National Review Panel

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

March 2015

1. Introduction

This review has been carried out in accordance with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* issued by the Department of Children and Youth Affairs in December 2014. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Children in care;
- Children known to the Agency's social work department or an Agency-funded service; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.
- In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:

- A child protection issue arises that is likely to be of wider public concern;
- A case gives rise to concerns about interagency working to protect children from harm;

  or
- The frequency of a particular type of case exceeds normal levels of occurrence.

2. National Review Panel (NRP)

A national review panel was originally established by the HSE (now replaced by the Child and Family Agency) and began its work in August 2010. The NRP consists of an independent Chairperson, a Deputy Chair, and approximately twenty independent members with 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 receives administrative support from the Child and Family Agency. When a death or serious incident fitting the above criteria occurs, it is notified through the Agency to the office of the CEO and from there to the NRP. The CEO/designate 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

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, key learning points and recommendations. Depending on the nature of the case, one of the following types of review will be conducted.

Major: to be held where contact with the Child and Family Agency 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 two 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: to be held where involvement of the Child and Family Agency 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, key learning points and recommendations.

Concise: to be held where the involvement of Child and Family Agency 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, key learning points and recommendations.

Desktop: 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 one panel member with oversight from the chair. 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, key learning points 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.

Internal: Under *Children First: National Guidance for the Protection and Welfare of Children*, all areas should conduct a review where a child in receipt of services has died. Internal reviews should be sent to the Chair of the National Review Panel. In certain circumstances, e.g. where the death has been from natural causes, or where the death or serious incident has more local than national implications, the internal review, once quality assured by the National Review Panel, may suffice and the NRP will not conduct one.

4. Death of young person

This review is concerned with the death of a young person, here called Donal, who died in an accident. The review covers the period between the first referral received by the Social Work Department (SWD) about Donal and his death, some five years later.

5. Level and process of review

This was conducted as a concise review. The methodology adopted was a review of social work records and files from residential services. Interviews were also held with staff for the purposes of clarification. The review was conducted by Bill Lockhart (Deputy Chair of the NRP) and Phil Mortell with input from the Chair of the National Review Panel, Helen Buckley.

The records reviewed by the team consisted of four files provided by the HSE, containing copies of correspondence, case notes and reports, and two files from one of two residential care units where Donal spent some time. Managers from both these services were interviewed, as were five frontline social workers and three managerial staff who knew Donal and his family. The review team met with Donal's mother and sister and also with his father; his Probation Officer (and her manager); and the Consultant Psychiatrist at the Child and Adolescent Mental Health Service (CAMHS) with responsibility for Donal. The team also interviewed the managers of a drug and alcohol addiction treatment service where Donal had attended; the manager of a Hostel for homeless boys where he lived for six weeks; and the provider of a supported lodgings service where he lived during his last few months.

6. Terms of reference

The review adopted the following terms of reference:

i) To examine the events leading up to Donal's death and determine whether action or inaction on the part of HSE Child and Family Services had been a contributory factor;

ii) To examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice;

iii) To provide an objective report to the Child & Family Agency.

7. Donal

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.

8. Background and reason for referral to HSE Children and Family Services

Donal's first contact with health and social services was his attendance at a child guidance service for behavioural problems when he was about eight years old. At 12 years, his mother made the first of many referrals to the local social work child protection team to request help in managing his aggressive, anti social and destructive behaviour which had recently deteriorated. The case was initially dealt with on duty very intermittently and a social worker was allocated two years later. In the meantime, he attended CAMHS where he was diagnosed with a conduct disorder; he was also known to the youth justice services and was later referred to an addiction service. He spent short periods in an adult mental health residential treatment 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. 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.

9. Services involved with Donal

- **School:** The information available about Donal's schooling is limited, but social work files indicate that he had resource support in primary school. After two months in secondary school the social work file notes that the Principal expressed concerns about Donal's disruptive behaviour and poor academic capacity. He was expelled from this school sometime during his first year (aged about 13½) and never returned.

- **National Education Welfare Board (NEWB):** A few incidental references on the social work file, indicate that Donal had involvement with the NEWB.
- **An Garda Síochána:** The Gardai were involved initially around Donal's reported violence towards his mother. He was subsequently arrested for, among other reasons, being drunk and disorderly, damage to property, attempted self-harm, suicidal threats, assaulting Gardai, stealing and assault (mugging).
- **Child Guidance/CAMHS:** Donal was diagnosed (at 13½) with "conduct disorder" and "possible disturbance of activity and attention". This diagnosis was subsequently amended to "mixed disorder of conduct and emotion". Donal's mother was given "psycho-education" and, on one of the few occasions that he attended himself, Donal was advised to read "Helping Kids to Chill." A principal social worker in CAMHS was assigned to the case for a period with a view to helping Donal's mother manage him. Eventually, CAMHS closed the case on the basis that Donal did not have any psychiatric illness.
- **Adult Psychiatric Unit:** Donal was admitted in an emergency on two occasions to the Adult Psychiatric Unit of a local Voluntary Hospital. One admission lasted for a week. On the second admission he was prescribed a mood stabiliser called Seroquel.[1]
- **General Practitioner:** Donal went through a period of intense and continuing concerns for his own health (reporting pains, hair falling out, fear of dying, etc), which were not borne out by medical examination. His GP was persistent in referring him to CAMHS.
- **Probation & Welfare Service**: For the last year of his life Donal was allocated a Probation Officer who met with him regularly and prepared reports for his various appearances in the District Court.
- **Community Drug and Alcohol Service (Tier 3 service)[2]**: Donal was referred on three occasions to this service for assessment. He attended twice. A psychometric and clinical assessment indicated that abuse was more likely than dependence and he did not meet the criteria for severity of use for a Tier 3 service and was referred to a more appropriate Tier 2[3] community based service.

[1] Seroquel is an atypical short-acting antipsychotic approved for the treatment of schizophrenia, bi-polar disorder and, along with an antidepressant, to treat major depressive disorder.
[2] Tier 3 interventions are mainly delivered in specialised structured community addiction services
[3] Tier 2 interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community- or hospital-based

- **HSE Children and Family Services SWD**: For the first two and a half years, Donal's mother was dealt with by social workers attached to the Duty Team. Three social workers from the Intake Team were assigned to Donal in sequence for the last three years of his life. During some of this time Donal was also allocated a social worker from the local HSE's Therapeutic Social Work Service and, later, a social worker from the specialist service for young people (at risk of being) out of home.

