setting.

5.85 The family continued to note their (and Vicky's) ongoing confusion as to why there was no suitable care setting in Northern Ireland. They advised that ongoing placement in England made Vicky feel isolated from her family and friends. The family believed they (and Vicky) had been told that placement in England would last for one year. Vicky's Mum felt that Vicky had a right to be within her own region and that the amount of time Vicky had spent in England was already punishment enough.

5.86 This echoed with a feeling expressed by Vicky that she would be able to return to Northern Ireland by being good, suggesting that placement in England is seen by her as a consequence of not being good. There continued to be a perception by Vicky and her family that her placement was punitive rather than therapeutic. The family also experienced delays in being given documentation to be used at reviews of Vicky's placement. At a review in May 2021 there was discussion of Vicky being moved to a different setting. It was noted that Vicky had found the delay and the uncertainty about her move difficult to cope with, and had reverted to some of the behaviours which she displayed at an earlier point in her admission.

5.87 Vicky's recent increase in incidents of self-harm and aggression towards others was suggested by the nursing report (which was part of the information before the review) to be caused by anxiety regarding her future placement due to having no clear movement date. During the meeting there was a repeat of the assessment made around the time that Vicky was moved to England, when professional opinion considered her heightened behaviour at that time may have been caused by the uncertainty of her living arrangements.

5.88 These comments fail to go a logical step further, to consider that how Vicky was being housed, how she was being treated and the ambiguity created for her by agencies might have been contributing to the behaviour that clinicians and statutory authorities found worrying. Heightened behaviour from Vicky may have been the only 'voice' she thought she had, the only mechanism she knew to express her frustration and annoyance with how she was being treated. Her communication difficulties had earlier been noted by a

clinician. Yet this does not appear to have been a factor in planning for her care.

5.89 Instead, focus was directed more at reacting to the consequences of this. A sense of the impact of this upon Vicky is evident from the comments attributed to her within the same documentation, as she had expressed fears that her recent behaviour may have jeopardised a potential move to another hospital and she had stated that she wanted to stay out of trouble. This shows Vicky thought she was being treated punitively, not clinically, and her own wish for a better life.

5.90 In August 2021 Vicky's family expressed fears of the effect on her of delay in being moved to a lower security setting. She had been told five months earlier that this would occur, but it did not. Her family worried this could result in Vicky believing she had done something wrong. In reply the WHSCT noted to the family by email that the intended placement (of which Vicky had been advised) had withdrawn from the arrangements. The hospital which had been the intended placement had been given it a 'requires improvement' grading by the CQC a year earlier, and a matter of days after removing its offer of placement for Vicky was given an 'inadequate' rating. Given Vicky's needs and history it would have been better to wait until the placement was confirmed before telling her it was a possibility.

5.91 Two other settings were considered by the WHSCT as potential placements for Vicky. Upon being made aware of this the family read publicly available inspection reports of each. The family expressed shock to the Trust that either setting was considered, because their understanding was that at inspection one had been rated 'inadequate' and the other as needing improvements. In the meantime, the existing placement was scheduled to close due to noted reports and ratings by CQC.

5.92 The family also noted ongoing difficulty in getting updates from the Trust. There was at least one instance where the family advised (and corrected) the Trust of what engagement their social workers had recently had with Vicky. This, together with uncertainty of placement (it appeared at one stage that Vicky had nowhere to go mere days before her residential setting was schedule to close) was stressful for Vicky and her family.

Planning

5.93 In September 2021 Vicky was moved to her third placement in England. If she later comes home, where she stays in Northern Ireland would be her fourth 'placement' since July 2018. This would be worrying for any young person, but is especially so for somebody described by clinicians as needing consistency. At present there appears to be no plan to bring Vicky home. An application made by the WHSCT in July 2019 to the HSCB for funding to pay for placement in England noted that local options had been considered before Vicky was moved to England. It concluded that there were no medium secure units in Northern Ireland for adults with an ID and did not report any further discussions about developing such units.

5.94 Documentation from a year later considered Vicky's potential discharge from her placement in England at that time, reporting that there was no information on the housing options that would be available to her, other than to be supported to present as homeless to the NI Housing Executive, and that a property would be allocated to her based on her assessed need. These

comments were made by Vicky's then social worker within the WHSCT, and suggests that, in reality, no consideration had been made of bespoke options for Vicky.

5.95 There was no quantification of what 'supported' meant; it suggests that Vicky, a young person with significant diagnosed needs, would be expected to take initiative to ask for housing and to also be homeless when doing so. That such an application would then be subject to general criteria, presumably including the existing (and long) waiting lists for social housing in Northern Ireland, confirms that bespoke planning in the form of partnership with social housing providers was not thought of.

5.96 Three years after Vicky was sent out of Northern Ireland nothing had been done to address the non-clinical reasons (lack of suitable accommodation locally) for why she was sent away to begin with. It appears that such inaction is being used as a reason not to bring her home. Representations made by the WHSCT showed that an ECR in England remained their method of choice for accommodating Vicky. The WHSCT commented that placement in Northern Ireland would be considered as a contingency if a placement in England were not available. No substantive detail of how this would be structured was given, or detail of why a placement outside of Northern Ireland is inherently preferred to developing one locally.

5.97 A 'Social Circumstances Report' completed on 2nd July 2020 noted that if Vicky were to return to Northern Ireland and engage in aggressive behaviour she would most likely enter the criminal justice system, because she did not meet MHO (NI) 1986 grounds for detention.

5.98 Another 'Social Circumstances Report' completed almost a year later repeated the earlier comment that, if Vicky came home she would be supported to present to the Northern Ireland Housing Executive as homeless and that a property would be allocated based on assessed need. She would also be encouraged to apply for social welfare benefits. Reference was made to an unsuccessful period of community support, presumably that of 2017.

