National Review Panel

Review undertaken in respect of the death of Adam, a child known to the child protection system

January 2012

1. Introduction

This review has been carried out in accordance with the HIQA 'Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care' issued in 2010. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Deaths of children in care including deaths by natural causes
- Deaths of children known to the child protection system
- Deaths of young adults (up to 21 years) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act 1991
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious incidents involving a child in care or known to the child protection service

2. National Review Panel

A national review panel was established by the HSE and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately 20 independent persons who have relevant expertise and experience in the areas of child protection social work and management, psychology, social care, law, psychiatry and public policy. The panel has functional independence and is administered by the HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the National Review Panel. The National Director and the Chairperson of the NRP together decide on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

Under the HIQA guidance, reviews should be conducted by individual teams of between two and four members including the chair. The process to be followed consists of a review of all documentation and data that is relevant to the case, interviews with parents or carers, families and children, and site visits. A report will be produced which contains a detailed chronology of contact by services with the child and family, an analysis thereof, conclusions, and recommendations. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

- **Major review** to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.
- **Comprehensive review:** to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations
- **Concise review:** to be held where the involvement of HSE services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations

- **Desktop review** to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

- **Recommendation for internal local review** to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death

This review concerns the death of Adam, a boy in his early teens who died by suicide in late summer 2010. He had been referred to the social work department (SWD) of the local HSE Children and Family Services in late 2009 and the case was still open at the time of his death, though involvement with social work services had been minimal.

5. Level and Process

This was a **concise review** as the involvement of the HSE services in this case was of relatively short duration and low in intensity. The review team consists of three members:

Professor Helen Buckley, Ms Margaret Beaumont and Dr Nicola Carr. Professor Helen Buckley chaired the review.

Based on this case file provided to the review, the review team compiled a chronology from the date of the original referral to social work via Garda notification in autumn 2009 to Adam's death in late summer 2010. Having read the case file, the review team members identified a number of people including family members, social workers and allied professionals to whom they wished to speak.

Letters outlining the nature and purpose of the review and requesting an interview were sent to the following individuals:

- Mother and maternal grandmother of the young person
- Birth father and paternal grandmother of the young person
- Family GP
- Duty social worker who had the main involvement with Adam's case
- Team Leader, Social Work Department (SWD)
- Principal Social Worker
- Child and Adolescent Psychiatrist
- Gardaí

Members of the review team met with the following individuals for interview on dates in the spring of 2011:

- Birth father and paternal grandmother of the young person
- Family GP
- Duty social worker who had the main involvement with Adam's case
- Team Leader, SWD
- Principal Social Worker
- Child and Adolescent Psychiatrist

The remaining individuals who were invited for interview either were unable or declined to attend.

Prior to attendance at interview, each participant received written information outlining the purpose and process of the review. Participants were invited to submit a written statement concerning their involvement with the young person prior to interview. Three individuals submitted written statements in advance of interview:

- GP
- Social Worker
- Child and Adolescent Psychiatrist

Each individual interview was recorded and subsequently transcribed. These transcripts form part of the record considered in the review. In addition to this the review team also requested a number of documents from the local HSE department. These included a document detailing the local organisational structure and a document detailing the case-weighting methodology used in this area.[1]

6. Terms of Reference

The review was undertaken under the following terms of reference:

- To establish the facts with particular reference to the role(s) played by the HSE and HSE funded agencies prior to the death/serious injury of the young person concerned
- To review the HSE child protection service in the context of compliance with:
    - Existing legislation
    - Policy directions
    - Key professional standards
- To consider issues of interagency and intra-agency cooperation and communication
- To prepare a report for the HSE which
    - Identifies opportunities for learning from this review
    - Makes recommendations

7. Details of young person

Adam, a young teenager was one of two siblings. His mother and father separated when he was younger and he resided mainly with his mother but maintained regular contact with his

[1] A document outlining the case-weighting methodology was sent to the Review Team in January 2012.

father, with whom he spent most weekends. The family had previous contact with the social services but this case had been closed in early 2009. There had been no other known social work involvement with Adam or his immediate family prior to the Garda referral in autumn 2009.

All of the people with whom we spoke, for the purposes of this review who knew Adam well describe a popular, outgoing young person who was well known and well liked and whose tragic death has profoundly affected them all.

