Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a young person who had contact with Tusla

Ava

July 2020

1. Introduction

This review concerns a young teenager, here called Ava who was 14 years old when she died tragically. She had been living with her mother and siblings in an area identified in this review as Area B. Her father lived nearby and was involved in her life. This case was referred to the National Review Panel because Ava and her family were known to the Tusla social work department (SWD) in Area B.

2. Background and contact with Tusla social work services

Just before her 14th birthday, Ava who was living in Area B made a disclosure of alleged child sexual abuse against a family member. The abuse was alleged to have taken place in another area (Area A) five years previously, and the alleged perpetrator was on trial at the time for a similar offence against one of Ava's siblings. The matter was reported to the Gardaí and to Tusla in Area A where the alleged perpetrator was residing. Ava was interviewed by specialist Gardaí in Area A and SWD A planned to meet the alleged perpetrator to assess whether he posed a risk to other children, using a process known as a Section 3 (S3) assessment[1]. At the time there was a waiting list of several months for S3 assessments in Area A. In the meantime, Ava's disclosure was referred by SWD A to her local social work department in Area B (SWD B) for support services.

SWD B spoke to Ava's mother and on hearing reports that Ava's behaviour was very challenging but that she was not in contact with the alleged perpetrator, they referred her with her mother's agreement to a local youth justice project which could assist her to deal with her behaviour. SWD B did not meet with Ava. The area had a waiting list of 120 initial assessments at the time and made the decision to refer her onwards without an assessment rather than leave her waiting for an indefinite period. This was because of the Tusla policy that children and families awaiting assessment could not receive services until the assessment was complete. SWD B understood that Ava's allegation of child sexual abuse would be dealt with by SWD A, and that it was likely that SWD A would interview her at that point. However, SWD A told the reviewers that children are not interviewed as part of their assessment of the alleged perpetrator. This ultimately meant that nobody in Tusla spoke to Ava about her alleged experience of sexual abuse.

[1] Section 3 –Tusla's statutory responsibility with regard to children derives from Section 3 of the Child Care Act 1991. Section 3 states, 'It shall be a function of the Health Service Executive (Tusla) to promote the welfare of every child in its area who is not receiving adequate care and protection'. Where an allegation of abuse is made, Tusla has a statutory duty to assess what potential risk if any the alleged perpetrator may pose to children. (HSE (2011) *Child Protection and Welfare Handbook,* p. 145).

Ava's referral to the youth justice service was accepted and she was waitlisted for a start date. Staff at the youth justice project were uncertain as to whether they would have the resources to deal with the full range of Ava's problems, but were aware they could contact the family support network coordinator to refer her to mental health services.

Shortly afterwards, Ava was admitted to hospital having made a suicide attempt. She was referred to Child and Adolescent Mental Health Services (CAMHS) from the hospital, assessed and given a follow on appointment. The Tusla SWD received a referral from the hospital but saw no need for involvement as they perceived that Ava's parents were protective and her needs were being met by the youth justice service and the mental health service. Ava was discharged from the CAMHS service after her second appointment, as she was judged to have no evidence of treatable mental illness. No further referrals for services were made. She started attending the youth justice project where she settled in well and was popular with staff and other group members. She attended 29 group and 10 drop in sessions over seven months. Workers at the youth justice service were aware that Ava had been allegedly sexually abused but she never mentioned it to them.

In the meantime, Ava's behaviour, which included getting into trouble at school, using alcohol, sneaking out of the house late at night and quarrelling with family members continued to cause concern to her parents who found it really difficult to address. Ava's mother attributed the behaviours to the abuse that had been alleged. She described herself as 'like a rabbit caught in the headlights' trying to deal with it. She had been told by the SWD that no child protection concerns existed and that she was acting protectively and proactively but she described the complexities of dealing with a child whom she believed had been sexually abused. Her question was 'how do you parent a child in that post traumatic state and try to give them as much of a normal life, but still recognising their additional needs?' In her view, children who had experienced trauma had a 'different set of needs' and different parenting models should apply but she did not know which ones. She described the various approaches she had tried to deal with Ava's behaviour but not knowing whether she was making the right choices. She also described feeling 'neurotic' and like she had no control when certain events occurred in the family and a sense of nobody to turn to. Lily felt that Ava's attendance at the youth project was beneficial but her overall view was that Ava required more assistance for her mental health and specialist work tailored to her needs which the project was not equipped to provide. She also expressed that where child sexual abuse occurs, family focused interventions should be provided.

Seven months after this, Ava was reported missing and her body was found a few days later. SWD A had commenced their S3 assessment four months earlier and requested a transcript of Ava's statement to the Gardaí. They had no plans to interview her.