10. Summary of Donal's needs during his involvement with HSE Children and Family Services

The first (and only) comprehensive assessment of Donal's needs on record was contained in a Social Work Report completed by his allocated social worker, here called Social Worker 1 when he was 14, which identified the following:

- Donal required a comprehensive assessment of his needs which took into account the impact on his development of early exposure to domestic violence and parental alcohol misuse and identified appropriate therapeutic responses.
- He needed an out of home placement in a suitable setting, preferably foster care, where he would be safe and helped to develop a positive trusting relationship. This view coincided with the opinion of the CAMHS psychiatrist.
- While in out of home care, he needed to have positive family contact.
- He needed an educational placement.
- He needed assistance to deal with his behavioural difficulties as reported by his mother and later diagnosed by the consultant child psychiatrist.
- He needed assistance with his alcohol and drug use.
- He needed a mental health service appropriate for young people of his age group.
- Following the deaths by suicide of several family members, he needed bereavement counselling.
- He needed to work on his attitude towards women.

11. Chronology of contact between Donal and his family and HSE Children and Family Services.

There is little on file in respect of Donal's early childhood and experience of family life, although there are references to a history of domestic violence. He was the youngest of a number of siblings. His father

left home permanently when Donal was about two years old, but remained living in the area and had occasional contact with Donal. His mother had and has significant health problems and, according to interviewees who spoke to the review team, she also misused alcohol.

When he was eight years old, Donal attended a Child Guidance Service, presenting with behavioural problems (his mother told the review team that he had a 'vicious' temper and was banging his head off the wall at the time). However, there are no records available to the review team from this time.

Age 12

When Donal was 12½, Social Work Department (SWD) records noted the first referral by his mother. In a phone call she told the Duty Social Worker (DSW) that Donal was out of control and had beaten her up. The DSW officially classified this referral as a child welfare concern: 'child beyond parental control.' This classification meant, in practice, that Donal's case was not wait-listed for allocation to a social worker on the Intake Team, and no action was taken.

Ten days later Donal's mother, this time accompanied by one of his older siblings, visited the SWD and told the DSW that she found Donal very angry and demanding. He kicked things, she said, and banged his head. Such behaviour was noticeable since he was four but had worsened over the previous 18 months. The older sibling added that there had been domestic violence in the home.

Two years and four months later a Record of Initial Assessment form on file notes that Social Worker 1 revisited this report and classified it as (a) physical illness or disability in the child and (b) mental health problems / intellectual disability. The recommended action was: Case referred to another agency (presumably CAMHS). More than three months later, this initial assessment was signed off by the social work team leader (SWTL).

Over the following year Donal's mother continued to visit and phone the Duty Social Work Team at regular intervals, on one occasion requesting foster care for him. She eventually told social workers that she could no longer cope with Donal's outbursts: whenever he did not get his way, she said, he resorted to smashing up the house and/or attacking her. The file does not record the SWD's response. When asked by the review team about the apparent lack of intervention by the SWD, the social work

manager from the time responded: "Intervention was provided; mother was seen, for instance, but because of the volume of work it was either that or nothing."

Age 13

All told, SWD records indicate that Donal's mother made a total of 10 visits or phone calls to the SWD over a 16 month period from her first contact. The file indicates that the DSW generally classified them as a "child welfare concern: child beyond parental control." Apart from meeting with Donal's mother or talking to her on the phone, the SWD continued to take no action on the matter.

Meanwhile, Donal had been twice referred by his GP to CAMHS. CAMHS subsequently twice requested a report from the SWD, stating that as there were child protection concerns re Donal, he needed to be assessed by the SWD as a priority. The SWD, in response, without ever having met Donal, or undertaking an assessment of him, counter-referred him to CAMHS, stating in a letter from an acting team leader that "from our assessment of the situation we feel Donal would greatly benefit from your service and I respectively *(sic)* request you consider him to be of urgent priority." Eventually, when Donal was 13½, he was seen at CAMHS. A report sent to the SWD from the consultant child psychiatrist notes a report by Donal's mother to him that she was afraid of Donal and spent her time appeasing him and avoiding confrontations with him. She reported that Donal got into tempers which could last all day; that he had broken objects and hit her; that he stole from her and from shops; that he was involved with the Juvenile Liaison Officer; and that he refused to go to school or do any homework. Seen on his own by the consultant, Donal was found to show no evidence of depression, anxiety or psychosis. He was, however, diagnosed with a conduct disorder, as well as a minor nervous disorder and a possible disturbance of activity and attention. The psychiatric report also included references to inconsistent parenting; exposure to alleged domestic violence; over self-reliance; paternal alcohol problem; maternal physical health, increased stress and possible depressive disorder. Donal's mother was given advice re maintaining consistency with Donal, not telling him lies and decreasing the amount of negative attention he received. Child Guidance also agreed to liaise with the SWD re the provision of family supports.

About the same time, his mother again contacted the duty social worker and reported that she was 'black and blue' from Donal; he had broken the handle of a brush on her back; he was smoking, drinking, and taking hash; he was disruptive at school; he had been barred from the local shop for stealing; he was taking money from her purse; and he was involved with the Juvenile Liaison Officer (JLO) for making

obscene phone calls. A month later a social work team leader (SWTL) sent an urgent memo to a duty social worker, instructing her to undertake an assessment of Donal. The memo stated that "from reading the file, it doesn't appear that a social worker has spoken directly with Donal" and "this child should have been getting a more intense assessment and intervention for the past year, so please make this a priority." There is no evidence on file that this assessment was ever undertaken or completed by the duty social worker or that the SWTL followed up on the implementation of her instruction.

In the following month CAMHS appointed a Principal Social Worker (PSW) within their own service to work with Donal and help his mother to manage him. A month later, the CAMHS PSW sent a written report to the SWD stating that Donal's mother had attended an appointment but Donal had refused to do so. Donal's mother had told the PSW that he was out of control; he refused to attend Clinic, School or GP; he was hanging around with a 19/20 year olds for the past year; she suspected that he was on drink and drugs; and he continued to be very aggressive and violent to her on a regular basis.

Donal's mother also told the CAMHS PSW that she had recently attended hospital with a dislocated finger caused by Donal; that he had smashed up his bedroom and the family home; that when she refused to give him money, he physically assaulted her and raided her purse; that his physical violence was escalating and she was afraid that he might kill her; that she had called the Gardai on several occasions; that she was terrified of Donal and could not continue to parent him as he was totally out of control.