8. List of services involved

The following is a list of the main services involved in this case:

- **HSE Social Work Department**
- **An Garda Siochana** – The original referral to social services in respect of Adam was made by the gardai.
- **Family GP –** Adam was known to his family GP since his birth. His GP referred him to the local Child and Adolescent Mental Health Services (CAMHS).
- **Child and Adolescent mental Health Services (CAMHS)**
- **Education and Welfare Officer**

9. Background and reason for contact with Children and Family Services

Adam was referred to the SWD in autumn 2009 after coming to the attention of the Gardai when he was a victim of an assault. This assault occurred late at night in a public area, and Adam was reported to be under the influence of alcohol.

10. Brief summary of child's needs

As outlined above, when Adam was first referred to the SWD by the Gardai, he had been the victim of an assault and had been reportedly under the influence of alcohol. Some months later, he was involved in incidents of self harm, including cutting, a suicide attempt with a rope and a suicide attempt involving an overdose. Interviews with Adam's family members and professionals who had contact with him in this period revealed a number of issues that may have impacted on his psychological and emotional wellbeing around that time. These

included the relatively recent death, by suicide, of a family member with whom Adam had a close relationship. During this period it was reported that Adam had poor attendance at school and was involved in a range of risk-taking behaviours including alcohol and drug misuse. He was reported missing from his mother's home on at least two occasions and had been the subject of a criminal investigation in relation to a theft and a driving offence.

All this information suggests that Adam was a young person who needed support and treatment in respect of his mental health needs. The social work records also indicate that members of his family were looking for support in managing Adam's behaviours.

11. Chronology of contact between HSE Children and Family Services and Adam between autumn 2009 and June 2010

When referring Adam to the SWD, the Gardai completed a 'standard notification form' noting the time of the assault and the fact that Adam appeared to have been under the influence of alcohol. This standard notification form was sent to the SWD four days after the incident. The faxed notification was received by the duty social worker and its receipt was acknowledged to the Gardai via a standard fax sent from the SWD on behalf of the principal social worker.

On receipt of this notification the duty social worker completed a 'preliminary inquiry form'. This 'preliminary inquiry form', a type of screening tool used across child protection and welfare social work services in this region, noted previous social work contact with Adam's sibling and recorded that nature of the referral as 'a welfare concern re alcohol'. The duty social worker then sent a letter to Adam's mother and father but sent this to the home address of his mother only. The previous case records had indicated that his parents were separated and no longer living together. This letter asked Adam's parents to make contact with the social work department.

The case files records that no contact was made by Adam's parents following this initial correspondence. A further letter was sent to Adam's mother's address five days later. Three days later a phone call was received by the SWD from Adam's mother, in which she asked for someone to contact her 'immediately'. The case file records that attempts were made to contact Adam's mother via telephone. However, these were unsuccessful and there was apparently no facility to leave a message. A further letter was sent to the family twelve days later, once again requesting that they make contact.

The case file indicates that three months passed before the SWD made any further contact with the family. In the meantime, the Gardai had contacted the SWD to enquire about the case.

In early 2010, a further letter was sent to Adam's family and some days later his maternal grandmother contacted the SWD and spoke with the duty social worker. Here the young person's grandmother informed the social worker that Adam was 'out of control' and voiced concerns regarding his possible drug use. Two days later Adam's mother contacted the duty social worker, this time to report that Adam had gone missing. She was advised to contact the Gardai. Later that day, Adam's mother contacted the SWD to report that Adam had returned. An appointment was offered to both herself and Adam at the SWD that afternoon. The social worker told the review team in interview that Adam's mother in fact contacted the department later that day to say that Adam was tired and did not want to attend.

The social worker arranged to visit Adam and his mother at home the following day. This home visit, in early 2010, was the first time that Adam met with a social worker. In interview with the review team, the social worker set out the context of the home visit, and described meeting with Adam's mother and discussing her concerns regarding her son's behaviour and the circumstances surrounding the Garda notification. The social worker's view was that the assault of which Adam was a victim involved another young person and was not of a 'serious' nature. During this visit, the social worker also met with Adam who admitted to alcohol use over the previous six months and also to using 'headshop' products. Adam told the social worker that he intended to stop using these substances. Adam's mother also discussed the family's experience of bereavement and the impact that this had had on Adam. The social worker suggested a referral to a counselling service to Adam; however, it is reported that Adam stated that he did not want to attend for counselling. At the end of this visit, the social worker informed Adam's mother that they would be in contact. However, no further appointment was arranged at this stage. The case notes from this visit record the areas of concern as a series of bullet points as follows:

- Poor school attendance
- Experience of bereavement
- Alcohol use
- Use of 'headshop' products

Following this home visit, further contact ensued between the social worker and other professionals involved with this young person. A case note from spring 2010, records telephone contact with the Garda who had made the original notification to the SWD. The case note records that the Garda and social worker discussed the case, noting the impact of the family bereavement on Adam and agreeing to keep each other appraised of any developments. The social worker had also spoken to the education and welfare officer (EWO) in relation to Adam in early March 2010, in order that the EWO would 'speak with the family before poor attendance at school became a crisis issue'.

