Review undertaken in respect of the death of Jennifer, a young person known to the HSE child protection services

August 2014

1. Introduction

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

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

2. National Review Panel

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

3. Levels of Review

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

Major review to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.

Comprehensive review: to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations.

Concise review: to be held **w**here the involvement of HSE services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.

Desktop review to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The

methodology should include a review of records and consultations with staff and family members for clarification. The output should be a summary report with conclusions. 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. HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death: Jennifer

This case refers to a young person known here as Jennifer who died aged 17. This case was referred to the National Review Panel because Jennifer had been known to the HSE Children and Family Services for a number of years prior to her death.

5. Level and Process of Review

This was a concise review as the involvement of the HSE Services in this case was of relatively low intensity over a medium-term period. The review team comprised two members: Dr. Helen Buckley and Dr Ann McWilliams. Neither of the members of the review team had any previous or managerial involvement in the case.

For the avoidance of doubt, where the review team has described the circumstances of any person mentioned in this report, the review team has based those descriptions on information contained in the relevant records furnished to the review team. The review team is not to be taken as expressing any view on the veracity or otherwise of any such item of information.

The review team read the HSE social work file, the psychology file and reports from the child care manager's office and compiled a chronology of contacts between Jennifer's family and HSE Children and Family Services.

A number of individuals were invited and accepted the invitation to attend for interview with the review team. These were Jennifer's parents who were accompanied by four other relatives, a social worker (SW2), the social work team leader (SWTL) and a psychologist who was accompanied by her current manager. Reports were sought and provided by the Child & Adolescent Psychiatric Services regarding their contact with Jennifer and the HSE General Hospital Accident and Emergency Department.

6. Terms of reference

The review was undertaken with the following terms of reference:-

- To establish the roles played by the HSE and HSE funded agencies in relation to Jennifer and her family prior to her death.
- To review the services provided by the HSE and HSE funded agencies to Jennifer, in the context of compliance with
    - Existing legislation
    - Policy directions
    - Key professional standards and practice
- To consider issues of interagency and intra agency cooperation and communication
- To prepare a report for the Child & Family Agency which
    - Identifies opportunities for learning from this review
    - Makes recommendations

7. Jennifer

Jennifer was described as a beautiful and affectionate young woman with a pleasant, though sometimes volatile, personality. She was sociable and had several friends including boyfriends. She was strong willed and talkative, but could become withdrawn at times, particularly when she was feeling down. She liked art, and had aspirations to do an art course when she left school.

8. Background and reason for contact with the HSE Children and Family Services

Jennifer's parents were married but separated when she was two years old and both later formed new relationships and had other children. Jennifer lived with her mother, here called Debbie, as a young child. The family became known to the HSE SWD because Debbie was having some parenting difficulties. Jennifer went to live with another family member when she was nine under an informal arrangement but with the agreement of both parents. She returned home at 16 years old after her relative carer died. Jennifer had ongoing behaviour difficulties over the years, and had been referred to psychology and other mental health services. The family had received social work services intermittently from when Jennifer was an early age.

9. Services involved with Jennifer

- The HSE Children and Family Services Social Work Department (SWD) worked with Jennifer and her family over a period of twelve years and then had more concentrated contact with her during the last two years of her life.
- The HSE Child and Adolescent Psychology Service who provided counselling for Jennifer at different times.
- A HSE Child and Adolescent Mental Health Service who assessed Jennifer the year before she died
- A HSE Adult Mental Health Service who assessed Jennifer a few months before she died.
- An Garda Síochána at different times.
- Two second- level schools attended by Jennifer
- A Counselling Centre who provided counselling for Jennifer when she was in her mid teens
- A voluntary agency who convened a Family Welfare Conference and a review the year before Jennifer died
- A HSE General Hospital where Jennifer was treated on several occasions including the week before she died
- A HSE child sexual abuse assessment service
- General Medical Practitioners

10. Brief Summary of Jennifer's Needs.

Emotional Needs

Jennifer had some emotional difficulties in respect of her sometimes difficult relationship with her mother, the conflict between her mother and her relative carer, the loss of her carer, and her scant contact with her father. She suffered from low mood at times, with reduced self esteem and thoughts of self harm. She needed help to deal with these difficulties as well as assistance with anger management and impulsive behaviour, which included episodic misuse of alcohol and drugs that had not been prescribed for her.

Educational Needs

Jennifer's academic performance had deteriorated in the months before she died; she had changed schools with her move back to her mother but had not settled and her attendance was poor. She needed additional educational supports.

Health Needs

Jennifer was in good physical health in general but was diagnosed as having a minor abdominal condition shortly before her death. There were concerns expressed at times by her family and professionals about weight loss and she needed monitoring by her GP.