A HSE child protection social worker subsequently officially classified this report from the Child Guidance (CAMHS) PSW as a "Child welfare concern: child's behaviour out of control." No action was contemplated or taken by the SWD. When Donal was nearly 14, he was expelled from his school. He obtained a place at a learning support project in a nearby town, but the file indicates that his attendance there was, at best, sporadic.

In the following month a duty social worker took a referral on Donal from the learning support project and a further telephone call from Donal's mother requesting a social work visit. The duty social worker, 16 months after Donal's mother's first telephone call to the SWD, subsequently made the first recorded visit by the SWD to the family home and spoke with Donal, then almost 14 years old, and his mother.

The social worker agreed to work with Donal and his mother on anger management issues. She gave Donal 'homework' to do and said she would check back on progress.

The file thereafter indicates that this social worker made one unanswered phone call to Donal's mother, but there is nothing further on file to indicate any follow-up to the original home visit and no case notes at all on file in respect of the next seven months.

Age 14

When Donal was 14½ a duty social worker met with his mother at home. Donal was still in bed at 2.30 p.m. and would not get up. His mother expressed her disappointment with the SWD On the same day the duty SWTL recommended that (1) the case transfer from Duty to the Intake[4] Team; (2) an assessment be made of Donal's present needs; and (3) a professional strategy meeting be arranged. A month later, a report by the CAMHS PSW, copied to a PSW in the SWD, documented Donal's pattern of escalating violence and recommended a meeting of professionals involved with him. This report was accompanied by a covering letter to the PSW in the SWD once more requesting a copy of Donal's risk assessment. Six weeks later, and 26 months after Donal was first referred to the SWD, his case was allocated to an intake social worker (Social Worker 1). Social Worker1 told the review team that Donal was one of many teenagers allocated to her (among a total caseload of 55). Donal was nearly 15 years old at that point. Social Worker 1 subsequently visited and attempted to negotiate more acceptable behaviour between Donal and his mother, so that he could continue to live at home.

Age 15

There is an entry in the social work file to the effect that, during the following month, Donal (now 15 years old) took an overdose of headshop-sourced tablets and was admitted to the Emergency Department and later discharged. His mother told the reviewers that this experience gave him "a terrible fright".

[4] The local social work managers told the review team that when Donal was first referred "there was a huge referral rate and case loads, and the waiting lists would have been in their 100s alright. Duty and Intake were combined at the time, so that a case might have stayed on duty without an allocated SW for quite some time." In theory, duty social workers handled all new incoming referrals and ongoing unallocated cases; intake workers were allocated child protection cases on a short-term basis, until some resolution was achieved or the case was transferred to the long-term team.

A few weeks later, Donal's mother and sibling told Social Worker 1 that they wanted him out of the home. He had, they reported, recently hit his mother on the arm with a hammer; caught his sibling by the throat; hit her in the side; and threatened her with a hurley. After this latest assault on his mother, Donal himself was seriously assaulted by an older sibling. Within a few days Social Worker 1 arranged for Donal to move in with his father, despite, as she told the reviewers, reservations expressed by the family GP, about Donal's father's history of alcohol abuse. This arrangement lasted for a few weeks. Social Worker 1 meanwhile applied for a foster placement for him. There is very little reference on file about Donal's father, apart from references to alleged domestic violence, alcohol abuse and mental illness. About this time Donal became convinced there was something wrong with him (he complained of tingly pains in his chest and body) and frequently visited his GP until the latter decided Donal needed to be "de-medicalised" i.e. he believed that Donal's symptoms were psychosomatic.

Social Worker 1 subsequently noted on file that she was "not recommending [Donal] returns home [from his father's house] in the near future until [he] gets the help he needs and home is a safe place for him to turn to." Social Worker 1 spent time with Donal's mother explaining the concerns of the SWD.

Despite Social Worker 1's recommendation, within a few weeks Donal was back living with his mother, but spending occasional nights at his father's place. In the ensuing weeks he was seen on one occasion by a psychiatrist and social worker when he presented to the Emergency Department after cutting himself with a knife. The file notes that, on another occasion, he was dealt with by the Gardai when his mother complained that he had held a knife to her throat. About this time Social Worker 1 completed a social work report which noted the following:

- The difficult relationship between Donal and his mother, involving fights, mutual threats and violence, as well as destruction of furniture and fittings.
- Donal's concerns for his own health (reporting pains, hair falling out, fear of dying, etc) which were not confirmed by medical examinations.
- Donal's attempts at self-harm and his seeming obsession with death.
- The consultant psychiatrist's recommendation that Donal needed a secure and stable home environment and emotional reassurance without violence, with adults he can trust.
- Donal's involvement with Gardai around domestic violence and criminal activity (fights with other teenagers and a break-in and theft from a residential property).

- Donal's virtual absence from education for over a year, despite attempts by Social Worker 1 to find a school placement.

The report concluded that it was not in Donal's interest or his mother's that he live with her and stated that Donal would like to live at an emergency hostel in a nearby town. Social Worker 1 did not consider this an appropriate placement for him. Instead, she wrote, "a placement with foster carers is the most suitable option in the event that his living arrangements break down." The social worker stated that "Donal's need for safety as well as an opportunity to develop a positive trusting relationship with a carer is a priority." The file indicates that Social Worker 1 referred Donal to the fostering department, but was told that there was no suitable placement available.

Donal was subsequently referred by Social Worker 1 (who remained the key worker) for one-to one work with a therapeutic worker in a specialist team. However, he never really engaged with this worker, who closed the case within six months. After summer Donal remained out of school. The file notes that he failed to contact two secondary schools identified by Social Worker 1 and also records his mother's conviction that he would not attend in any case if offered a place. A subsequent report by a registrar in CAMHS diagnosed Donal as suffering from a mixed disorder of conduct and emotion (anxiety, perfectionism, and loss of self-esteem). It also suggested a specific developmental delay in scholastic skills and noted that Donal's intelligence was apparently normal, although no formal testing had been done. Donal was subsequently said to be sleeping with a hatchet under his pillow. CAMHS agreed to ask their psychologist to meet with him. The review team was told by the consultant psychiatrist that the clinical psychologist, on reviewing the file, wrote that 'At this point I do not feel Donal needs specific psychological interventions but would be happy to reconsider if improvements are not maintained at your next review'.