In the three-month period following this home visit there is no record of any further social work involvement with the family. However, in summer 2010 a letter was sent to Adam's mother by the SWD informing of the intention to hold a Family Welfare Conference. In interview for the purpose of this review, the social worker stated that plans for a Family Welfare Conference were instigated following a further telephone discussion with the Garda in early spring 2010. The Garda had reported that Adam was still involved in 'risk behaviours', specifically staying out late and drinking alcohol.

The social worker attempted a further home visit in summer 2010, however, neither Adam nor his mother were at home on that occasion. The social worker was unaware at this stage that Adam had been admitted to hospital following a suicide attempt. The SWD was not informed of this admission until they were copied into correspondence between the consultant child and adolescent psychiatrist (who saw Adam following this admission) and his GP. The social worker therefore only became aware of this suicide attempt over a week after the failed home visit.

The review team was told by the social worker that no contact was made with either the family or the psychiatrist directly after receipt of this letter. The case was brought up by the social worker with the team leader, and it was agreed that it would be discussed at the joint CAMHS-Social Work meetings, which take place in this area on a bi-annual basis. The social worker told the review team that it had been clear from the letter that Adam was receiving an intervention from CAMHS and that the social worker had a number of other high priority cases in this period, had annual leave due, and was about to move to another post within the HSE.

The Family Welfare Conference did not take place and there is no further record of social work involvement with the family. Adam died by suicide later that summer.

CAMHS INVOLVEMENT

Separately from the social work involvement, Adam had been referred to the Child and Adolescent Mental Health Service (CAMHS) by his GP in June 2010 following an incident of self-harm by cutting. This incident was not considered to be life threatening. Adam was seen for an initial (mental health) assessment with a senior clinical psychologist and a consultant child and adolescent psychiatrist. It was concluded that he did not have a major mental health disorder. However, this assessment noted that Adam was experiencing 'an unresolved grief reaction' due to a recent bereavement and that he was engaged in 'risk-taking behaviours' including alcohol and drug use.

Following his initial assessment Adam was discharged from the CAMHS service on the basis that he did not have a major mental health disorder. It was agreed with Adam and his mother that he would be referred for bereavement counselling. The consultant child and adolescent psychiatrist also recommended ongoing support from the social work department and supports from the family support team. This recommendation was made in a letter from the psychiatrist to the family GP, which was copied to the SWD. No direct contact had ever been made by CAMHS with the SWD in relation to this recommendation. Bizarrely, this correspondence (dated a month after the consultation); was not received by the social work department until after Adam's death.

In interview for the purpose of this review, the consultant child and adolescent psychiatrist told us that the recommendation for supports to be provided by SWD via a family support team was made in the expectation that the SWD would conduct their own assessment of the case and allocate this resource to the family. However, as outlined above, no direct approach was made by CAMHS to the SWD in relation to this case. Furthermore, this information was not received by the SWD until after Adam's death - two months after the initial appointment. In interview the psychiatrist explained that this was possibly due to an administrative delay in her department.

At interview, the CAMHS psychiatrist explained the context of the recommendation that the SWD should provide family support:

> *I suppose at the time of the initial assessment the case wasn't active to the social work department and when a case isn't active to the social work department -- I suppose the experience we have is that they won't actually engage in strategy meetings or dialogue, meaningful dialogue with CAMHS until the case is active. They have to do*

their own assessment, and that is why I would have put it in as a recommendation and copied it in the report.

The psychiatrist further explained that she understood that there has been an overall increase in the level of referrals to the SWD and because of capacity issues there was a waiting list in operation at that time. She said that if the social work department was actively involved with a case it was easier to engage with social work personnel. However, the psychiatrist also noted:

... unless there is an actual child protection concern, a specific child protection concern, our findings are noted but it is documented in the file and the case would have to reach the social work department's threshold before it would become active with them.