5.99 This does not suggest that efforts were being made to find a way to bring Vicky home. In the same report, it was noted that Vicky was currently in receipt of full-time treatment and support in a hospital setting and the WHSCT stated that it was unable to replicate this level of care and support in Northern Ireland. They predicted that Vicky would be likely to come to the attention of the criminal justice system within a short period of time, resulting in a custodial sentence.

5.100 The possible reaction of Vicky to the shortcomings of WHSCT care became the basis upon which the WHSCT should not have responsibility for directly caring for her. Thus, a failure to have already developed an amenity for Vicky became a reason to not try to do so. Further comment within the same documentation continued in similar vein. While the WHSCT recognised Vicky's desire to return to Northern Ireland, they argued that she appeared to have limited understanding of what would be expected of her to make such a plan possible. It was further noted that staff would continue to educate her on same. It is notable how much of an onus was placed on Vicky and there was no indication that an alternative solution to replicate the necessary level of care and support was being considered for Northern Ireland.

5.101 It was thus taken as a given by statutory agencies that Vicky could not come home, with a default acceptance of ECR as the only ongoing 'solution.' There appeared to be no discussion that the reason for this was ongoing absence of effort by the Trust (and other statutory agencies) to develop amenities satisfying the requirements of Northern Irish law. This was seemingly despite improvements in Vicky's presentation and condition whereby consideration could be given to her moving to a lower security setting.

5.102 When the WHSCT applied to HSCB in October 2021 for further for placement in England it again noted that Vicky had been assessed as needing placement in a low secure / high dependency setting and that this provision did not exist locally within Northern Ireland. Once again there was no discussion of what had been done to develop such provision. In the meantime, Vicky's placement in England cost more than £1,440,000.00 for the period of 2018 – 2021. As this placement is an ECR the HSCB rather than the WHSCT paid those costs. It is unclear the extent to which the WHSCT is required to or has accounted to the HSCB for the costs that might be involved (and potentially saved) if a bespoke facility was to be developed in Northern Ireland for Vicky.

5.103 The above noted sums could be better allocated in developing bespoke facilities within Northern Ireland. Such an approach could avoid moving vulnerable children and young people out of the jurisdiction, away from their families and familiar surroundings, thereby avoiding further distress or trauma. This is particularly relevant in light of HSCB guidance in respect of requests for ECRs.[69] Paragraph 3.5 thereof notes that

'Other than in exceptional circumstances ... Trusts should not submit ECRs for the following ...

... Care or treatment which is potentially capable of being developed locally but which has not yet been the subject of a Trust submission or Commissioner determination.'[70]

5.104 Given the ongoing position taken by WHSCT to date in respect of Vicky's continuing care and living arrangements, it is not known how this has been complied with. This is part of an overall issue as to how Vicky's placement is being monitored. In care planning documentation and tribunal reports there is no commentary suggesting ongoing uncertainty as to diagnosis or reasons for Vicky's presentation. This is significant given that part of the rationale for sending Vicky to begin with was to allow for an assessment. Instead, the Trust raise no objection to Vicky being moved between further placements in England.

5.105 When asked for contemporaneous documents regarding Vicky's care, WHSCT was unable (over the course of several months) to provide such. Subsequent correspondence advised that the noted relevant information could have been accessed and shared. This raises significant questions as to the level of partnership working in Vicky's in best interests. It also casts further doubt on to how effectively WHSCT are monitoring Vicky's placement.

69 https://hscboard.hscni.net/download/PUBLICATIONS/TRAVEL%20OUTSIDE%20NI%20FOR%20TREATMENT/ECR-Arrangements.pdf

70 Ibid

Adverse Finding 5.5: Failure to ensure that the ECR did not become an end in itself, with no planning in place for return to Northern Ireland.

- One of WHSCT's stated purposes in having Vicky transferred to England was the assessment that her condition might need a reduction in medication and doing so would require a type of medium security setting not available in Northern Ireland, which suggests that the placement would subsist only as long as such a setting was still required but not available in Northern Ireland;
- WHSCT failed to plan for the ECR, both before and after it started, to ensure that it did not become a long-term setting for Vicky by default;
- There is no evidence of any discussion as to how to develop a Northern Ireland based placement for Vicky following the initial assessment in England; rather evidence shows that social workers now consider that if Vicky is to come home, she would need to apply to the Housing Executive for accommodation;
- The review panel in England in 2019 explicitly commented that it was concerned to hear that no arrangements had been made in Northern Ireland should Vicky be released, which suggests WHSCT continues to rely on its own failure to make it possible for Vicky to come home, as a reason for not bringing her home.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Paragraph 9.53, Volume 4, The Children (NI) Order 1995, Guidance and Regulations;
- Regulation 3, The Arrangements forPlacement of Children (General) Regulations (Northern Ireland) 1996;
- Regulation 4, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Paragraph 4, Schedule 1, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Paragraph 3, Schedule 2, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Paragraph 3, Schedule 4, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Paragraph 9, Schedule 2, The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996;
- Article 20, United Nations Convention on the Rights of the Child;
- Article 23, United Nations Convention on the Rights of the Child;
- Article 8, European Convention on Human Rights.

Adverse Finding 5.6: Failure to ensure that Vicky's voice did not get lost in the process.

- Vicky explicitly stated she feared going to England, but it was retained as an option and her behaviour declined as this move was further discussed;
- Self-harming became a coping mechanism for Vicky and clinical opinion was that she felt hopeless;
- Clinical comment noted that the symptoms Vicky displayed before transfer to England may have been anxiety in relation to that move;
- Vicky has continually and repeatedly stated that she wishes to be brought home to Northern Ireland.

