LOOKED AFTER?

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

EXECUTIVE SUMMARY

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 – relate 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.

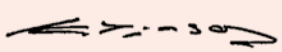
The first standard of conduct for social care workers is 'to protect the rights and promote the interests and wellbeing of service users and carers'[1] (NI Social Care Council). I am deeply ashamed of what the children's social care system became during the care of Vicky – paying scant attention to the 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 is a summary of the report 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)[2] establishing the Office. 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. 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]. Article 16 of the 2003 Order empowers the Commissioner to conduct "formal investigations" and further sets out the legal framework under which these can be conducted.

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 exhibited self-harming behaviour requiring protective measures while in the JJC. It also appeared 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.

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; 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 life and the actions and decisions of relevant authorities throughout her lifetime were pertinent to this investigation.

The substantive chapters in the 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

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

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. 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. Her 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.

METHODOLOGY AND PROCESS

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The formal investigation was conducted in accordance with the statutory requirements of the 2003 Order and by way of a document review of all the evidence that recorded engagement with the relevant authorities throughout the young person's life as well as through evidence sessions with the relevant authorities against which adverse findings could be made.

The names and places that could identify the young person, family or individuals involved have been changed or removed.

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.

NICCY also procured the legal expertise of Ms Monye Anyadike-Danes KC as Counsel to the formal investigation.

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.
- Dr David Foreman: Consultant Child and Adolescent Psychiatrist.
- Dr Eveline Knight-Jones: Consultant Paediatrician.

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 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)[5] 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.'[6]

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[7] 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[8] 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'.*[9] 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'.*[10]

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

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

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

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

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

10 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.'[11]

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

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

CHAPTER 1
POST BIRTH PERIOD (AGED 0 – 2)

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

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 Children (NI) Order 1995, Articles 17, 18, 21, and Schedule 2;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraph 2.18;
- United Nations Convention on the Rights of the Child, Article 6;[12]
- European Convention on Human Rights, Articles 5 and 8.

12 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 - incorporated into UK law by virtue of Section 6 of The Human Rights Act 1998.

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

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

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)

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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 Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.53, 3.3, 4.27, 5.1;
- The Foster Placement (Children) Regulations (Northern Ireland) 1996, Schedule 2(1);
- The Review of Children's Cases Regulations (Northern Ireland) 1996, Regulation 5, Schedule 2 (paragraphs 5 and 7);
- UK National Standards for Foster Care 1999, Sections 6.1 and 6.3;
- United Nations Convention on the Rights of the Child, Article 23;
- European Convention on Human Rights, Article 8.

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 Fetal Alcohol Syndrome (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 Children (NI) Order 1995, Article 46
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18 and 2.34

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

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

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)

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Adverse Finding 3.1: Lack of adequate supervision of Vicky's foster placement.[13]

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 Children (NI) Order 1995, Article 66, and Schedule 2, Paragraph 4;
- The Education and Libraries (Northern Ireland) Order 1986, Article 45;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18, 2.19, 2.44, 2.53, 2.79, 3.11, 4.54, 4.55, 5.1, 5.3, 5.20;
- Co-operating to Safeguard Children, May 2003, Paragraph 2.3;[14]
- United Nations Convention on the Rights of the Child, Articles 8 and 12;
- European Convention on Human Rights, Article 8.

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.

13 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.

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

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

- 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.

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

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

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

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 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.