The day after his initial appointment with CAMHS, and his subsequent discharge from the service, Adam was admitted to hospital following what was described by the psychiatrist 'as an impulsive overdose'. He was first seen in hospital by an on-call consultant adult psychiatrist who 'did not find any evidence of clinical depression, major mental health disorder or suicidal thoughts, plans or intent.' The CAMHS psychiatrist saw Adam three days later and similarly concluded that he was not at that time expressing active suicidal intent. This was the second time that Adam was seen by CAMHS. At this stage it was agreed that Adam would be discharged from hospital, and a discharge plan was agreed with Adam and his father. At interview, the psychiatrist stated that she understood that both parents had agreed that Adam would be discharged to the care of his father. The psychiatrist told the review team that they would normally 'put responsibility back to the parents' provided they felt that parents were capable of taking responsibility and providing supervision. Otherwise, CAMHS would discuss the case with the SWD.

The discharge plan included a follow-up appointment with the CAMHS clinic two days post-discharge; referral to counselling and an agreement that Adam would be under 24-hour adult supervision. The report also noted that safety-planning information was given to Adam's father, i.e. he was advised to ensure that Adam did not have access to medication.

Adam was seen with his mother by CAMHS for a follow-up appointment two days following his discharge from hospital. This was his third consultation with the psychiatrist. In interview the psychiatrist stated that the intention had been for Adam to stay with his father, but it transpired at this follow-up appointment that he had in fact stayed with his mother. The

psychiatrist said that she presumed this was decided between both parents. Following this appointment a letter was sent by CAMHS to Adam's GP, again with a copy to the SWD. The letter noted Adam's admission into hospital following a suicide attempt, his discharge from hospital and the proposed plans following discharge. This social work case file records that this letter was received five days following this out-patient appointment. This was the ***first*** correspondence that the social work department had received from CAMHS in relation to Adam (despite the fact that it was the third occasion that CAMHS had met with Adam). At this stage the social work department had not received the copy of the letter initially sent by CAMHS to Adam's GP which detailed the first assessment conducted by CAMHS.

Adam was offered a further appointment with CAMHS later that month. He did not attend for this appointment. A letter was sent by CAMHS to Adam's mother requesting that she contact the clinic to arrange a further appointment. There is no record of contact being made and Adam did not attend for any further appointments prior to his suicide the following month.

The social work file contains copies of ***three letters*** from CAMHS to Adam's GP i.e. correspondence between the CAMHS and Adam's GP, copies of which were sent to the SWD. The dates on which the correspondence was received by the SWD, as evidenced by the date of letters and stamped date of receipt by SWD, are in incorrect chronological order. For example, the first correspondence received by SWD as outlined above pertains to Adam's hospital admission; the second correspondence pertains to a failed follow-up appointment following this hospital admission. The last correspondence received by the SWD in fact relates to Adam's ***first*** contact with CAMHS for initial assessment, which related to a self-harm incident in June. The correspondence relating to this initial assessment was not received by the SWD until after Adam's death, almost two months after Adam's first contact with CAMHS

Garda Involvement

The Garda involved in this case was invited to attend for interview with the review team, but declined. The available information (from the social work case file and interviews with others), outlines that as well as being the source of the original referral to the SWD, the Gardai had had ongoing contact with Adam in relation to other matters, which included the theft of a car for which he was facing possible prosecution. It is also evident from the social work case notes and from the interview with the social worker, that there was telephone communication between him and a Garda concerning Adam and that the Gardai had in fact

checked the status of the case on a number of occasions. Given the involvement of the Gardai with this young person it is regrettable that no member was available for interview.

12. Analysis of the involvement of HSE Children and Family Services

12.1 Social work response to initial referral

It appears from the outset that this case was considered relatively low priority in terms of child protection risk, and the social worker confirmed this at interview. It is the practice within this SWD for appointment letters to be sent to parent/s in the context of such referrals. This places the onus on parent/s to respond to the social worker. In this instance, when there was a delay in the response and when the social worker was unable to contact the young person's mother by return call, there was recourse to sending further letters. The review team does not consider this practice as a proactive method to engage with young people and their families. If a referral is received and the initial screening suggests a need for further assessment (as this case did), then in the view of the review team, it is the responsibility of the SWD to carry this out rather than waiting for the next contact from the family.

Contact was eventually made via telephone with the social worker by Adam's maternal grandmother in early 2010. She described Adam as 'being out of control' and requested social work intervention. Following this contact, a home visit was arranged by the duty social worker and took place shortly afterwards. This is the first point at which Adam was seen by a social worker following the original referral in autumn 2009. Judging from the number of concerns that were noted, it could be reasonably inferred that a speedier response to the initial referral should have been made.

