National Review Panel

Review of the death of a young person, Donal, known to Children and Family Services

Executive Summary

March 2015

1. Background

This concise review is concerned with the death of a young person, here called Donal, who died in an accident. Donal was the youngest in his family and lived at home with his mother until his admission to care. His father had left home some years earlier and there was only occasional contact between them. Donal, although he could be aggressive, reckless, and destructive at times, was generally described by staff who worked with him as a friendly, even charming, young man who was articulate and sociable. However, it is also suggested that he had a darker side and could be prone to low moods. While he appeared to engage with professionals, he sometimes lacked motivation to accept guidance. He attended Child and Adolescent Mental Health Services (CAMHS) from the time he was eight years old, where he was eventually diagnosed with a conduct disorder and his mother made the first of many referrals about him to the HSE Social Work Department when he was 12 because of her inability to manage his behaviour. The case was initially dealt with on duty very intermittently and a social worker was allocated two years later. It was categorised as a 'child welfare' case, despite the severity and the destructiveness of his behaviour.

There were numerous services involved with Donal, as well as CAMHS he was also known to the youth justice services and was later referred to an addiction service. He was known at different times to the Gardaí, to the National Education Welfare Board and to Youthreach. He spent short periods in an adult mental health residential treatment service, while his social worker advocated for a more specialist adolescent mental health service. At one point he was allocated a specialist adolescent social worker in addition to his allocated social worker. At 17 he was placed in an emergency hostel. His behaviour continued to cause concern and he moved from there to a supported lodgings placement for respite and then to two residential placements where he did quite well. The cessation of funding for those placements meant that he had to move again, back to the supported lodgings but with the benefit that he was nearer home. His behaviour deteriorated once again and he reported feeling low with suicidal thoughts. He was killed in a car accident shortly before his 18th birthday; the inquest concluded that he died by misadventure.

2. Review Findings

The review identified many policy and practice deficits in respect of this case. However, it does not find that any action or inaction on the part of the HSE Children and Family Services contributed to

Donal's death. It is difficult to assess if the outcome would have been different had Donal and his family had received an earlier comprehensive assessment and a care plan had been put in place suitable to his needs. The review found that the Social Work Department (SWD) was slow in responding to Donal's mother's frequent requests for help with him. Two social work managers told the review team that there was a long waiting list at the time and a case might have stayed on duty without an allocated worker for a lengthy period.

The review has found that the failure to consider Donal as a "child protection" (as distinct from "child welfare") case from an early stage is, however, significant. It led to a serious delay in, first, allocation to a specific social worker and, second, the completion of an assessment of Donal's needs and thirdly, his listing on the CPNS. This, in turn, compromised the possibility of meeting his care needs through the HSE's fostering or residential services (at an age when it would have been easier to find a suitable placement for Donal). As outlined above, it is noted that a new policy issued by the Child and Family Agency in 2014 and entitled 'Thresholds for Referral to Social Work' lists 'Challenging behaviour resulting in serious risk to child and others' and 'Child/young person beyond parental control' as meeting the threshold for child protection.

The review also found that the absence of an accessible, functioning case conference system deprived social workers and their local managers of an independent level of consultation, advice, oversight and decision-making. It found that whilst the level of communication between services was generally satisfactory, the review found some shortcomings, specifically in respect of the working relationship between CAMHS and the SWD, and the almost complete absence of involvement with the National Education Welfare Board. The case highlighted a gap in mental health services for young people who suffer from behavioural and associated emotional problems but do not reach the threshold for intervention by CAMHS.

Although social work practice in the SWD was not 'state of the art', in the context of limited resources and high caseloads, staff members who were interviewed presented as committed, hard-working, well informed and child centred. Likewise, local management presented as compassionate towards clients, capable of constructive reflection on their own roles, supportive of their frontline staff, and with a good understanding of the pressures and resource limitations they are facing.

The fact that the HSE Children and Family Service was functioning in a context that was demonstrably overstretched and under pressure undoubtedly affected the quality of its response to Donal and his needs. The findings from this report must be understood in that context.

3. Key Learning Points

The review has identified the following key learning points:

- **Early intervention**

Donal presented with behavioural difficulties from an early age. At first these were dealt with by GP referral to CAMHS. There was no Social Work Department involvement until he was 12. The available evidence suggests that the GP and CAMHS should have involved the SWD at an earlier stage. There were a number of adverse family factors, particularly a history of domestic violence and alcohol misuse by both parents which would have impacted on Donal's behaviour and well being. The primary learning point from this review is that if a troubled young person particularly one who has been exposed to these adverse factors does not receive an early response, any interventions made will not achieve maximum effectiveness. Donal's mother had sought help from the Social Work Department on numerous occasions from when he was 12 but received no meaningful support for over two years. This would have been a very de-motivating experience for her and was likely to impact on trust, expectations and long term relationships between her and social workers.