Breaches

The relevant legislative and rights frameworks which were breached or otherwise not upheld and were applicable at the time are cited below:

- Article 26, The Children (NI) Order 1995;
- Paragraph 2.44, Volume 3, The Children (NI) Order 1995, Guidance and Regulations;
- Article 12, United Nations Convention on the Rights of the Child;
- Article 10, European Convention on Human Rights.

NICCY recommends that the relevant authority/ies :

R41 Extra contractual referrals should only be used as a last resort and only after all possible avenues of support/service provision have been effectively considered and ruled out.

R42 Extra contractual referrals should be considered by a Panel (akin to the Restriction of Liberty Panel) with independent representation. A review should be conducted every six months to include monitoring of progress in returning the child to Northern Ireland. Where sustained improvement or change in circumstances is established this should be at three-monthly intervals.

CONCLUSION

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It was not NICCY's intention to undertake a lifelong review of the services that Vicky had received but it quickly became apparent that failings had occurred throughout her life. The initiation of the investigation was not taken lightly and the NICCY team were determined to be impartial and go wherever the evidence led, which turned out to be that the 'system' failed Vicky. That the system is made up of individual professionals is not lost on NICCY, but it is clear that it was not until Vicky was in custody for a number of months that some professionals shared their concerns with NICCY. The fact that this was not done earlier demonstrates a level of acceptance of poor services that is deeply concerning. Whilst it is impossible to assess how or where Vicky would be today, had she and her family received the services and care from the relevant authorities that they should have, it is reasonable to assume that her life would be very different.

The evidence of failure is irrefutable and it is NICCY's belief that in the light of that failure, the recommendations are reasonable. The vast majority of these concern the system with the purpose of ensuring that lessons are learned and there can be no more young people left in the same situation as Vicky, ever again. It is our intention that, through the recommendations, the social care system is able to meet the reasonably high expectations we have of it when it becomes a child's legal parent – that the child experiences compassion, stability, kindness and love – that their best interests are always at the centre. It is apparent that all relevant authorities must have return to the basic principles of the child being the focus of the work – rather than completing paperwork. They must work better together sharing plans to support vulnerable children and improved outcomes but also be constructively challenge of each other if/when necessary in the best interests of the child.

It is the Commissioner's expectation that many of the recommendations will be implemented through the Independent Review of Children's Social Care which is currently underway.

However, it is important that we do not ignore Vicky's current situation. She has been deprived of her liberty for nearly six years, the last four and a half of which has seen her hundreds of miles away from her family and home. Her focus is to return to Northern Ireland and the lack of a reasonable plan to address that at time of writing, is deeply frustrating and also, she believes, detrimental to her mental health. Her rights continue to be breached and this is an unacceptable situation. The final three recommendations are concerned with Vicky's current circumstances and will be a focus for NICCY as we work to monitor the implementation of all recommendations.

Vicky has struggled for her whole life to have her voice heard and her views taken into account. Her frustration, trauma, and ill-health have meant that her distress has been communicated in ways that were harmful to her and, on occasion, to others (in a very serious way). It is right that minimisation of those behaviours was a core focus of investigation. However, there must be an acceptance that ignoring her and her wishes is one of the most egregious failures of all relevant authorities, and the WHSCT in particular.

"Do I have to stay in England if they make me?

I am really worried if I stay in England I may get worse?

I am going to try really hard to be ok so I can get home."

There must be no more Vickys.

EPILOGUE

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Throughout the formal Investigation the Commissioner has engaged with Vicky as set out above.

As part of this engagement with Vicky, the Commissioner visited Vicky in early December 2022. The Commissioner also met with the clinical staff to discuss Vicky's current presentation, needs and capacity including in relation to the formal investigation. It was confirmed by clinical staff that Vicky was doing well and that there were no concerns in relation to her capacity. Vicky reported to the Commissioner that she understood that the WHSCT were exploring options in relation to alternative placements in Northern Ireland or the Republic of Ireland. A Care Programme Approach (CPA) meeting took place in the following days and following that meeting the Commissioner has continued to engage with Vicky by telephone.

Recent engagement between NICCY and relevant professionals within her current placement has confirmed that the clinical team are concerned that the current setting of a high dependence/ low secure ward is no longer suitable and believe that she would benefit from small bespoke community accommodation with support to meet her needs and manage any risks. It has also been confirmed that there is support from within the team who are currently working with her in her placement that all possible options for her return should be explored and that they are supportive of Vicky's return, to live in reasonable proximity to her Mum and family. There is still no plan in place to bring Vicky home.

Having taken the above into account and Vicky's own views we make the following recommendations.

R43 There should be concurrent planning for Vicky:

1. An independent expert clinician should be appointed to assess Vicky with a view for her to return. An action plan should be agreed and implemented based on the assessment.

2. Suitable accommodation and support services should be identified and secured, as close to her hometown as is feasible. This should be made available within two months of a clinician assessing that it is in her best interests to do so.

R44 Vicky and her family should be involved at every stage of assessment and their views and wishes must be taken into account in the agreement and execution of the action plan.

R45 An independent advocate should be appointed to support her through this process and for at least one year after her return home.

RECOMMENDATIONS

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Schedule of Recommendations (in Themes)

There is already regulation, guidance, policy, and established practice in place for some of the matters for which Recommendations are made. However, the existence of these has not stopped the failings noted in this report from happening. Given the severity of Vicky's experiences it is important that underlying causes of systemic failures be fixed. The only way that can be done is for effective structures and mechanisms to be put in place, including by review and remedy of those already there.