12.2 Assessment

The evidence of social work assessment in this case is limited. As outlined, a preliminary enquiry form was completed following the original referral. This contained basic information on the composition of the immediate family. Following the home visit to Adam and his mother, the social worker's case notes provide further assessment of the family situation. These notes, based on interviews with both Adam and his mother, provided some indication of the behaviours that were of concern; including Adam's alcohol and drug misuse, and his non-attendance at school. The social worker's assessment of the situation appears to have been corroborated by discussion with the referring Garda.

While it is possible that this assessment may have been valid in relation to the information available at the time, this assumption cannot be adequately evidenced because a comprehensive assessment was not undertaken in respect of this young person. For example, while the social worker was aware that Adam spent time with his father, there is no record of Adam's father being contacted at any stage by the social worker. In fact at interview with Adam's father and paternal grandmother for the purpose of this review, it emerged that there was much more contact between Adam and his father than the social work record implied. Adam's father had brought him to hospital following his overdose attempt and Adam had been discharged to his father's care on this occasion. Adam's father reported to us that social workers had not made contact with him at any stage despite his being a legal guardian of both Adam and Adam's sibling. The review team regards this as a breach of good practice.

12.3 Compliance with Regulations

This case was originally received by the SWD following a Garda Notification. This was processed in accordance with the guidance set out in Children First (Section 7.7.4, (i)). The SWD acknowledged receipt of the notification indicating that a duty social worker would be dealing with case in accordance with Section 7.7.4 (ii) of the Children First guidance.

The first telephone contact between the SWD and the Gardai was made, in fact by the referring Garda approximately two months following the notification. This was in breach of Section 7.7.4(iii), which stipulates that direct contact should be made by the assigned social worker to the assigned Garda without delay.

12.4 Quality of Practice

12.4.1 Interaction with the child and family

When the social worker first met Adam and his mother, a range of issues was discussed relating to Adam's behaviour. As a result of the discussion, a proposed regime of limit setting was agreed between the social worker, Adam and his mother. However, three days later the social work notes record that Adam's mother had telephoned the social work department to report that Adam had 'gone missing' again and that Adam has sent his mother a text stating that he did not wish to return home. The case notes record that Adam's mother was advised to report the matter to the Gardai immediately. There is no

information on file to indicate whether this occurred and there is no record of a follow-up from the SWD in respect of this report.

A letter on the case file dated summer 2010 from the social worker to Adam's mother indicated a plan to hold a Family Welfare Conference and arranged an appointment to meet with Adam's mother the following week to discuss this. There is no record of social workers following up on this correspondence. At interview, the social worker explained that at this stage he was on leave and was preparing to leave this team to begin another job. It therefore appears that there was no one with delegated oversight of this case.

In summary, the social worker met with Adam and his mother on one occasion four months following the initial referral. A comprehensive assessment was not completed in respect of this case and there was limited social work engagement with Adam and his family. This according to the social worker was because the case was not viewed as a high priority and was viewed as a 'welfare' case rather than a 'child protection' case requiring more intensive intervention. At interview for the purpose of this review the social worker described his perception of this case:

> *You know, it was a bottom drawer case...It was one of these...it wasn't a child protection case; it was very much a welfare case. Based on the initial engagement, based on the hesitance or the inability to engage initially, my own sense of it was 'this is a slow burner'.*

12.4.2 Child and Family Focus

When the social worker did meet with Adam and his mother it appears that there was a genuine focus on the issues that Adam and his family were facing. The case notes and the social worker's account of this meeting indicate that he engaged with Adam, offering to refer him to counselling. In the event, Adam did not want to do this. However, overall the limited social work intervention in this case suggests that the child and his family were not a pressing focus for this department.

12.4.3 Quality of Recording

On the whole the information available is recorded clearly, however, the information is limited and this reflects the limited nature of the social work intervention.

12.5 Management

12.5.1 Case-weighting system

At interviews conducted for the purpose of this review, the principal social worker, team leader and allocated social worker all described how the extent of referrals to the SWD exceeded the capacity of the team to manage this load. As a response to this long-standing issue the principal social worker explained that a case-weighting system had been devised in the local area to manage the social work caseloads.