Donal's behaviour and the home situation continued to deteriorate. Donal was said to be drinking at weekends and "taking something," according to his mother, who wanted him out of the house as she did not feel safe. Donal had threatened to kill her and/or himself, saying things like: "The next time you will see me is at my removal." Twelve months after a duty SWTL and the PSW in Child Guidance (CAMHS) separately had requested it, a strategy meeting was held, chaired by a SWD Team Leader. Those in attendance included Donal, both his parents, the JLO, a registrar from Child Guidance (CAMHS), the therapeutic social worker and Social Worker 1. This was five months after Social Worker 1's

assessment concurred with the consultant child psychiatrist's recommendation that Donal needed a secure and stable home environment and emotional reassurance without violence with adults he can trust. Nevertheless, the meeting recommended a shared-care arrangement, involving Donal continuing to live with his mother but spending Friday nights with his father and Saturday nights with a sibling. It appears that, although not specifically stated on file, the strategy meeting took the view that a fostering placement for a boy of Donal's age and history would not be forthcoming. The social work managers from the time told the review team that Donal's involvement with drugs made it particularly difficult to source a foster placement. Social Worker 1 told the reviewers that she regretted in hindsight that she "didn't push with fostering more, or asked my team leader for help with that."

Social Worker 1 agreed to refer Donal, now aged 15½, and still out of school, to the Education Welfare Officer for his area. Both parents agreed to attend a parenting course: there is no evidence on file that they ever did so. In the same month a friend of Donal's died by suicide.

Some two months later Donal attended at CAMHS with his mother. A report from this meeting recorded that Donal was given psycho-education (advice) regarding the effects of alcohol/drugs by the registrar. He was also advised to read 'Helping Kids to Chill' to help him manage his anger. The registrar subsequently informed the social worker that as Donal did not have any psychiatric illness, the case would be closed to CAMHS but could be re-referred any time.

In the same month Social Worker 2 replaced Social Worker 1 as Donal's social worker for a period of approximately two months. Coming up to his 16th birthday Donal was cautioned by the JLO for being drunk in public and told that next time he would be charged. The JLO subsequently referred Donal to an addiction service for young people.

Age 16

Shortly after he turned 16, Donal was visited at home by the recently appointed Social Worker 3, accompanied by the JLO. Donal agreed to attend the addiction service for assessment. A psychometric and clinical assessment indicated that abuse was more likely than dependence and he did not meet the criteria for severity of use for a Tier 3 service and was referred to a more appropriate Tier 2 community based service.

The following month he was arrested for stealing a bottle of wine in his home town. Three months later Donal was arrested after he attempted to attack Gardai with an iron bar. In the same month Social Worker 4, from a specialist adolescent team, was allocated to work with Donal, with Social Worker 3 maintaining a watching brief. Just before Christmas, Donal's older sibling died by suicide. The following spring, Donal's cousin died from suicide and within two weeks, another cousin also died from suicide. In the same month a strategy meeting recommended that if Donal continued to pose a risk to himself and others, consideration might need to be given to seeking alternative care for him. His name was put, for the first time, on the Child Protection Notification System (CPNS) because of the risk he placed himself at.

Shortly afterwards, Donal was arrested by Gardai as he was attempting to harm himself; he was admitted to the adult psychiatric unit of a general hospital for a week. When his mother and sibling visited him on the ward, they reported that he was very angry and threatening towards them. Nevertheless, Donal was discharged to his mother's home. Shortly before his 17th birthday, Donal was arrested and charged with being drunk and disorderly. About the same time, he started attending a FAS project.

Age 17

Just as Donal turned 17, a strategy meeting was held, chaired by a SWTL and attended by Donal, his parents, the Probation Service, Donal's GP, the Gardai, Social Worker 3 and Social Worker 4 (the social worker from the specialist adolescent team). A long list of decisions and recommendations included:

- Donal needed to be placed in an emergency hostel immediately. He was placed there on the same day.
- SWD to make application for a Special Care placement

Asked about the rationale for the hostel placement, given Social Worker 1's recorded opposition to it, Social Worker 3 told the reviewers that it certainly wasn't the environment Donal needed in terms of structure and full-on support, but there weren't any local options available. In addition, she said, he was getting past the age when most residential centres would be happy to have him.

Three days later Donal appeared in Court for stealing a bottle of wine from a shop. Mention was also made of a serious assault in which Donal was a suspect. In her report, Donal's newly appointed

Probation & Welfare Officer suggested "his placement in [the hostel] brings with it new risks, as it is possible Donal may link in with a pro-criminal peer group . . . the main factors influencing his risk include his substance abuse, his family circumstances, his limited involvement in training or education and his lack of involvement in organised activities."

Hostel staff subsequently reported a number of anti-social and aggressive incidents involving Donal, culminating in his admission to the adult psychiatric unit once more, under a Garda escort. The latter incident included drug and alcohol fuelled threats by Donal to kill himself. On the following day, while visiting Donal in the psychiatric hospital, hostel staff found two belts tied together with a noose at the end: this fact was conveyed to the staff of the adult psychiatric unit who, nonetheless, discharged Donal as, according to Social Worker 4, his difficulties were not considered to be primarily to do with his mental health. While Donal was in the unit, Social Worker 4 advocated for an appropriate mental health service, and for consideration of an inpatient unit for adolescents. In the same month, a letter from the regional Central Admissions Committee [5] confirmed that, although it was gravely concerned for Donal's safety in the hostel, it was unable to provide a residential care placement.

Some days later, hostel staff reported that Donal got into a fight with another resident. Both reported injuries and were later taken to the local Emergency Department for treatment. Not long after, Donal was seen by the adult psychiatric service and prescribed a mood stabiliser called Seroquel. A week later Donal was seen at CAMHS by a senior registrar, who subsequently reported that whilst Donal was not actively suicidal, the risk of suicide was increased due to multiple family bereavements in a short space of time. He recommended that Donal be put under increased supervision and increased restrictions with less opportunity to consume alcohol and other substances which increased the risk.

About the same time Gardai were called to the hostel on several occasions. On one of these Donal had attempted to assault a staff member with the leg of a chair and was only prevented by another resident. He was later picked up by the Gardai and brought to the Garda station to sober up.

In the same week Donal was arrested in a neighbouring town (with another youth from the hostel) for mugging a young foreign boy and taking his mobile phone and earring. He was later admitted again to

[5] A committee which oversaw admissions to HSE residential facilities in the region.

the adult psychiatric unit from the Garda station, where he had made a serious suicide attempt. A week later he was discharged back to the hostel.