Strategic Care Planning

NICCY recommends that the relevant authority/ies:		Relevant authorities
R1	Review procedures and practice for co-ordination between health and social care staff within and across HSCTs to ensure that vulnerable prospective parents who may present a risk to expectant children are identified and engaged with, to prevent harm and promote the welfare of the child.	WHSCT
R2	Ensure timely identification of 'children in need,' and the planning and implementation of an action plan at relevant stages.	WHSCT
R4	Develop and implement policy and guidance that ensures consistent monitoring and reporting to senior Trust officials and regulatory authorities in the event of a delayed hospital discharge due to lack of availability of accommodation and care in the community.	WHSCT
R5	Monitor and record adherence to the welfare check list prior to a decision being made with regards to the application of formal orders and initiation of court proceedings.	WHSCT
R6	Ensure the provision of appropriate short-notice options for new born and young babies.	WHSCT
R17	Identify and record tangible actions that should be progressed and monitored when a risk to stability of homelife or deterioration is identified. Such monitoring should continue until the child experiences sustained safety and stability.	WHSCT
R19	Ensure that policies, practice and training are implemented and that the named social worker for the child is given time and support to understand the child's life and situation. There should be evidence that this informs the way they work with and advocate for the child and foster family.	WHSCT
R21	Ensure that assessments are undertaken and recorded in a timely manner and that interventions and supports are identified and provided accordingly. If this cannot be the case then reasons must be recorded and an action plan identified.	WHSCT
R22	Ensure that statutory planning and reviews consider all relevant information including an assessment of the child's mental health and cognitive ability and that there is an understanding of the causes and impact of any changes in behaviours. These should be addressed according to the best interests of the child and not available resources.	WHSCT

Collaborative Working and Information Sharing

NICCY recommends that the relevant authority/ies:		Relevant authorities
R3	Ensure that there are systems in place for data collation and information and that they are available for relevant professionals to access when required.	WHSCT/ EA/YJA
R11	Ensure that all relevant assessments (eg LAC Review) take into account a child's education and well-being and where this is not readily available is requested.	WHSCT/ EA
R23	Ensure that systems and procedures are in place to have one set of comprehensive records prepared and shared with those responsible for the care of a child.	WHSCT/ EA/YJA
R24	Ensure that care pathways between different disciplines in health and social care are seamless – there should be a 'no wrong door' approach.	WHSCT/ EA/YJA
R25	Ensure communication, cooperation and partnership working is effective for all looked after children in the JJC – with weekly contact between the Corporate Parent and the JJC. Similarly, the JJC and SCH should ensure effective communication when children move between the centres.	WHSCT/ YJA
R26	There must be a continuity of services (eg mental health and social work) which follow the child whether living in the community, residential or secure care, when assessed to be in their best interests.	WHSCT/ DOJ/EA
R27	Ensure that the education, youth justice, health and social care systems agree (in consultation with the child) the care plan and work together to deliver and review it accordingly.	WHSCT/ DOJ/EA
R28	Trust staff and managers must monitor records to ensure that there is accurate and contemporary information that assists and informs the care of the child across all systems.	WHSCT/ DOJ/EA

Education, SEN Support and Services

NICCY recommends that the relevant authority/ies:		Relevant authorities
R14	Work together to ensure that the child receives an effective education. A Corporate Parent must attend relevant meetings and take cognisance of reports and be held to account (including legally) in the same way as a birth parent when they fail to do so.	WHSCT
R15	Ensure that SEN and LAC Review processes work together (e.g by attending meetings, sharing information, and communicating regularly), so that a shared understanding of the child's circumstances and needs can be developed to improve planning and decision-making.	WHSCT/ EA
R16	Develop and implement effective guidance for schools, EA staff and their supervisors to ensure that assessments and reports are informed by the child's circumstances and their impact on their education.	WHSCT/ EA
R20	Review the role of Educational Welfare Service to consider what further role they may have when a child is known to social services, is looked after or has mental health issues.	EA

Foster Carers

NICCY recommends that the relevant authority/ies:		Relevant authorities
R7	Develop and implement policy and guidance that ensures effective training, support and supervision of foster carers specifically for children with complex needs. Such guidance should be monitored to ensure compliance.	WHSCT
R13	Develop and implement effective policy and practice to ensure that the views and concerns of foster carers are treated with respect and given due consideration. The Corporate Parent must engage with, record and properly respond to issues raised by foster carers.	WHSCT

The Corporate Parent

NICCY recommends that the relevant authority/ies:		Relevant authorities
R8	Ensure that the Corporate Parent effectively understands how different systems work and discharges their role as the advocate for the child with all other authorities, particularly education. They must persist when proposals are not in the best interests of the child.	WHSCT
R9	A child must never be threatened with removal from their home unless it is the only option to keep the child or others safe. Proper records must be kept of such decisions.	WHSCT
R10	Ensure that the Corporate Parent makes concerted efforts to understand the causes of a child's behaviour by engaging with them directly and responding appropriately.	WHSCT

The Voice of the Child

NICCY recommends that the relevant authority/ies:		Relevant authorities
R12	Ensure considered and appropriate responses are given when responding to a child's distressed behaviour and records are kept and monitored accordingly.	WHSCT
R18	Ensure the views of the child are being actively sought before all formal processes or decisions are made with regards to every aspect of their life. This should include, but not limited to, providing children with support to be active participants in their care, health and education and to understand the reasons that decisions are made.	WHSCT/ EA/DoJ
R29	Ensure that care planning involves the child or young person and is undertaken in a way that meets the child's assessed needs and cognitive abilities.	WHSCT