The team leader responsible in this case explained that the process for weighting cases involved a measure of 'risk', an assessment of the complexity of the case, including the level of access arrangements and the distance that the social worker would be required to travel to visit the child and family. The team leader in the following excerpt from the interview conducted for the purpose of this review describes this:

> *How we do it is, we will say for children in the community or in care and you rate risk, 1, 2 or 3. So 3 would be the highest in terms of risk and then complexity again is 1, 2 or 3 and a very complex case obviously if there is a lot of Court, case conference strategy meetings, maybe if clients are very aggressive I think that is another noncompliant clients again is a point because if people don't want to engage and you feel you have to engage, then that is a difficulty and if people have to travel .... So, you know, we have to allow for travel as well and access. I think if there is a lot of access that it another, you know, some children that would have a lot of access with parents, you know, if the plan is that the children would return home but if it is a long term, access is reduced, but there would be a point if there is a lot of access then, there would be a point for that as well. So that is how we do it.*

In the course of the interviews it emerged that the 'case-weighting' system was something of an 'ad-hoc' management tool, in that the three members of staff (social worker, team leader and principal social worker) to whom we spoke appeared to have different understandings of the use of the tool, and in any event the points system devised did not seem to prevent a social worker being allocated a case even where they were perceived to have a high case load.

12.5.2 Restrictions on travel

A further noteworthy issue raised in the context of this review was the limit on mileage imposed across the HSE which had directly affected levels of contact with children and

families particularly in a wide geographical area. At interview, the social worker observed the following:

> *...like letters we were getting from the childcare manager and our principal, you know, keep your mileage down, reduce your mileage, you know, you're restricted to 300 kilometers a year, or something crazy like that...And, you know, even – you know, when we knew that this review was coming up, you know the question was actually asked of me, you know, why didn't you go out? ...From the same person who wrote me letters saying, your mileage is too high you need to cut it back.*

While this specific issue may not have directly impacted on the case under review it is clear, given the relative low priority afforded the case from the outset, that this restriction affected social work practice and contact with children and families more broadly.

12.5.3 Supervision of social work staff

The stated practice for supervision of social work staff in this area is three-weekly supervision with the team leader. The reality of supervision practice, however, appears to have been somewhat more fluid. Although supervision sessions were scheduled between the team leader and the social worker, it was reported that these did not always happen as a result of other arising work demands.

At interview the team leader told us that the purpose of supervision with social workers was to discuss allocated cases and the weighting and management of these. The agreed practice involved discussing a case, and then writing a log which would be copied into the case-file. Given the high case loads and demands of the work, the social worker explained that not all cases are discussed in supervision. This pattern is evidenced by the lack of a supervision log pertaining to Adam's case on the social work file.

In turn, it is stated that the team leader meets with the principal social worker for formal supervision every three to four weeks. Here the principal social worker described the cases he discussed in supervision with the team leader were those perceived as being more 'risky' and most 'urgent'.

A reason put forward for the lack of consistency about supervision was that staff felt 'overstretched' as a result of high and complex workloads. Compounding this sense of being overstretched was the stated practice of discussing only what were perceived to be the 'most serious cases' in supervision. This practice was also replicated in supervision between

the team leader and the principal social worker. The net effect of this was that cases that were perceived to be relatively 'low risk' or 'welfare' cases such as Adam's were not in fact discussed at all in supervision and therefore it is difficult to see how social work managers have a more global sense of social workers' case loads.

Furthermore, supervision did not appear to address issues of staff welfare. In the same vein, the case-weighting system may have been originally designed as a tool to manage staff workload, but its ad hoc implementation did not seem to address the issue of staff support.

12.5.4 Allocation

The social work teams in this area operate a daily rotating duty system amongst social work staff. This process of caseload allocation therefore places the onus on the duty social worker to take responsibility for cases that are received when on duty. The case-weighting system does not appear to be used consistently in determining caseload allocation as it seems to be applied retrospectively after cases have been allocated, and in any event is a moveable entity.

Issues of case allocation cannot be separated from broader staffing and resource issues. Both the social worker and the team leader interviewed raised issues in relation to staff 'burn-out' both as a result of the volume and complexity of cases. The review team requested information on the caseload levels in the area, but this has not been made available. In any event this data does not appear to be available on a national level to enable comparison. It is worth noting however, that since the time of this young person's death there has been a 25% increase in the number of social workers employed in this area, indicative at least of a previous shortfall in social work resources.

12.5.5 Interagency Collaboration

As outlined, a number of different agencies had contact with Adam and his family in the period before his death. The original referral to social work came from the Gardai in autumn 2009. Separately, and at a later date Adam visited his GP with his mother following an incident of self-harm and was referred by his GP on to CAMHS.