- **Repeat referrals**

The NRP has noticed a pattern whereby, in many cases, multiple reports are made about a particular child and are responded to by the duty system. The weakness of this type of response is firstly, that while a certain amount of information may be gathered, a full assessment is rarely carried out. Secondly, there is increasing recognition that repeat referrals are indicative of cumulative harm. Cumulative harm refers to "effects of patterns of circumstances and events in a child's life, which diminish a child's sense of safety, stability and wellbeing"[1]. A major practice implication is the need to assess each notification as bringing new information which needs to be considered in line with knowledge already recorded. Likewise, the fact of multiple referrals should alert the system to the need for allocation or at least a thorough review of the case to examine what interventions are required.

[1] For a full discussion of cumulative harm and its implications, see 'Cumulative Harm: a conceptual overview' by Robyn Miller http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/589665/cumulative-harm-conceptual-overview-part1.pdf

- **Impact of trauma and family violence on children**

There is evidence on file to indicate that Donal was exposed to domestic violence in his early years and to ongoing violence as he grew up. Research indicates that witnessing or experiencing domestic violence is a strong predictor of adolescent male abusive behaviour[2]. However, the significance of this, although averted to in a report from CAMHS, was not sufficiently appreciated by the SWD. A comprehensive assessment should pick up the impact of domestic violence on a young person and recommend an appropriate therapeutic intervention. The impact of complex trauma in early life is also being increasingly recognised. Traumatised children have behavioural impulsivity, hyper arousal and cognitive distortions that have resulted from their earlier traumatic experience[3]. Recognising this fact enables workers to externalise a child's behaviour, recognise its cause and plan appropriate interventions.

- **Child welfare or child protection**

The difference between the classification of 'child welfare' and 'child protection' has arisen in a number of cases reviewed by the National Review Panel which indicate that the distinction seems to have been largely determined by the capacity of the SWD to respond to a child protection case. The review team has seen a new policy issued by the Child and Family Agency which determines thresholds for intervention. Under this policy, the referral by his mother of 12 year old Donal would reach the threshold for child protection. This policy was not, however, in existence at the time. In addition, the fact that Donal's mother was seeking help and appeared to be a concerned rather than an abusive parent may also have contributed to the classification of the referral as 'child welfare' . It is essential that the child's own needs, including the impact of his own behaviour on his safety and protection are considered in making an assessment. In this case, both Donal and those around him appeared to be at higher risk than the classification of welfare would imply.

- **Placement in Supported Lodgings**

Placing a young person in isolated supported lodgings can be a lonely and unsustainable experience. Accepting that there were few choices available it would seem that Donal's placement in supported lodgings in a rural area far from his home neighbourhood may have been both premature and ultimately unworkable. Proximity to his home had been identified as a primary reason for terminating his previous placement. The learning point here is that placements should be

[2] Buckley, H., Whelan, S, and Holt, S. (2005) *Listen to Me! Children's experience of domestic violence,* TCD: Children's Research Centre http://www.tcd.ie/childrensresearchcentre/assets/pdf/Publications/listen.pdf
[3] Miller, as above.

based on an assessment of the child's needs, and failure to do so will exacerbate any risks in the situation.

- **Case conference system**

It is notable that no child protection conference was held on this case, even though Donal appeared to be at considerable risk from the time his mother started drawing attention to his very violent behaviour. While other multi-disciplinary meetings were held, they did not carry the same weight as a child protection conference. The review team were given to understand that the case conference process was time consuming and difficult to arrange at the time in the area. The review team is aware that the Child & Family Agency is currently implementing a standard national protocol for the conduct of child protection conferences. Under the protocol, a child must be deemed to be at ongoing risk of significant harm before a child protection conference is held; in this case the classification of 'welfare' would have precluded the conduct of a child protection conference in respect of Donal. The question also arises as to whether a child like Donal, who was at risk from his own behaviour as opposed to at risk from his carers would qualify for a child protection conference under current Child and Family Agency policies. This paradoxical situation requires some reflection.

- **Mutual understanding between CAMHS and the SWD**

Although Donal received services from CAMHS over a considerable period, mutual expectations held between the SWD and CAMHS appear to have been mis matched and resulted in delayed responses when Donal was first referred. The key learning here is the importance of clarifying consistent referral and acceptance norms between the Child & Family Agency and CAMHS, and adhering to whatever is agreed.

4. Recommendations

- A system should be introduced to routinely review multiple referrals.

- It is important that the child protection conference system is adequately resourced so that young people like Donal can benefit from a multi-disciplinary response at an early stage.

- The Child & Family Agency should review the availability of therapeutic services to young people with conduct disorder/behaviour problems and associated emotional difficulties that do not meet the threshold for intervention by CAMHS.

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