Meanwhile, the A/Child Care Manager issued an Alert Notice addressed to the local health managers in the area. He noted that Donal was "currently an extreme risk in [the hostel] due to his mental health, suicidal ideations and use of alcohol and drugs." He went on to make a number of recommendations, including:

- Donal to be assessed in a secure residential service by an appropriate psychiatric service such as the adult psychiatric unit where he had already been an in-patient.
- Staff work with Donal's social workers to obtain a more suitable placement than the hostel
- A Special Care Application to be made for Donal.

Donal subsequently spent the weekend with an experienced foster family who provided supported lodgings for young people.

Two months after he turned 17, Donal's mother signed an application for his admission to care because of his "risk behaviour and concerns for his safety." On the same day he was placed in a privately run residential home in another part of the country. A month later, a report from the residential home positively connoted his engagement there. He had responded well to structure and routine and was taking part in bereavement counselling, off-road driving lessons, and a course in horse care.

About the same time a Family Welfare Conference (attended by Donal's mother and father, uncles and sibling; 3 social workers, 1 SWTL, staff of the residential home and the Gardai) agreed:

- Donal was not in need of special care or protection at this time but if his behaviour deteriorated and/or he re-engaged in at-risk behaviours, the HSE would apply for a special care order.
- Placement at the residential home would continue for the agreed three months, followed by three months at an associated residential home, so that by the following January a move to supported lodgings or alternative care arrangements in his home area would be feasible.

Two months later, Donal had moved from the first private residential unit to a partner residential unit and a progress report from there noted:

- Donal was due to start work in an equestrian centre
- He visited home once a week, facilitated by residential care staff

- He was attending counselling weekly and was said to be engaging well.

Early in the new year (Donal was then 17½), a Review Family Welfare Conference noted, among other things, that:

- Funding for Donal's residential placement would cease at the end of January. The PSWs responsible when Donal was placed told the reviewers that money was not the primary consideration and that the six month placement was agreed in light of the need to get Donal back to the local area and back into supported lodgings before he reached 18.
- A supported lodgings placement was available, provided by the family with whom he had already spent a weekend (before going to the residential unit). This was located about a 90 minute drive from Donal's home town.

A programme to transition Donal from the residential unit to the supported lodgings by the end of January was also planned. In the meanwhile arrangements were made for him to return to the FAS programme he had previously attended (and adjacent to his home town) on Mondays and Tuesdays. This was the only training option open to him at the time as he was not resident full time in the area. He was also to attend a Youth Reach programme in the town near his supported lodgings once he settled in the area. While visiting home towards the end of January Donal came to the attention of the Gardai and was charged with a public order offence.

Social Worker 4's case notes began to indicate that, from the beginning of Donal's placement in supported lodgings, he was spending more and more time near his home area and losing interest in the area around his supported lodgings, some 40-50 miles away. He told Social Worker 4 that he was bored as he had no friends there. He continued to attend the FAS programme (nearer his home town) on Mondays and Tuesdays.

At a court hearing in late January, the Judge remanded Donal on bail on condition that:

- He remained in his supported lodgings on all nights except Monday night (When he was scheduled to stay overnight at home)
- He attended Youth reach and FAS when due to do so
- He obeyed a curfew when he was at home (on Monday nights) between 18.00 and 7.00

- He consumed no intoxicants

Social Worker 4's case notes indicated that Donal had finally started at Youthreach one month later. A review meeting held some two weeks later heard a positive report from the supported lodgings provider, although it was noted that he was frequently staying overnight at home in breach of his bail conditions.

In late March Donal was arrested for being drunk and disorderly in his home town. He was taken to Court and the case was adjourned. A few nights later he was arrested again in respect of criminal damage to a number of cars and to a pub and supermarket in his home town. He claimed he was under the influence of drink and drugs at the time. He was placed briefly in St Patrick's institution in Dublin.

Back in Court a few days later, Donal was remanded on bail with the following conditions:

- He did not go outside his supported lodgings area without permission
- He did not consume intoxicants
- He signed on at the local Garda Station daily before 9.00 a.m.
- He was on a Probation bond for 12 months
- All previous charges disposed of.

Early in April Donal's supported lodgings provider informed Social Worker 4 as follows: on the Saturday morning just gone, he had found the door of Donal's cottage kicked in. Donal had bruises to his eye and both ears. He claimed he had been burgled during the night and been beaten up while asleep, but he refused to attend his GP for medical attention. Over the next week or so he gave several different accounts of what had happened, but the full truth never emerged.

Social Worker 4's case notes from a few days later record a phone call to Donal's mother in which the latter reported that she had spoken with Donal on the previous night – he said he was feeling down and having suicidal thoughts due to living so far away in supported lodgings. He wanted to be moved nearer to home, he told her, or else he would take his own life. Donal's mother said he was not used to spending so much time on his own. On the same day Social Worker 4 visited Donal who spoke of feeling depressed when he was on his own but also stated he did not intend to take his own life. His social worker encouraged him to take responsibility for his life and suggested he take up boxing.

Social Worker 4's case notes from three days later reported on a telephone conversation with the supported lodgings' provider during which it was noted that Donal had an OK weekend and was visited by cousins on Sunday. However, the provider had had an irate phone call at the weekend from a neighbour alleging that Donal had threatened to put his son "through the pub window." Donal was subsequently persuaded by the provider to apologise to the neighbour. Social Worker 4's case notes **on** the following day reported on a telephone conversation with Donal's Probation & Welfare Officer in which the latter reported that she was concerned for Donal whom she had met in Youthreach some days previously. He had told her then that he hated his life; and that he wouldn't hang himself but was considering other ways of taking his life.

Social Worker 4 noted that she had spoken with Donal after this conversation with the Probation & Welfare Officer and both she and the Probation & Welfare Officer agreed that counselling for Donal should be a priority. Social Worker 4 later telephoned a counsellor who agreed to consider working with Donal. On the next day Social Worker 4's case notes report on a telephone conversation with the manager of Youthreach. The latter was concerned about Donal being linked with a female Youthreach student who was two years older than him. He was also worried about the risk of self-harm: he said that Donal had cuts on his arms. However, he said that Donal was engaging well in class, getting on well with teachers and very able for the work at hand. Social Worker 4 visited Donal late that evening.

On the following day the file notes that Donal died in a tragic accident. A Coroner's Inquest held six months later returned a verdict of Death by Misadventure.

12. Analysis of involvement of HSE Children and Family Services with Donal

12.1 Initial response

Donal's mother first referred him to the SWD in a phone call when he was 12½. She told the duty social worker that Donal was out of control, had beaten her up, and her injuries were so bad that she could not lie on her side. Over the following 16 months, the file records that his mother phoned or visited the SWD on 10 occasions, each time reporting, to a succession of duty social workers, Donal's ongoing violence against herself as well as continual damage to furniture and fittings in the home.