3. Review Findings

3.1 Initial Response

The review has found that the SWD made an expedient decision in a highly pressured context by diverting the referral they received about Ava to the PPFS project with her mother's agreement. However, it had consequences, for example the fact that the SWD did not meet Ava or did not carry out an assessment meant that they did not know the nature of her alleged abuse or what needs she had arising from it, or which service would best meet those needs. The assumption was made that her needs were met by the youth justice service and by CAMHS. Understandably, the SWD did not want to interfere with a Garda investigation by interviewing Ava, but in actual fact her statement had been completed by the time the referral was made, and there was no evidence of any contact between the SWD and the Gardaí to discuss the ongoing investigation and the roles that may be played by each service. The reviewers note that there seemed to be an expectation by SWD B that Ava would be met by the SWD in Area A as part of their assessment of the alleged perpetrator and thereby any further needs could be identified. However, this was not the intention or policy of SWD A. In any case, the focus of the investigation in that area would have been on any risk imposed by the alleged perpetrator and not on Ava's experience or therapeutic needs. Staff in the youth justice project were aware of the allegations but similarly had no further information, and Ava never mentioned it to them.

3.2 Post closure

The review has found that the early closure of the case and the lack of any formal process to respond to Ava's disclosure at the outset meant that no professional network developed through which information could be exchanged. The reviewers were told that there had traditionally been a good relationship between the SWD and other services including the Gardaí, but in this case there was no ongoing communication between the two SWDs, or with the Gardaí or the mental health service. It appears that certain assumptions were made about the extent to which Ava's needs were being met, i.e. that she was engaged with CAMHS or that SWD A may be interviewing her and thus in a position to identify her needs but in fact neither of these processes were in train.

The early closure of services by the SWD also left Ava's mother isolated while trying to deal with Ava's challenging behaviour and mental health needs once CAMHS had had concluded that she did not meet the criteria for a medical psychiatric service. While her attendance at the youth justice project was undoubtedly beneficial, neither Ava's mother nor the project staff felt that it was totally adequate to meet Ava's complex needs.

3.3 Tusla Policies

A central question that arose for the reviewers was why nobody apart from the Gardaí had spoken to Ava about her alleged abuse or facilitated her to talk about it in a therapeutic setting in order to assess both the impact it may have had on her and the interventions that would best meet any needs that she might have had arising from it. The review has observed that a number of policy issues significantly impacted on the way this case was managed in the SWD. Firstly, the early diversion of the referral to community services was influenced by the waiting list in the area and the fact that children waiting for assessment do not receive services. Once a case is diverted to preventive and support services, social work involvement ceases. These factors combined meant that Ava was not met by a Tusla social worker. Secondly, the Tusla policy on responding to allegations of child sexual abuse stipulates that the Section 3 assessment must take place in the location of the alleged perpetrator. If the child or young person resides elsewhere, this policy puts the timing of the response out of the control of the SWD in the area where the child lives and in this case had the effect of causing delay and misunderstanding on the part of SWD B about whether or not Ava would have a social work interview in Area A. Both SWDs outlined to the reviewers the steps that would have been taken had the child and alleged abuser lived in the same area, and in both cases the steps cited by them would have included seeing the child as part of the response to her disclosure. On the basis of the evidence available to the review, it appears that the current policy can create significant gaps and delays which can result in alleged victim being left without appropriate services.

4. Conclusions

The review team notes the loss that has been experienced by Ava's family and the professionals who worked with the family and extends sympathy to them. The following conclusions were reached.

- There was no single point at which the timing or circumstances of Ava's tragic death could have been foreseen or prevented. The reviewers have noted the love, commitment and pro-

tectiveness shown to her by her family, the commitment of the youth justice project that she attended and the affection with which she was held there.

- The waiting lists in the SWDs in Areas A and B had a significant impact on the way this case was managed and the remaining conclusions of this review must be considered in that context.

- Certain policies operated by Tusla can create gaps which limit the availability of services to children and families, i.e. the requirement to withhold services while assessment is pending and close cases once a referral has been accepted by PPFS. The review has also found that the Section 3 policy on responding to child sexual abuse allegations has the potential to cause delay and role confusion.

- There was poor communication between the SWD and the Gardaí in this case; no strategy meeting was held and notifications were not sent in a timely way by the Gardaí.

- Ava did not receive a child centred service from the SWD and her therapeutic needs were not assessed. In the absence of an initial assessment, the response that she and her family received was uncoordinated. Although her engagement with the youth justice service was appropriate and beneficial, neither the service nor her mother considered at the time that it was sufficient to meet her needs.

- The default position of referring young people who self-harm or attempt suicide to CAMHS is ineffective as the service will not treat people who are not suffering from a treatable mental illness. Treatable mental illness does not automatically include suicidal ideation or emotional distress.

- Ava's mother was left feeling 'like a rabbit in the headlights' with nowhere to turn when she was told that her daughter was not at risk and was not eligible for a CAMHS service. The extent of her need and wish for assistance in parenting was not known to the SWD.