Safety and Protection Needs

Jennifer disclosed three separate historical incidents of child sexual abuse involving three different alleged perpetrators. All her disclosures were considered to be credible by a child sexual abuse assessment service which she attended when she was in her teens. It appeared that Jennifer did not feel adequately supported in relation to these disclosures and did not feel she was believed by certain family members with regard to different incidents.

11. Chronology of contact by HSE Children and Family Service with Jennifer and her family

Early childhood up to 15 years of age

The HSE SWD had some intermittent contact with the family when Jennifer was a young child. Her mother, here called Debbie, was experiencing difficulties parenting her children. The family was referred to a HSE family support service.

When Jennifer was nine, she and a sibling alleged physical abuse against their mother, Debbie, and were placed by the Gardaí in hospital. A medical examination was inconclusive; an emergency child protection conference was held. Debbie denied beating them but did acknowledge that she slapped them. The children were placed with relatives for a short period but were returned home and a family support supported the family. A few months later, Jennifer again alleged ill-treatment and this time she went to live with a relative, here called Barbara. The arrangement was informal, i.e. Jennifer was not in care, and it was agreed by her parents. Debbie told the review team that she had been under the illusion that she could not remove Jennifer from this relative's care and did not realise for several years that it was a voluntary arrangement. The case was managed intermittently by the duty social worker team leader.

Jennifer's behaviour became disruptive and she was prone to temper tantrums when she was living with Barbara, and she was referred by the SWD and GP to a HSE psychology service. She had to wait two years before she was seen by this service. There is information on file to the effect that, a year

after she went to live with Barbara, Jennifer had disclosed a sexual assault that she claimed had taken place some years previously. However, her mother disputed Jennifer's allegation, insisting that the alleged perpetrator could not have been present in her home at the time the incident was alleged to have occurred. At the time, Jennifer was still on the waiting list for the psychology service and her mother said she would prefer her to be seen there rather than by a child sexual abuse assessment service as she was sure the abuse had not occurred. The matter was not investigated any further.

Jennifer was eventually seen by the psychology service when she was 12 and diagnosed with anger management issues. There was no evidence that the allegation of sexual abuse was addressed. After four months of intervention, her behaviour calmed down and she was discharged from the psychology service by mutual consent.

When Jennifer was 14, she again disclosed child sexual abuse. This time, three separate incidents were alleged, including the incident that she had formerly disclosed. The second one involved a relative and was alleged to have taken place in Barbara's home. The third one had allegedly occurred more recently and was of a less serious nature. A referral concerning the disclosures was sent by a school guidance counsellor to the HSE SWD and HSE Psychology Department. There was no evidence on file that an investigation took place or that the Gardai were informed.

16 years old

When Jennifer was 16, she was admitted into her local general hospital, semi conscious as a result of alcohol consumption. She had been staying that night with her mother, Debbie, and had gone out with friends. In hospital, she repeated her disclosure of sexual abuse by a relative and the hospital reported the matter to the SWD.

When the duty social worker investigated the allegation, Barbara was not inclined to believe it, and told the social worker that Jennifer had a tendency to lie and make allegations when she was in trouble to try and divert attention away from herself. Barbara disclosed that a similar episode of Jennifer passing out while drunk had taken place a few months earlier while Jennifer was in her care. The duty social worker talked with Jennifer and Barbara together about her behaviour, including the health risks involved. Jennifer again raised the matter of the two child sexual abuse allegations she had made. It was decided that she should have a formal child sexual abuse assessment at this point, and a formal child protection notification was completed in respect of both the child sexual abuse

allegation and the recent hospital admission. Debbie told the duty social worker that she wasn't happy with Jennifer staying with Barbara because she felt was not being kept informed of various incidents that had occurred, including Jennifer's allegation of sexual abuse by a relative. Jennifer was wait-listed for allocation of a social worker.

At this stage, a student social worker was allocated to the case for around three months. The child sexual abuse assessment was completed and confirmed the three incidents of child sexual abuse that Jennifer had alleged. The report also concluded that Barbara had been conflicted in her loyalties to Jennifer and the perpetrator of one of the incidents and this had undermined her willingness to believe Jennifer. The psychologist who completed the assessment expressed serious concern about Jennifer's emotional wellbeing and recommended therapy over an extended period to help her deal with her feelings about her parents. The report also recommended a family welfare conference (FWC), referral to the psychology service (where Jennifer was still on a waiting list) and a parenting course for Barbara to enable her to manage Jennifer's sometimes difficult behaviour. It advocated more contact between Jennifer and her father, and it stipulated that the SWD pursue any outstanding child protection matters in respect of the three alleged perpetrators.