During this time, CAMHS also referred Donal to the SWD, requesting a child protection assessment, and the SWD referred him back to their service without providing the assessment. When queried about this,

the social work managers from the time told the reviewers that there was "an ongoing difficulty, a kind of "ping pong", going on in cases referred [to CAMHS] by us, or by the GP with our encouragement, or a parent." At times, they said, CAMHS would put on hold working actively with the child until there was a stable care placement or a risk assessment, whereas the social workers felt that the child still needed support from CAMHS irrespective of the level of SWD involvement. This indicates a lack of mutual agreement over referral norms.

As already indicated in this review, the SWD was remarkably slow in responding to Donal's mother's frequent referrals and requests for help with him. The two social work managers in post at the time Donal's mother first referred him to the SWD were interviewed together by the review team. Asked about the delays in, first, meeting with Donal and second, allocating a social worker to him, the managers indicated that at the time there was (and continued to be) a huge referral rate to the duty system and very high case loads held by social workers. Waiting lists for allocation to a social worker would have been, they said, in the 100s and a case might have stayed on duty without an allocated social worker for a lengthy period. Hence, they said, you could have a case being attended to by different social workers over a period of time until eventually it received a more in-depth assessment. The managers also indicated that there was a high turnover of young and inexperienced front-line staff at the time.

Shortly after Donal's death, in a memo addressed to both local social work managers, a SWTL noted that "there are currently 147 children who have no allocated social worker, who have been referred to the SWD because of child protection concerns or child welfare concerns. The duty social workers are struggling with the volume of work that is being referred to this department and there is no social worker available to meet these children and their parents and to conduct a social work assessment. Hence these children remain unscreened and un-assessed by this department and may be in a seriously at risk situation where they are being abused."

Asked why, for four years, Donal's case was classified as (less urgent) "child welfare", as distinct from "child protection", the local social managers explained as follows: In general, the threshold for "child protection" was quite high. It was applied when a case came in "and immediately presents as something that has to be done now, particularly if you're talking about a younger child." Whereas the "child welfare" classification was applied where the issue was the young person's behaviour and "it

might have been seen that maybe if something could be done around the home situation and around his addiction, around his schooling, then things could have been kept together." In the opinion of the review team, this classification did not take cognisance of the risk Donal was posing to himself and others at the time.

In effect, the categorisation of a referral as "child welfare" functioned to remove a child from consideration for allocation to an individual social worker's caseload, and as a means of managing the high rate of new cases and rationing the allocation of scarce resources. In other words, the bombardment rate and not the child's assessed need determined the level of service offered. This, of course, is a commonly observed phenomenon across the entire range of state-provided services but runs counter to the provisions of *Children First: National Guidelines for the Protection and Welfare of Children* (DOHC 1999) where interviewing the child, for instance, is a routine requirement of the assessment process. It is also increasingly recognised that multiple referrals should elicit a particular focus on a case.

Categorisation as "child welfare" also precluded notification of Donal to the Child Protection Notification System (CPNS), even if it had been in operation in the SWD (which it was not) some seven years after being prescribed in *Children First* (1999). The 1999 version of *Children First* operating at the time describes this system as "a health board record of every child about whom, following a preliminary assessment, there is a child protection concern. A child's name is placed on the CPNS by the Child Care Manager/designate following completion of a preliminary assessment." Notification to the CPNS thus entailed a level of scrutiny by, and accountability to, the Child Care Manager. It could be argued that such scrutiny might have benefited Donal by raising the profile of the case and introducing an element of objectivity missing (perhaps understandably) at the level of the SWD. In the event, it was more than four years after first being referred to the SWD that Donal's name was placed on the CPNS.

In hindsight, the local social work managers acknowledged that "had [Donal] had maybe only one social worker who could have done the assessment quicker, and drawn all the relevant information together quicker, he definitely would have been in care quicker."

In a memo to the Local Health Office Manager, written a few months after Donal's death, the local social work managers detailed the pressures with which social workers were trying to cope. They noted that

"best practice would suggest that a workable caseload is approximately 16 cases. Currently in this department social workers have up to 40 cases. This leads to stress, questionable practice and possibly poor decision-making. . . . There are currently 168 cases on duty/intake which we have been unable to allocate. These are cases that are screened as needing a social work service but we are unable to provide same . . . At this stage this workload has become untenable and unsafe for both staff and clients."

Objectively, therefore, it is clear that the SWD did not respond in a timely fashion or in accordance with *Children First* (1999) guidelines relevant at the time, to Donal's presenting needs. But as the local SW managers whom the review team spoke with made very clear: "You can never guarantee a perfectly safe practice, but you can facilitate it, particularly if you have manageable caseloads and provide good supervision. The people at management level that have responsibility for resource allocation and staff allocation should be party to this review and really should be the first port of call."

12.2 Assessment

An assessment should measure the impact of social factors on a young person's development as well as the capacity of the parent/carer to meet them. In this case it does not appear that a comprehensive assessment was conducted; the root cause of Donal's destructive and aggressive behaviour was not apparently explored, nor was his mother's parenting capacity or her ability to learn to manage his behaviour. Several interviewees commented that a lot of alcohol was consumed in the family home; this fact appeared to be known to most people who knew the family and its impact should have been a factor in the assessment.

Social Worker 1's assessment, completed 2½ years after Donal was first referred to the SWD, concluded that "Donal's need for safety as well as an opportunity to develop a positive trusting relationship with a carer is a priority" and that "a placement with foster carers is the most suitable option." Unfortunately, the assessment was completed two years too late. At 15+, placements in fostering that might have been open to Donal as a 12 - 13 year old, and which might have begun to meet his needs, were not available. Appropriate educational opportunities might also have been made available to Donal, who effectively remained out of school from age 13. And Donal himself might have been more malleable, more open to constructive intervention, at that earlier age. Donal's placement with his father was not made as a result of an assessment of his own needs or of his father's capacity to care for him. It was

made knowing that his father had a history of alleged domestic violence, alcohol abuse and mental illness and in the absence of anything more suitable.

It is also the opinion of the review team, acknowledged to be in hindsight, that the SWD underestimated the impact of family violence upon Donal in his early years. The review team also believes that this underestimation may have contributed to a view of Donal as the agent of problems in his family as well as the victim of them, and may also have influenced the frequent classification of referrals to the SWD by his mother as "child welfare concern: beyond parental control." It is noted that the impact of domestic violence was acknowledged by the consultant child psychiatrist.