Adam was seen and assessed by CAMHS; however, a copy of this assessment was not received by the social work department until after Adam's death (approximately eight weeks following the assessment). A later correspondence had been received by the social work department following Adam's discharge from hospital after a suicide attempt. At interview,

the social worker informed that it was only when this letter arrived that he became aware of CAMHS involvement in the case. There was no *direct* contact between the CAMHS team and the local social work department. This is regrettable given that the CAMHS team had met with Adam on three occasions and had conducted the most comprehensive assessment of his situation. At interview for the purpose of this review, the psychiatrist stated that the delay in the initial assessment being sent to the social work department was a result of a possible administrative oversight.

The process for interaction between the CAMHS and the social work department was outlined to the review team. The main level of interaction occurs between the principal social worker, child care manager, team leader and CAMHS, with cases of concern being brought to meetings which are held on bi-annual basis.[2] The channels of communication between the CAMHS team and main grade social work staff appear less open and were described by the social worker in this case as 'hierarchical'.

It is the view of the review team that, given the range of factors identified in this case, including three known attempts of suicide / self-harm by a young person within a relatively short period, greater efforts should have been made by CAMHS to communicate this information to the social work team, or to at least have engaged in a discussion regarding this case. This did not occur at any point, despite the fact that CAMHS were aware of some social work involvement in this case. An important contextual issue to note is that there is only one child and adolescent psychiatrist for the whole of the region dealing with an increased number of referrals of young people engaging in self-harm and/or suicidal behaviour.

Conclusions

The review of the role of the HSE and HSE funded agencies prior to the death of this young person has highlighted a number of shortcomings in practice and structures. While no inference is being made that these shortcomings directly or indirectly caused or contributed to the death of the young person, it is nonetheless important to highlight the deficits in service. These include:

[2] At a later date the review team were informed that if the situation requires cases can be discussed with the CAMHS team and that members of the CAMHS team attend strategy meetings arranged by social workers. However, such contacts did not take place in this case.

- An inadequate response by the social work department to the initial referral received from the Gardai.
- A failure to conduct an assessment of this case beyond initial screening.
- Limited management oversight of this case
- A complete lack of engagement with the young person's father.
- Poor communication between CAMHS and the SWD

These shortcomings must be placed in the context of a social work staff that were clearly overstretched and placed in the position of managing complex caseloads. This appears to have had the effect that cases which were not initially perceived as 'child protection' or presenting as high risk were placed in the 'bottom drawer'. Viewed through this lens the case was not given sufficient attention. This is evident in the fact that the young person was not seen until four months following receipt of the original referral and no comprehensive social work assessment was conducted in this case.

Due to the lack of a comprehensive assessment, there is limited evidence that an appropriate response was made to this young person's needs and no evidence that the case was being actively managed. It was treated as a low priority from the outset and this perception permeated throughout.

There is little evidence of management oversight in respect of this case. In interviews, it was explained that scheduled supervision is regularly postponed and when it does take place only the most urgent or 'high risk' cases are discussed. This is replicated across the management structure. Again this highlights the relative low-priority afforded to cases which are perceived to be 'welfare' (i.e. where intervention is necessary and desirable but risk is not regarded as high) rather than 'child protection' (where the risk is considered high) and raises questions about the social work team's capacity to deal with these.

A further point worthy of note is the lack of engagement of the social work department at all stages with Adam's birth father who was joint guardian of Adam and his sibling. All correspondence from the social work department was sent to Adam's mother's address and there is no evidence of an attempt to contact Adam's father, with whom it emerged at interview, Adam had had a close relationship. The child psychiatrist who had met with both parents corroborated this view.

In this case CAMHS involvement was initiated through a referral from the family GP. Here a comprehensive assessment was undertaken but this was not received by the social work department until after this young person's death. There is some correspondence on file into which the social work department was copied but there was no *direct* communication between the CAMHS team and the social worker concerned. In light of a succession of self-harm/suicide attempts this must be seen as a shortcoming.

Key Learning Points

The first contact with families regarding a child protection and welfare concern is critically important. The practice of issuing appointment letters to parents/guardians following a notification or referral, thereby leaving the family with the responsibility to get in touch, should be reviewed and alternative means of contact should be considered.

In this area when a case is received by the duty social worker, the expectation is that the social worker on duty is allocated the case. This process should be reviewed to ensure that the allocation of cases handled and overseen by management, with due regard to workload so that the onus is not placed on the duty social worker.