5. Learning points

The review has noted the following practice issues

Families' understanding of the child protection system

- The internal review completed by the QA directorate of Tusla has pointed out that it cannot be assumed that families fully understand the standard business process operated by Tusla. This review upholds that view which replicates research about service users' understanding of the processes operated in the child protection and welfare system. Families may understandably find it difficult to distinguish between child protection and child welfare services, as well as the limits of a Section 3 investigation as far as the alleged victim's needs are concerned. Likewise, it is not always easy for families to comprehend the criteria for attendance at CAMHS or to navigate the pathway to alternative mental health services.

Child protection and child welfare

- This review has illustrated that the division between the two models of practice (child protection and child welfare) can mean that certain family situations do not fit easily into either one. In a study carried out as part of the evaluation of the PPFS programme in Ireland, McGregor and Devaney (2019) have also highlighted the issue of families 'in the middle' whose difficulties range from need to risk that can potentially be prevented and addressed with appropriate intervention. One of the staff in the youth justice project suggested to the reviewers that their work would be considerably enhanced by having a specialist youth worker, trained in not only identifying mental health problems, but in making interventions and teaching young people coping strategies. This point is affirmed by McGregor and Devaney, who suggest that the successful implementation of PPFS depends on a number of factors, including access to professional skills[2].

Effects of Child Sexual Abuse on children and the need for assessment and therapy

- It is known from the literature and clinical experience that CSA is a significant risk factor for a variety of problems both in the short term and in terms of later adult functioning (Fergusson, Horwood & Lynskey1996) (Kendall-Tackett, Williams & Finkelhor, 2001). CSA can be

[2] McGregor, C and Devaney, C (2019) 'Protective support and supportive protection for 'families in the middle': Learning from the Irish context. *Child and Family Social Work,* https://onlinelibrary-wiley-com.elib.tcd.ie/doi/epdf/10.1111/cfs.12683

painful, frightening, shame inducing and confusing and can lead to responses in childhood that can interfere with normal developmental processes. There is evidence that victims of CSA report higher rates of emotional and behavioural problems than their non-abused peers (Boney-Mc.Coy & Finkelhor 1995); they have more depressive symptoms and more anxiety and lower self-esteem than non-abused comparison children (Dubowitz et al. 1993), (Mannarino & Cohen 1996). They also tend to be less socially competent (Stern et al 1995. In addition, sexually abused children are consistently reported to have more sexual behaviour problems than non-abused peers (Friedrich et al 2001)

Many studies have examined demographic and abuse characteristics as predictors of long-term negative sequelae. Important mediating variables have been identified including the characteristics of the abuse experienced and the support the child receives following their disclosure. Children who experience one or a few incidents of less serious abuse committed by a person who is not important in their lives, who then tell a supportive adult who believes them and takes protective action may have only minimal and or transient distress (Berliner L, Elliott D.M, APSAC Handbook on Child Maltreatment 2002). In contrast the longer the abuse has been occurring, the seriousness of the incidents i.e. penetrative vs. non-penetrative abuse, the degree of relationship between the child victim and perpetrator and whether the child is disbelieved following their disclosure have all been found to be associated with more negative outcomes.

It is therefore essential that in planning interventions for children who have disclosed sexual abuse that they are given an opportunity to talk about the range and extent of their abuse to professionals whose approach validates and supports their experience. A child who is not given the opportunity to disclose or to discuss their feeling state in relation to their abuse can go on to use the maladaptive technique of avoidance (Briere J., *Child Abuse Trauma: Theory and Management* Sage Publications 1992).

6. Recommendations

- The NRP is aware that Tusla is to implement a revised Child Abuse Substantiation Policy. It recommends that any guidance issued to support the policy addresses the potential for confusion and misunderstanding between areas where alleged victims and alleged perpetrators

live in different administrative areas. It will be important that no aspect of the policy pre-empts opportunities for children to disclose in a therapeutic setting.

- The management of cases where children/young people have needs which put their own safety in jeopardy and parental abuse or wilful neglect does not exist needs to be specified in relevant guidance. This should be specifically referenced in the Tusla Guide for the Reporting of Child Protection and Welfare Concerns and any other relevant documentation issued under Children First 2017.

- This case raises the issue of young people who have mental health services but are not considered eligible for a medical psychiatric service such as CAMHS which will offer services only where a treatable mental illness is diagnosed. The review recommends that Tusla publish clear guidance for practitioners about the appropriate channels through which to access mental health services for young people experiencing ongoing emotional distress which often includes suicidal ideation and self-harming behaviour.

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Morrison, E. et al, 2018, Children's Disclosure of Sexual Abuse: A Systematic Review of Qualitative Research Exploring Barriers and Facilitators. *Journal of Child Sexual Abuse* 27(2):1-19. 10.1080/10538712.2018.1425943