Young Person in Residential/ Secure Settings

NICCY recommends that the relevant authority/ies:		Relevant authorities
R30	Ensure that police attendance and interventions in children's homes are a measure of last resort.	
R31	The HSCT must never suggest or agree to bail conditions which are aimed at 'managing' a child or compelling their compliance with care home rules.	WHSCT
R32	Ensure that all residential settings including secure settings adopt an approved holistic and therapeutic approach to children in their care and that staff are supported and trained to implement the approach.	WHSCT
R33	All staff should be properly trained to support young people with additional needs.	WHSCT/ YJA

Follow up to Inspections

NICCY recommends that the relevant authority/ies:		Relevant authorities
R34	RQIA must follow-up and monitor recommendations of inspection reports on a monthly basis when in reference to or arising from a care of a particular child.	RQIA
R35	Legislation and regulations should be revised so that RQIA has powers to ensure compliance with recommendations.	DOH

Deprivation of Liberty

NICCY recommends that the relevant authority/ies:		Relevant authorities
R36	The law regarding bail must be revised to remove the JJC as a place of safety (removing lack of accommodation as a reason to remand).	DoJ
R37	The YJA should robustly challenge a Trust if they believe that they are not properly discharging their duty of care to a child. This includes escalating it to Ministerial and Permanent Secretary level if necessary.	YJA
R38	When a child is in single separation in the JJC for longer than three days an independent assessor must examine and assess the situation and report to the YJA CEO.	YJA
R39	The Assessor should escalate it to the DoJ if they deem that suitable action is not being taken.	DoJ
R40	No decision to apply levels of sensory and material deprivation in the JJC should be taken without consultation with an independent expert. Such decisions must be taken by the Centre Director.	YJA

Extra Contractual Referrals (ECRs)

NICCY recommends that the relevant authority/ies:		Relevant authorities
R41	Extra contractual referrals should only be used as a last resort and only after all possible avenues of support/service provision have been effectively considered and ruled out.	DoH (SPPG)
R42	Extra contractual referrals should be considered by a Panel (akin to the Restriction of Liberty Panel) with independent representation. A review should be conducted every six months to include monitoring of progress in returning the child to Northern Ireland. Where sustained improvement or change in circumstances is established this should be at three-monthly intervals.	DoH (SPPG)

Next steps for Vicky

NICCY recommends that the relevant authority/ies:		Relevant authorities
R43	There should be concurrent planning for Vicky: 1. An independent expert clinician should be appointed to assess Vicky with a view for her to return. An action plan should be agreed and implemented based on the assessment. 2. Suitable accommodation and support services should be identified and secured, as close to her hometown as is feasible. This should be made available within two months of a clinician assessing that it is in her best interests to do so.	WHSCT
R44	Vicky and her family should be involved at every stage of assessment and their views and wishes must be taken into account in the agreement and execution of the action plan.	WHSCT
R45	An independent advocate should be appointed to support her through this process and for at least one year after her return home.	WHSCT

Monitoring of Implementation of Recommendations

Article 19 of the 2003 Order sets out NICCY's required action following publication of a report on a formal investigation such as this. NICCY will therefore, as required,[71] maintain a register as to action/s to be taken by relevant authorities[72] and notice of same provided to them, containing details of:

(a) recommendations (together with the reasons for them) contained in reports made under Article 18;

(b) action taken by the Commissioner under paragraphs (1) and (3); and

(c) the results of any such action.

We will monitor periodically i.e. within three months of initial notice issued to the relevant authorities as to whether each has complied with NICCY's recommendations and if this is not the case, require a statement of the reasons for noncompliance. [Art 19 (1) (a) (b)].

Should the action taken, or proposed to be taken, be inadequate or the reasons given for non-compliance inadequate, NICCY may issue a further notice requiring the relevant authority to reconsider and respond within one month.

NICCY will also as required, ensure the Register is open to inspection[73] in specific circumstances as set out.

As stated earlier in this report, the intended expectation is that relevant authorities will implement NICCY's recommendations in addressing the systemic failings noted herein and change practice so that no child is subject to these going forward.

71 The Commissioner for Children and Young People (Northern Ireland) Order 2003 Article 19 (5)

72 The relevant authorities for the purposes of this investigation are WHSCT, RQIA, EA, and JJC (YJA/DoJ)

73 The Commissioner for Children and Young People (Northern Ireland) Order 2003 Article 19 (5) (6)

APPENDICES

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Appendix 1

Relevant authorities and other statutory body or organisations	Summary of information received
Business Services Organisation	Copies of documents held in relation to Vicky including: Health Visitor contact sheets Family assessments Growth charts Relevant correspondence School Health Records and Reviews Vaccination and immunisation records Health assessment forms Initial/Review health assessment forms Communication sheets Care planning meeting notes
Department of Justice	Copies of documentation in relation to Vicky including: Risk Assessments and updates Admission forms Behavioural and Physical Management Handling Plans Planning and review meeting minutes Progress/monthly summary documents Management plans LAC Review documents Key worker reports Case review reports Monthly summary reports Criminal record Social work correspondence Probation correspondence Community services correspondence Youth conference correspondence Key work records Intervention sessions records Records of Incidents Physical restraints records LSI forms Single separation records Accident Forms Complaints Forms Sanctions Forms Minutes of care planning meeting Psychological assessment Psychology notes Self-injury forms Records of discussions with the child

Relevant authorities and other statutory body or organisations	Summary of information received
Department of Justice	Admission Information Legal Orders Assessments and plans Pre-release meeting minutes Property records Daily records Progressive regime documentation Monthly summary Approval/Restriction contacts documentation Records of visits Youth Justice Agency assessment Psychiatric reports Custody records Criminal record Crisis management plan
ECR Placements	Copies of documents held in relation to Vicky including: Relevant correspondence Care programme approach reports and review documents ECR panel summary ECR referrals Care plans Incidents record Meeting minutes Individual Placement Agreement Consultant reports ECR referral documents including funding request documentation Social circumstances reports Records of transitions meetings Significant incident reports Summary reports Multi-disciplinary Care Co-ordination Meetings LAC Reviews
Education Authority	Copies of documentation held by EA in relation to Vicky including: Statements of SEN Annual review documents Clinical assessments Supporting SEN documents
Northern Health & Social Care Trust	Hospital notes, records, and documents held in relation to Vicky.
Regulation and Quality Improvement Authority	Inspection reports for relevant secure care centres for relevant periods of time.