12.3 Compliance with regulations

12.3.1 Early protective action

Children First: National Guidelines for Child Protection & Welfare (DOHC 1999) required Children and Family Services to respond to reports made to it. Interviewing the child was central to this process (*Children First,* 8.12). Donal was 12½ when his mother made the first of a total of seven recorded visits or telephone calls with duty social workers. One year later, a SWTL noted (in a memo to a DSW) that "from reading the file it doesn't appear that a social worker has spoken directly with Donal" and stated that "this child should have been getting a more intense assessment and intervention for the past year". She instructed the duty social worker to undertake an assessment. There is no evidence that this assessment took place.

Four months later a duty social worker visited the family home for the first time and intimated that she would begin working with Donal and his mother on his anger-management problems. However, there is no evidence of any follow-up by this social worker and, indeed, no case notes of any kind on file from anyone in the SWD for the next eight months. Three months further on again, Donal and his mother were visited by his newly-allocated social worker, referred to here as SW 1. At that point it was two years and three months since Donal's mother had first asked for help from the SWD. Donal was then just a month shy of his 15th birthday.

12.3.2 Child in Care Review

For the last nine months of his life Donal was in the voluntary care of the HSE, placed at first in a hostel, then in residential care, and finally in supported lodgings. Apart from a Young Person Plan, produced

when Donal had just been placed in the hostel, there is no evidence on file of the statutorily required Child Care Plan or Child in Care Review *(Child Care Regulations 1995).* The local social work managers told the review team that at the time an independent SWTL from another team was responsible for chairing Child in Care Reviews – which were waitlisted when requested by the allocated social worker. The local social work managers said that they did not know why this did not operate in Donal's case.

12.3.3 Child Protection Conference

Children First: National Guidelines for Child Protection & Welfare (First Edition, DOHC 1999) required the holding of a child protection conference "when decisions of a serious nature are being considered which require the input of a number of professionals from different disciplines and agencies" (*Children First,* 8.19.2). It was more than four years after his mother first contacted the SWD that a strategy meeting was convened which decided to escalate Donal's risk status by placing his name on the Child Protection Notification System (CPNS).

Even then, placement of Donal's name on the CPNS did not trigger the convening of a child protection case conference. The current SW managers indicated to the review team that the case conference system in the region was separately managed by another SWD and operated a waiting list of up to 12 months. Conferences, they also told the review team, often involved an entire day of deliberations and required advance preparation of detailed reports. As a consequence, case conferences appear to have been used primarily for decision-making in respect of children in long term care.

In the event, Donal was never the subject of a child protection case conference. Instead, three strategy meetings and two Family Welfare Conferences were convened in the last 20 months of his life.
All three strategy meetings were convened and chaired by an Acting Social Work Team Leader (A/SWTL), in other words by a social worker temporarily acting-up in the SWTL role, and were attended by Donal's social worker, the JLO and a social worker from an associated service. Donal and his parents, as well as a registrar from Child Guidance/CAMHS attended the first and third Strategy Meetings. The third Strategy Meeting, in addition to the above, included a Garda Sergeant, a Probation Officer and Donal's GP.

Both Family Welfare Conferences were held in the last year of Donal's life, when he was in residential care. These were attended by a wide range of professionals and agencies as well as Donal, his parents, sibling and relatives.

What is remarkable about the participants at these meetings is that they were almost entirely front-line staff. This was standard practice in the SWD, where the social work managers told the review team that if they attended all Strategy Meetings they would have time for nothing else. Hence, they did not attend any. Neither did a Child Care Manager or any social work manager above the level of Acting Social Work Team Leader.

Without in any way detracting from the commitment and ability of the front-line staff involved, it is difficult to understand what these meetings (apart from acting as information-sharing opportunities) contributed in terms of added value at an oversight and decision-making level. In other words, strategy meetings and family welfare conferences are no substitute for properly convened child protection case conferences which are attended by, among others, independent practitioners and senior representatives (with decision-making authority) from the major disciplines involved.

12. 4 Quality of practice

12.4.1 Interaction with child and family

There is no doubting the commitment of the individual social workers who were assigned to work with Donal and his mother. The case files record the names of 13 social workers from the duty/intake and specialist teams who dealt with them over a five year period. The review team interviewed three of those who worked most closely with Donal.

Social Worker 1 was Donal's first allocated social worker and spent twelve months in that role. She told the review ream that she took an instant liking to Donal. She described him as "a deep boy" who had "lots of different things going on in his head." Nevertheless she acknowledged that she "didn't have a whole lot of social work contact with him" and his case "would not have been prominent in the context of the cases I was dealing with at the time, I had 55 cases and he was one of many teenagers I had." Social Worker 1 completed the first and only assessment of Donal on file. She readily acknowledged that it was not fully comprehensive, particularly in that she missed out on the impact of domestic violence on Donal himself.

Social Worker 2 was only involved with Donal for a short period and was not interviewed by the review team.

Social Worker 3 was Donal's social worker for 15 months. She remained involved (on behalf of the intake team) when **Social Worker 4**, from a specialist adolescent team, was allocated to Donal's case. He was then 16½. Social Worker 4 told the review team that Donal was referred to her because "there was a need for a more specialised adolescent service that Donal wasn't engaging with the intake workers and we had unique resources of time."

Social Worker 4 was conscious of the number of professionals Donal had been asked to relate to in a short few years and concentrated on pacing her intervention in order to build up a relationship with him. She felt that, although he was vulnerable and at risk, he was responding to her efforts to engage with him.

Social Worker 4 was probably the worker who spent most time with Donal and had the most insight into him. She was also the most therapeutically skilled and was in regular one-to-one supervision. She recognised that he had a very sad story and was struggling to cope: she emphasised his vulnerability rather than the risk he posed to others. She felt that "he was beginning to see in himself that there were opportunities for him and that actually he was a gentle fellow." Social Worker 4 had reservations about the six month limitation on the residential placement and took the view that it served as respite rather than facilitating any therapeutic development.

In addition to the 13 social workers he was involved with, Donal was asked to relate to, among others, four different psychiatrists in CAMHS; a probation officer; a Juvenile Liaison officer; and in his last year, the numerous staff members of the hostel and two residential care units.