The SWD followed the recommendations from the child sexual abuse assessment service in respect of the alleged perpetrators. Jennifer ultimately decided not to make complaints to An Garda Síochána. She remained on waiting lists for psychology and social work for a further five months, though she began counselling in relation to the sexual abuse in a community based service. A new social worker (SW 1) was to be appointed who would take on the case, and the psychology service requested a fresh referral in order to set up a review appointment, which was their practice with children or young people on waiting lists. Significantly, Barbara was diagnosed at this time with what turned out to be a terminal illness.

The newly appointed SW1 began working with Jennifer. Around this time, Jennifer's school reported to the SW1 that she was becoming very distressed about her carer's declining health. Her vulnerability and state of mind were also noted at her psychology review. The psychologist referred her to her GP, and she reported feeling better after a few days. She remained vulnerable however, and was recognised as having long term needs.

17 years old

Over the next few months, Barbara was hospitalised and Jennifer became increasingly anxious about her future. A FWC was planned, the psychology service commenced treatment with her and offered very regular appointments, some of which she missed. After a waiting period, she was seen by the

Child and Adolescent Mental Health Service, who identified her as unhappy and indicated some concerns in respect of her living situation but did not diagnose her as depressed or at risk of suicide.

Speaking about this period in Jennifer's life, SW1 told the review team that she had a number of concerns about Jennifer's continued placement with Barbara, including the impact of Barbara's deteriorating health on her ability to meet Jennifer's emotional needs and her lack of support to Jennifer in relation to her child sexual abuse disclosures. SW1 felt that Jennifer was being put under conflicting pressure by Debbie and Barbara, in respect of whether she should make a statement to the Gardaí or not. Jennifer had also alleged to SW1 that incidents of domestic violence between Barbara and her partner took place, which made her feel uncomfortable and inclined to stay in her room. SW1 advised Jennifer to avail of foster care for a short period of respite. Jennifer was initially reluctant to consider this but agreed that she would appreciate a break. A Reception into Care form was signed by her mother. A foster placement was arranged for her and she moved in, but she could not settle and stayed only one night.

The planned FWC was held shortly afterwards, the stated purpose of which was to enable Jennifer and her family to agree on some supports for Jennifer, and a plan for her future care and accommodation. It was decided at the FWC that she would remain with Barbra but build on her relationships with her family and see her father more often. SW1 met with Barbara and her partner, who both denied the alleged domestic violence and agreed to keep SW1 informed of any concerns in relation to Jennifer. At a review FWC four weeks later, some positive changes were noted. Jennifer had been having more beneficial contact with her mother and extended family. However, it was noted that her relationship with her father and her school attendance needed to improve.

The next few weeks were difficult for Jennifer as Barbara's condition deteriorated. She became very conflicted about where she should live; she felt guilty about leaving Barbara but uncomfortable about staying with her when she was so ill, and discussed this with SW1. She had another alleged episode of binge drinking which was followed up by the SWD. She then moved back to her mother's home with a plan to spend some weekends with Barbara.

In the meantime, the SWD held a child protection conference to discuss the outcome of Jennifer's child sexual abuse assessment. Problems with Jennifer's school attendance were discussed; it was considered that communication between the various family members, the SWD and the school needed to improve. The tensions between different family members and their impact on Jennifer were also discussed and SW1 expressed her concerns about the lack of support being provided to Jennifer by Barbara in respect of the child sexual abuse incident and allegations made by Barbara that she was being left unsupervised at home. It was agreed that Jennifer should stay mainly with

Debbie, with psychology and social work input to improve relationships and keep her safe. Arrangements were to be made to facilitate weekend contact between Jennifer and Barbara.

Shortly afterwards, Jennifer attended a psychology appointment where she spoke of a recent row with her mother about Barbara; a lot of past issues were brought up including the fact that she had been left in someone else's care in the past and the issue of her future living arrangements was also part of the quarrel. Jennifer was so upset after the row that she had indicated her intention to jump off a bridge, but was prevented by her boyfriend, who brought her to an aunt's house to calm down. The row was resolved shortly afterwards by an apology from her mother. Tests conducted during the session with the psychologist indicated that Jennifer was 'moderately depressed' but without suicidal intention. She acknowledged that she had experienced suicidal thoughts in the past; she said she would not kill herself, but admitted that she wanted to hurt herself at times.

About six weeks later, Barbara passed away. Jennifer received support from a number of professionals. She was very grief stricken, and she was offered the option of increased counselling from the psychology department. Debbie, while noting no specific issues for concern, expressed anxiety about Jennifer's ability to cope with her bereavement.