Relevant authorities and other statutory body or organisations	Summary of information received
South Eastern Health & Social Care Trust	Files and documents held in relation to Vicky including: Therapeutic assessments Case consultation documentation Case management plans Relevant correspondence Family and professional information records Closure records Young person profile Individual crisis management plan Chronology of significant events records Secure accommodation and restriction of liberty panel decision forms LAC placement plans Vicky's safety plan Statutory visit records Contact records Admission checklists Transfer records Daily event records Clinical notes and records Discharge summary
Western Health & Social Care Trust	Files and documents held in relation to Vicky (whether paper or electronic) commencing with date that she was received into care and extending to 16/2/2018 including: Initial Fostering Assessment The link social work files Annual reviews and reports ECR documents Hospital notes and records Crisis Management Plans Risk Assessments LAC pathway assessments Contact records Event records LAC Statutory Visit Records Clinical assessments Care Planning Meeting documents LAC Review minutes LAC Care Plans LAC placement plans Individual Crisis Management Plans Monthly progress reports Medication records

Relevant authorities and other statutory body or organisations	Summary of information received
Western Health & Social Care Trust	Daily Event Records Correspondence between practitioners IQ tests Relevant meeting minutes UNOCINI documents Record of play therapy work Youth Justice documents Referrals for external support Medical record Court reports Trust diary sheets Trust telephone records Medical reports and assessments Health assessments SEN Review documents

Appendix 2

Glossary Of Abbreviations

ADHD	Attention Deficit/Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BHSCT	Belfast Health and Social Care Trust
BPD	Borderline Personality Disorder
CAMHS	Child & Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPA	Care Programme Approach
CPR	Child Protection Register
CQC	Care Quality Commission
CRH	Children's Residential Home
CSE	Child Sexual Exploitation
DoJ	Department of Justice
EA	Education Authority
ECR	Extra Contractual Referral
ECHR	European Convention on Human Rights
EEG	Electroencephalogram
ELB	Education and Library Board
EOTAS	Education Other than at School
EWO	Education Welfare Officer
EWS	Education Welfare Service
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
FIS	Foetal Insult Syndrome
GAL	Guardian ad Litem
GP	General Practitioner
HSCB	Health & Social Care Board
HSCT	Health & Social Care Trust
ID	Intellectual Disability
IQ	Intelligence Quotient
ICMP	Individual Crisis Management Plan
LAC	Looked After Children or Looked After Child

LD	Learning Difficulties
MAP	Model of Attachment Practice
MLD	Moderate Learning Difficulties
NI	Northern Ireland
NICCY	Northern Ireland Commissioner for Children and Young People
NHSCT	Northern Health & Social Care Trust
PACE	Police And Criminal Evidence
PICU	Psychiatric Intensive Care Unit
PR	Parental Responsibility
QIP	Quality Improvement Plan
PSNI	Police Service of Northern Ireland
RTM	Regional Therapeutic Model
RQIA	Regulation and Quality Improvement Authority
SCH	Secure Children's Home
SEBD	Social & Emotional Behavioural Difficulties
SEHSCT	South Eastern Health & Social Care Trust
SEN	Special Educational Needs
SENCo	Special Educational Needs Coordinator
TCI	Therapeutic Crisis Intervention
UNCRC	United Nations Convention on the Rights of the Child 1989
UNOCINI	Understanding the Needs of Children in Northern Ireland
VOYPIC	Voice Of Young People In Care
WHSCT	Western Health & Social Care Trust
WISC	Wechsler Intelligence Scale for Children
YJA	Youth Justice Agency

Appendix 3

Glossary of Defined Terms

Guidance	Children (Northern Ireland) Order Guidance and Regulations 1995
1995 Order	The Children (Northern Ireland) Order 1995.
Adverse Findings	A determination as a result of an investigation in relation to a failing or breach of a relevant authority.
Care and Treatment reviews	Reviews undertaken to improve the quality of care of patients in Learning Disability and Mental Health hospitals.
Corporate Parent	Corporate Parent Chapter.
Declaratory Order	An Order from a court that defines the rights of the parties regarding legal question presented.
Vicky's family	Vicky's foster family.
Foyle Trust	Foyle Health and Social Care Trust (later included within a newly established Western Health and Social Care Trust).
Health and Social Care Board	The Health and Social Care Board is the organisation responsible for the commissioning of health services for the people of Northern Ireland. (The Health & Social Care Board closed on 31st March 2022 with transfer of its functions to Department of Health and with staff from the Health and Social Care Board undertaking on 1st April 2022 to exercise their functions as part of SPPG).
JJC	Juvenile Justice Centre.
LAC Review	A LAC Review is a meeting with all those that are concerned with care and related planning for a looked after child.
MHO (NI) 1986	The Mental Health (Northern Ireland) Order 1986.
Mum	Vicky's foster Mum.
Relevant Authority	The relevant authorities for the purposes of this investigation are WHSCT, RQIA, EA, and JJC (YJA/DoJ).
SCH	Secure Children's Home.
Secure Accommodation Regulations	The Children (Secure Accommodation) Regulations (Northern Ireland) 1996.
SEN Review	A review of a Statements of Special Educational Needs that is in place (usually annual review).
Statement	Statement of Special Educational Needs.