Most if not all of these HSE social workers and other workers made strenuous and sustained efforts to engage with Donal and his family. But as the consultant child psychiatrist who knew Donal told the review team, "My view is that care decisions take precedence over therapeutic decisions. If you don't get the care right, you don't get the trusting relationship right." Exposure to domestic violence over several years, the psychiatrist suggested, made it very difficult for Donal to consider that adults were trustworthy enough to let him know what was going on. This suggests that the failure by the SWD to meet Donal's identified need for "a secure and stable home environment and emotional reassurance without violence with adults he can trust" – as recommended by the child psychiatrist and endorsed by Social Worker1 – undermined the best efforts and intentions of those working with Donal. Donal's

older sibling touched on this when speaking to the review team, saying: "Don't spend more time referring them here, there and everywhere." Donal himself had commented similarly.

12.4.2 Quality of Record Keeping

The quality of record keeping by the social workers who were allocated to Donal was adequate, particularly given the large caseloads they carried. There are good records of family and interagency contact.

12.5 Management

12.5.1 Allocation

Donal was not allocated a social worker until 26 months after his mother first began repeatedly reporting her very serious concerns about him. The categorisation of these referrals by a succession of front-line Duty SWs as "child welfare" as distinct from "child protection" was key to this prolonged failure to allocate the case (see 12.1 above). The fact that this categorisation should have been, but routinely was not, reviewed and signed off by a SWTL is also significant. 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. In the opinion of the review team, descriptions of Donal's behaviour at the time would have been compatible with these thresholds.

12.5.2 Inter-agency meetings or cases conferences

Three Strategy Meetings and two Family Welfare Conferences were convened to discuss Donal. As noted above (12.3.3), these meetings may have functioned well in terms of inter-agency consultation and communication. But because of the complete absence of senior management staff, their decision-making capacity was extremely limited, as was the level of oversight to which management of the case was formally exposed. As already discussed in 12.3.3 above, a case conference was not held in respect of Donal at any stage during the more than five years he was known to the SWD.

12.5.3 Supervision

Although there is little or no reference to supervision in their case notes, Donal's intake and duty social workers reported that they were supervised regularly by their respective team leaders. Given, however, the high number of cases they held (Social Worker 1, for instance, told the Review Team that she held

55 cases), it is difficult to evaluate the quality and effectiveness of such supervision. The two specialist social workers had more controlled caseloads, and their case notes make frequent reference to supervision.

It is notable that a number of recommendations made in relation to Donal were not followed, e.g. a more intense assessment, which was suggested by the SWTL, and measures suggested in the first assessment which included placement in out of home care. There appears to have been no review of why no action took place.

12.5.4 Policy

A paper published in the Irish Journal of Applied Social Studies in 2012[6] states that "High caseloads impact on the type and quality of service provided to children and families, and on worker retention and job satisfaction." The paper goes on to argue that "the recommendations of successive child abuse inquiries in Ireland have given rise to expectations and demands on child protection and welfare teams that are not possible to meet *(emphasis added)* given the increasing level of referrals and the high numbers of children for whom social workers are responsible."

The SWD which dealt with Donal, as is probably evident by now, could provide ample evidence for this thesis. In a system where referral rates, already high, are continuing to rise, more children are being received into care, and the complexity of cases is increasing, the requirements of policy become secondary to survival. This review has already noted that *Children First* was largely unimplemented for many years and care planning just did not feature. In addition, there is no standardised framework in place to guide the assessment of the needs of children coming to the attention of social workers; the quality of basic information systems to support practice is extremely poor; and there are no processes in place which would enable management at all levels to provide oversight of, and be accountable for, the quality of services and care.

12.5.5 Inter-professional and inter-agency cooperation

The files provide evidence of significant communication and cooperation between the duty/intake teams, the (HSE) specialist social work teams, the staff of the emergency hostel and the residential units

[6] Burns, K. and MacCarthy, J. (2012) "An Impossible Task? Implementing the Recommendations of Child Abuse Inquiry Reports in a Context of High Workloads in Child Protection and Welfare," Irish Journal of Applied Social Studies: Vol. 12: Iss. 1, Article 3.

where Donal lived for some time, as well as with the providers of his supported accommodation during the last few months of his life. Good use was made of strategy meetings and FWCs to consult and share information with a wide range of allied professionals and agencies, and – especially at the FWCs – with members of Donal's family.

The exceptions to this generally positive picture are twofold. First, Donal was out of school completely for at least 2½ years before he reached 16. During this entire time there is only one mention on file of contact between a social worker and the National Education Welfare Board, but no evidence that anything ever came of it. Second, the relationship between the SWD and CAMHS, particularly in the first few years, seems to have been marked by mutual miscomprehension of each other's roles.

13. Conclusions

- The remit of this review is confined to the child protection services provided by the HSE. However, the breadth and severity of some of Donal's problems, which included suicidal ideation and threats, significant alcohol and drug misuse, a diagnosed behavioural disorder and a history of violent and criminal behaviour, brought them well beyond the range of Children and Family Services. While the review has identified many policy and practice deficits in respect of this case, it does not find that any action or inaction on the part of the HSE Children and Family Services contributed to Donal's death. However, it is difficult to assess if the outcome would have been different if Donal and his family had received an earlier comprehensive assessment and a care plan had been put in place suitable to his needs.

- In a recent paper[7] Barry Higgins estimated that for social workers in child protection in Ireland "with a **caseload of 18**, the average contact time available for children and families is 1½ hours per month." He further estimated that with each additional case allocated the quantity of core tasks increases, while the remaining time available for clients is not only reduced, but is also divided between a greater number of families.

[7] Higgins, Barry (2013) "The Evolution of Standards in Social Work Practice: In Search of the Missing Link" in *The Irish Social Worker*, Autumn 2013, pp.15-22.

- Precise figures for caseloads of those who worked with Donal are not available, but we do know that in the year after his death social workers in the SWD responsible for Donal and his family had an **average caseload of 35.**[8] Any review of the service offered to Donal and his family must find, therefore, that in the circumstances, the SWD generally responded adequately, despite not always complying with national policies and procedures.

- 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 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.
- 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,

[8] Principal Social Workers' Report to Area Managers, Children and Family Services, 6 December 2012

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.

14. 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 domestic violence, 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"[9]. 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.

- **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[10]. 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[11]. 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

[9] 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

[10] 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

[11] Miller, as above.

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 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.

15. 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.

- The review team understands that the National Office of the Child & Family Agency is coordinating a response to the high level of suicide amongst young people known to the service. The NRP recommends that as part of this response, access to special counselling services should be offered to young people who have **experienced** the suicide of a near relative or friend. They should also be subject to support and monitoring for at least one year following the event. This support or monitoring may come from a variety of sources.

  Dr Helen Buckley
  Chair