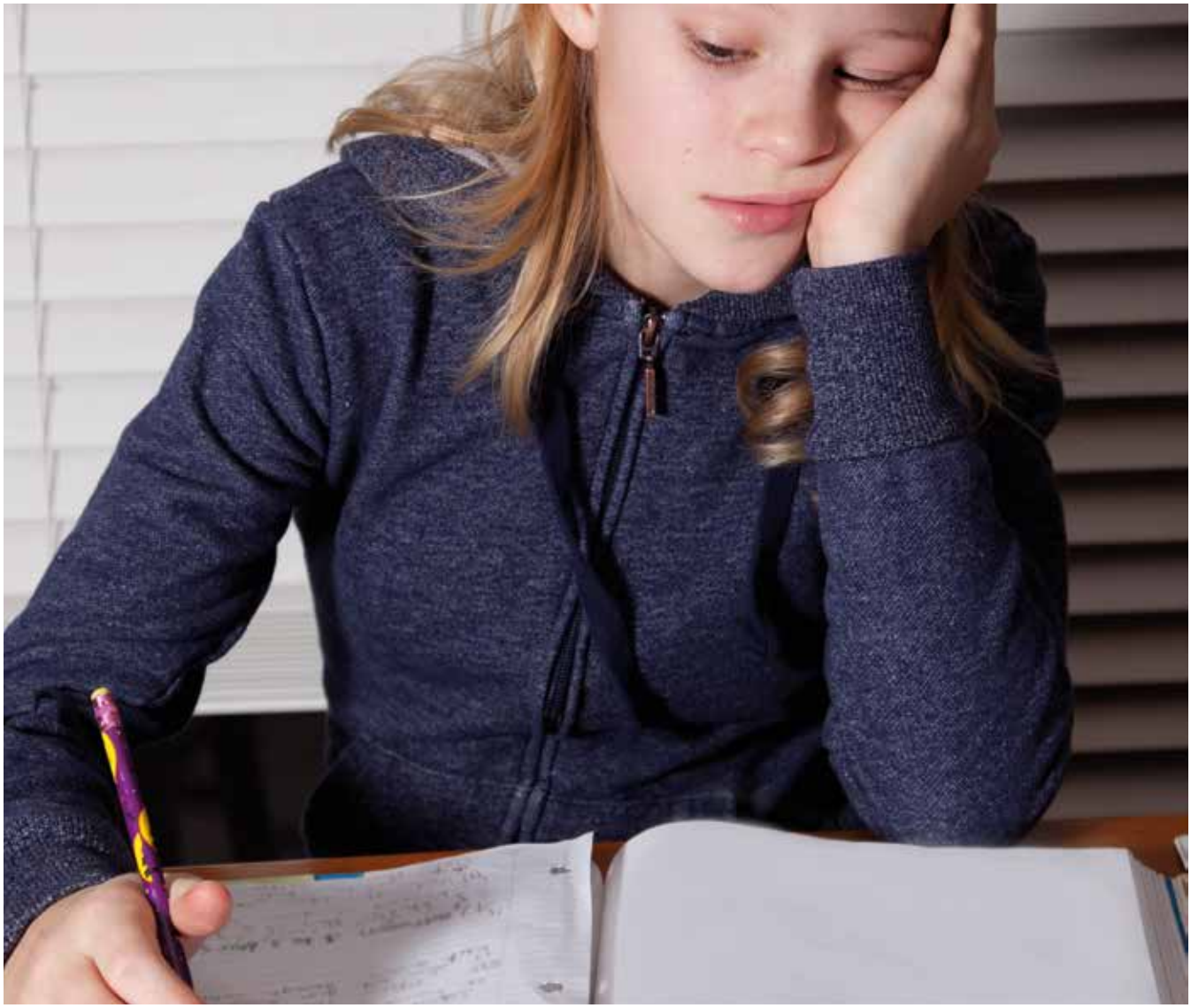
Whilst the Corporate Parent did at times note that Vicky did not cope well with change, experienced a lot of stress and anxiety, lacked social skills, and could interpret and process information differently, there is no evidence of the Corporate Parent seeking to explore this further or using the information 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 Children (NI) Order 1995, Article 66,
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18, 2.19, 2.26, 2.44, 2.53, 2.79, 2.80, 4.52, 4.54, 4.55, 5.20;
- The Review of Children's Cases Regulations (Northern Ireland) 1996, Schedule 2, Paragraphs 5 and 7;
- Co-operating to Safeguard Children, May 2003, Paragraphs 1.15 and 2.3;[15]
- United Nations Convention on the Rights of the Child, Articles 12 and 24;
- European Convention on Human Rights, Article 8.



15 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

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 Children's Residential Home (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 Children (NI) Order 1995, Articles 26, 27 and 72;
- The Children (NI) Order 1995; Schedule 2, Paragraphs 4 and 7;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18, 2.19 and 2.53;
- United Nations Convention on the Rights of the Child, Articles 12, 18 and 23;
- European Convention on Human Rights, Article 8.

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.

Model of Attachment Practice (MAP) and Therapeutic Crisis Intervention (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 Children (NI) Order 1995, Article 72;
- The Children (NI) Order 1995, Schedule 2, Paragraph 7;
- Paragraph 2.18, The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.19, 2.53, and Volume 4, Paragraphs 1.5, 2.3, 4.1, 4.4, 4.7.
- he Children's Homes Regulations (Northern Ireland) 2005, Articles 11, 25, 29;
- Minimum Standards for Children's Homes, April 2014, Standards 3.13 and 6.15;
- United Nations Convention on the Rights of the Child, Articles 18, 20, 27, 37, 40;
- European Convention on Human Rights, Articles 5, 8 and 14.