Appendix 4

Terms of Reference

Terms of Reference for Formal Investigation (as updated)

Introduction

1. These are the Terms of Reference for a formal investigation by the Northern Ireland Commissioner for Children and Young People ("the Commissioner") into a complaint we have received that a looked after child spent more than 290 days on remand in custody. This investigation is conducted pursuant to the Commissioner for Children and Young People (Northern Ireland) Order 2003 ("the Order")

Statutory Framework

2. The NI Commissioner for Children and Young People has powers and duties which flow from the Order.

3. The principle aim of the Commissioner in exercising her functions under the Order is to safeguard and promote the rights and best interests of children and young persons - Article 6(1).

4. In determining whether, and if so, how to exercise her functions under the Order the Commissioner shall have regard to any relevant provisions of the United Nations Convention on the Rights of the Child – Article 6(3)(b).

5. The Commissioner has a duty to keep under review the adequacy and effectiveness of law and practice relating to the rights and welfare of children and young persons – Article 7(2).

6. The Commissioner has a duty to keep under review the adequacy and effectiveness of services provided for children and young persons by relevant authorities – Article 7(3).

7. The Commissioner may, for the purposes of any of her functions, conduct such investigations as she considers necessary or expedient – Article 8(3).

8. The Commissioner may conduct an investigation into a complaint made by a child or young person that his/her rights have been infringed by any action taken by a relevant authority; or that his interests have been affected by any such action – Article 12(1) (a)(b).

9. Under Article 3(4) of the Order, anything which is required or authorised by the Order to be done by a child or a young person may be done by his parent or any other person acting on his or her behalf; and references in the Order to things done by a child or young person include reference to things done on behalf of the child or young person.

10. The Commissioner may under Article 16(1)(c) conduct a formal investigation into a complaint made under Article 12(1).

11. Article 16(4)(b) requires the Commissioner to provide any relevant authority an opportunity to comment on any allegations made in the complaint and to give oral or other evidence respecting those matters. Under Article 16(9) if at any point during the course of the investigation it appears to the Commissioner that there may be grounds to make adverse report or recommendation the Commissioner shall afford to the authority the opportunity to give evidence and to test the relevant evidence upon which the Commissioner has relied.

12. Article 18 provides that the Commissioner shall prepare a report on the outcome of the investigation and send it to the relevant authorities. The report may include recommendations as to the actions to be taken by the relevant authority. Article

18(6) provides that where a report contains a recommendation as to action to be taken by a relevant authority, it shall be the duty of the authority to—

(a) consider the recommendation; and
(b) determine what action (if any) to take in response to the recommendation.

13. Where the Commissioner has made a report under Article 18 which contains a recommendation as to action to be taken by a relevant authority, in accordance with Article 19 the Commissioner may by notice require that authority to provide the Commissioner within three months of the date of the notice with—

(a) such information as will enable the Commissioner to determine whether the authority has complied with the recommendation or will be complying with it; or
(b) a statement of the authority's reason for not complying with the recommendation.

14. Article 19 further provides that failure to respond may be published in such a manner as the Commissioner considers appropriate. If the Commissioner considers that the response or proposals received from the authority is inadequate, a further notice from the Commissioner may be sent seeking that the authority reconsider the matter within one month. Failure by the authority to provide a satisfactory response may be published in such a manner as the Commissioner considers appropriate.

15. Article 20(1) states that for the purposes of a formal investigation, the Commissioner may require any person who in her opinion is able to supply information or produce documents relevant to the investigation to supply any such information or to produce any such documents.

16. Article 20(2) states that for the purposes of such an investigation, the Commissioner shall have the same powers as the High Court in respect of:

(a) The attendance and examination of witnesses, including the administration of oaths or affirmations and the examination of witnesses abroad and;
(b) The production of documents.

17. Where the Commissioner considers it necessary for the proper conduct of a formal investigation, the Commissioner may, at any reasonable time, enter any premises managed by a relevant authority in which:

(a) A child or young person is living or being looked after;
(b) A child or young person is being detained under any statutory provision; or
(c) Education, Health, Welfare or other services are provided for children or young persons.

18. If any person without lawful excuse obstructs the Commissioner or any officer of the Commissioner in the conduct of a formal investigation or is guilty of any act in relation to such an investigation which, if that investigation were proceeding in the High Court, would constitute a contempt of court, the Commissioner may certify the offence to the High Court – Article 22 (1)(a)(b).

Rationale for the Investigation

19. NICCY received a complaint (in accordance with Article 12(1)) that Vicky had, while a looked after child on the date of the complaint been held on remand in JJC for at least some two hundred and ninety days.

20. The complaint notes that this young person has Foetal Alcohol Syndrome and an IQ of 56, and that she exhibited self-harming behaviour requiring protective measures while in JJC.

21. It appears that while Vicky was in JJC there remained significant ambiguity as to her learning disability, including a lack of referral to appropriate services and professionals, despite her being held there on remand for a considerable length of time.

22. Having been made aware of the child's situation, the Commissioner is concerned that the child remained on remand in custody for such a protracted period of time and that there remained significant ambiguity surrounding her Learning Disability (and associated referral to appropriate services) whilst she was on remand in JJC.