The original hypothesis formed by the duty social worker, that this case was a 'welfare' case meant that greater efforts were not made to make contact with the young person and his family at an earlier stage. Research literature tells us that initial hypotheses can be made on the basis of inadequate information, and practitioners can be resistant to changing their initial assessment by failing to be open to new information (Broadhurst et al, 2010).[3] It is important therefore that cases are reviewed regularly and discussed in supervision.

The central importance of adequate assessment is emphasized in a range of research literature and inquiries into child deaths (Broadhurst et al, 2010; Bunting and Reid 2005)[4]. Key elements of best practice include gathering and assessing information from a range of sources and recognising the dynamic nature of young people's life circumstances. This is

[3] Broadhurst, K., White, C.; Fish, S.; Munro, E.; Fletcher, K. & Lincoln, H. (2010) *Ten Pitfalls and how to Avoid Them. What Research Tells Us.* London: NSPCC

[4] Bunting, L. & Reid, C. (2005) 'Reviewing child deaths: learning from the American experience.' *Child Abuse Review,* 14,2: 82-96

particularly pertinent in the case of young teenager involved in a range of 'risk behaviours' (Brandon et al, 2008).[5]

Furthermore, the importance of eliciting information from the wider family network is critical. Care should be taken to ensure that social work practice is inclusive of separated fathers. In this case the young person's father was not contacted at any point by the social work department despite his significant role in his son's life. A shortcoming in social work practice in engaging fathers has been documented in a range of literature (e.g. Daniel and Taylor, 2001; Featherstone, 2004).[6] This is particularly highlighted in the context of parental separation (Buckley et al, 2008).[7] Meaningful engagement with fathers is important for a number of reasons, in particular when social workers are conducting an assessment of the young person's needs.

Care should be taken to ensure that child protection and welfare systems and practices are responsive to the specific needs of teenagers. Some research has demonstrated that social work services can underestimate the child protection and welfare needs of teenagers, because of difficulties with engagement or through an over-optimistic view of young people's resilience (e.g. Hicks and Stein, 2010).[8] In this case, the young person' age (early teens) at the time of referral to the social work department may have influenced the low priority afforded to this case from the outset. This suggests that more attention should be paid by social work services to the specific needs of adolescents and the manner in which services respond to these young peoples' needs.

Interagency working is a key component of child protection and welfare practice. In this case a range of professionals were involved at various points, most notably social work, GP, gardai and CAMHS. The lines of communication between the social work department and CAMHS were hierarchical in that the main communication occurred between senior members of social work staff rather than with main grade social workers. Furthermore, the

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[5] Brandon, M., Belderson, P., Warren, C.. Dodsworth, J., Gardner, R., Howe, D., Dodsworth, J. & Black, J. (2008) 'The preoccupation with thresholds in cases of child death or serious injury through abuse or neglect.' *Child Abuse Review,* 17,5: 313-330

[6] Daniel, B. & Taylor, J. (2001) *Engaging fathers. Practice Issues for Health and Social Care.* London: Jessica Kingsley Publishers; Featherstone, B. (2004) 'Fathers Matter. A research review.' *Children and Society,* 18,4: 312-319.

[7] Buckley, H.. Whelan, S., Carr, N. & Murphy, C. (2008) *Service Users' Perceptions of the Irish Child Protection System.* Dublin: Office of the Minister for Children and Youth Affairs.

[8] Hicks, L. & Stein, M. (2010) *Neglect Matters. A multi-agency guide for professionals working together on behalf of teenagers.* London

matter of delays in sending correspondence from CAMHS to the social work department should be addressed. In this case an assessment was not received by the social work department until after the young person's death. Where there are a number of agencies involved with a young person and their family it is important that information is shared appropriately. This means that practitioners in different agencies should be clear about each other's responsibilities and that information should be communicated in a timely manner through open channels.

Recommendations

1. Where referrals exceed the capacity of an area to respond in a timely manner, there should be an agreed method of managing intake and these capacity issues should be considered at a higher level than the local area.
2. The home visit is a core aspect of social work practice. The HSE should review the guidance issued to social work staff which places a limit on travel allowances.
3. The social work records in this case are minimal, reflecting the limited contact with the family. The HSE should agree a national policy on adequate record keeping and ensure that systems are in place to review records in all social work cases, not just cases considered to be higher priority. This could involve sampling and quality assurance of files.
4. The interface between CAMHS and Children and Family Social Work should be reviewed nationally.

Signed: Helen Buckley

Professor Helen Buckley

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