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

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

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; during that period there are numerous examples of poor communication, collaboration and co-ordination between the relevant authorities, particularly the Corporate Parent in not responding to appeals from the YJA to find alternative accommodation.

Each of the relevant authorities had a duty to co-operate with each other in the interests of Vicky's well-being.

The poor communication between agencies and confusion regarding her IQ, whether she had a learning disability as well as 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 Children (NI) Order 1995, Articles 26, 27 and 46;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraph 2.4, 2.18, 2.19, 2.53;
- Co-operating to Safeguard Children, May 2003, Paragraphs 1.15 and 2.3;
- United Nations Convention on the Rights of the Child, Articles 20 and 23;
- European Convention on Human Rights, Articles 8 and 14.

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

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

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

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

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.

She 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, which 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 engaged in such interactions, or in any event to actively seek Vicky's views so as to enable her voice being given proper weight or consideration in decisions regarding her care or her future.

Breaches

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

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.

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

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

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

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 Children (NI) Order 1995, Articles 27 and 72;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18 and 2.19;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 4, Paragraphs 1.2, 9.44 and 9.53;
- The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996, Regulation 3;
- The Committee on the Rights of the Child, (2016) Concluding Observations, Recommendation 61(c).

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; such reports it failed to act upon at the time, effectively acknowledged 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 Children (NI) Order 1995, Articles 26, 27 and 72;
- The Children (NI) Order 1995, Guidance and Regulations, Volume 3, Paragraphs 2.18 and 2.19.

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. This suggests that the placement would exist only as long as such a

setting was still required but not available in Northern Ireland.

WHSCT failed to plan in respect of the ECR - both prior to and after it had begun - to ensure that it did not become a long-term 'situation' 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/when Vicky was 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 put in place / progressed 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 Children (NI) Order 1995, Guidance and Regulations, Volume 4, Paragraph 9.53;
- The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996, Regulations 3 and 4, Schedule 1 (paragraph 4), Schedule 2 (paragraphs 3 and 9), and Schedule 4 (paragraph 3);
- Article 20, United Nations Convention on the Rights of the Child, Article 20 and 23;
- European Convention on Human Rights, Article 8.

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

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

NICCY
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It is clear that 'the system' failed Vicky. That the system is made up of individual professionals is not lost on NICCY, but it was only once Vicky was in custody for several months that some professionals shared their concerns with NICCY. The fact that this was not done earlier demonstrates a level of acceptance of a paucity of 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 vast majority of NICCY's recommendations relate to '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 and that their best interests are always at the centre. It is apparent that all relevant authorities have to return to basic principles of the child being the focus of their work – rather than completing paperwork. They must work better together - sharing plans to support vulnerable children and improve outcomes but also be constructively challenging of each other if/when necessary. It is NICCY's expectation that many of the recommendations will be addressed / implemented through the Independent Review of Children's Social Care in Northern Ireland, currently underway.

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 have seen her hundreds of miles away from her family and home. Her desire is to return to Northern Ireland and the lack of a reasonable plan 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 unacceptable. Our final three recommendations are concerned with this and will be a focus as we monitor the implementation of all recommendations.

Vicky has struggled during her 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 minimising those behaviours was a core focus. 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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CHILDREN & YOUNG PEOPLE

Throughout the formal investigation the Commissioner has engaged with Vicky. As part of this engagement 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 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, 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

NICCY
PROMOTING THE RIGHTS OF
CHILDREN & YOUNG PEOPLE

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 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,[16] maintain a register as to action/s to be taken by relevant authorities and notice of same provided to them,[17] 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 non-compliance.[18]

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 in specific circumstances as set out.[19]

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.

16 The Commissioner for Children and Young People (Northern Ireland) Order 2003 Article 19 (5)
17 The relevant authorities for the purposes of this investigation are WHSCT, RQIA, EA, and JJC (YJA/DoJ)
18 The Commissioner for Children & Young People (Northern Ireland) Order 2003 Article 19 (1) (a) (b)
19 The Commissioner for Children and Young People (Northern Ireland) Order 2003 Article 19 (5) (6)

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