23. These concerns give us cause to seek to formally investigate whether the child's rights have been adversely impacted by the action and/or inaction of any relevant authority (and potential associated systemic failings) in relation to the care and other services provided to her as a looked after child and, if they have, the effect it has had (or may have) on her.

Aim of the Investigation

24. The aim of the investigation shall be to:
    - Ascertain all relevant circumstances which led to the young person being held on remand for a period longer than 290 days;
    - Identify the realisation and any breaches of her rights;
    - Ascertain why there remained ambiguity surrounding the young person's learning disability and associated referral to appropriate services; and
    - To make recommendations where necessary.

Investigation Methodology

25. This investigation shall be conducted in private. Documentation shall be sought including, but not limited to, all care records held by the Trust in relation to the young person from the date of her reception into care to present. Where required, records will be sought from other relevant authorities. If necessary, evidence sessions will take place with relevant persons. All information will be analysed and a report on the findings of the investigation shall be produced with recommendations.

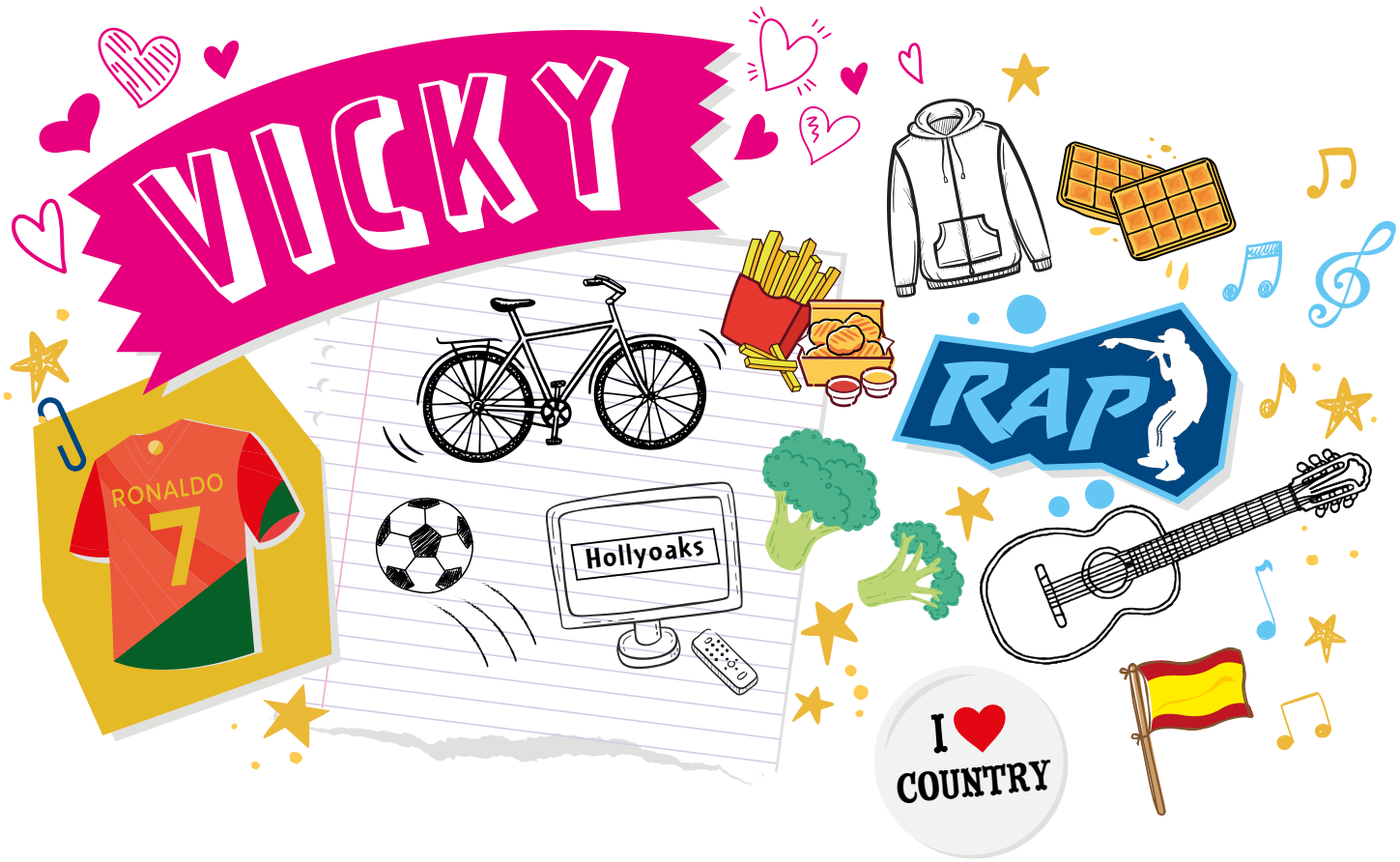
26. If an adverse finding is considered against any relevant authority they will be given the opportunity to comment on same and give oral or other evidence in respect of those matters before the report is finalised and any recommendations made.

27. No definitive timeframe has been set for the completion of the investigation however we will, at all times, endeavour to complete same with due expedition.

28. This investigation shall be conducted in line with our statutory powers and in accordance with best practice on investigations.

Ethical Considerations

29. This investigation shall be conducted in accordance with NICCY's corporate ethical guidance which can be accessed on request.



For further information:
Email: info@niccy.org
Phone: 028 9031 1616

Please contact the communications team at NICCY if you require an alternative format of this material.

Northern Ireland Commissioner for Children and Young People

Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

T: 028 9031 1616
E: info@niccy.org
W: www.niccy.org

nichildrenscommissioner
@nichildcom
niccy_yp

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