A review child protection conference was held as arranged a few days later but Jennifer was not present as she was in hospital for a minor but emergency surgical procedure. SW1 recommended that Jennifer should continue to live with her mother, Debbie, where her needs were being met and there were no evident risks. She needed to change schools, because the long commute to her former school was not sustainable, so plans were made for her to go to a school in a nearby town. She had been supported through her recent bereavement by her family and continued to receive counselling through the psychology department (although she had missed several appointments but wanted to continue). The SWD continued to work with Jennifer and her mother and considered them to be managing well.

It was reported at the review case conference that the FWC outcomes had also been reviewed and the meeting between family members had helped to reduce tensions between them and facilitated Jennifer's return home to her mother. SW1 confirmed that the required work had been carried out in relation to two alleged perpetrators. However, there was some uncertainty about whether work in relation to the third alleged perpetrator had been completed and the SWTL agreed to check this. Jennifer's mother did not appear to know anything about this incident and it transpired that she had

not received feedback following Jennifer's assessment. Subject to the required consents, it was agreed that the SWD would arrange for this to be given to her.

In view of the previous history of alleged physical abuse of the children by Debbie when younger, the chair of the child protection conference specifically asked her to use alternative forms of discipline when required and she agreed. Other concerns, including supervision, were addressed. The conference concluded that Jennifer should continue to reside with Debbie, with support from the SWD and psychology service.

At psychology appointments some weeks later, Jennifer recounted her anger, grief and sadness about Barbara's passing; she recalled that the time around the death had been stressful due to family tensions. She also reported having met her father. She said she was making friends at her new school and had broken up with her boyfriend whom she felt had become too reliant on her. She had started seeing someone else. The psychologist noted that Jennifer had also decided not to facilitate the Garda investigation of the child sexual abuse incidents.

An incident occurred shortly afterwards, which culminated in Jennifer going to live with another relative on a short term basis. She had got into a physical altercation with a sibling, had run from her home and been picked up by the Gardaí, and told them she was suicidal. She was brought to the local hospital by the Gardaí who notified the SWD. When she heard this, SW1 requested an assessment of Jennifer by the mental health team in the hospital. The assessment took place, and mental health team concluded that she was not clinically mentally ill. It was subsequently agreed between her parents and SW1 that a 'cooling down' period during which she would stay with another relative was the best option for the moment. SW1 followed up this incident and visited Jennifer in her relative's home; she discussed matters that had been brought to her attention including possible drug use. Reconciliation between Jennifer and her mother was mediated and she agreed to continue using the available supports. It was suggested that Jennifer and Debbie might together attend a counselling/family therapy service to work on their relationship. Debbie was not keen on this because she felt that Jennifer wasn't ready for joint work. She subsequently contacted a sexual abuse counselling service to try and gain some insight into how the child sexual abuse incidents had affected Jennifer.

Jennifer returned to Debbie's house after a couple of weeks. Over the following months her attendance at the psychology service was erratic. Her behaviour was of concern to Debbie; her school work had slipped, her relationship with her boyfriend became fractious; she was frequently

angry and spent a lot of time on her own in her room and also complained of physical ailments such as stomach aches. Debbie continued to resist the option of joint counselling, claiming that Jennifer still needed time to grieve. Jennifer's psychologist became concerned about her low weight.

The SWD decided, after some months, that their role in the case was minimal and other services were and would continue to be involved. Jennifer was approaching 18 years and SW1 had no concerns about Debbie's parenting. On these grounds, it was considered justifiable for them to consider terminating their involvement in the case. SW1 told the review team that there had been no child protection concerns and no need for major social work input, and they had kept the case on longer because of crisis driven circumstances and the fact that she had a good relationship with Jennifer who trusted her. She told the review team that if they had believed there was a need for a greater social work role, they would have transferred it earlier to the SWD in the area in which Jennifer now lived. In the view of the SWD, Jennifer's issues were predominantly about her emotions rather than her safety.

From the record and information provided to the review team at interview, it seems that Jennifer's behaviour and mood deteriorated further around this time; Debbie told the psychologist that Jennifer was sleeping all day, would not go out, was quarrelling with friends, having temper tantrums in which she became destructive and aggressive, not eating and missing a lot of school. Debbie thought Jennifer might have been upset that SW1 was considering closing the case to the SWD. At a home visit, SW1 noted that Jennifer looked pale and thin and physically unwell. Jennifer herself was still expressing anger about the way she believed that her family limited her involvement with Barbara prior to her death. While she denied wanting to harm herself, she acknowledged having taken some tablets and admitted she had no interest in school or any concern about her future. She was disinterested in moving into foster care.

17 years and three months old

The records kept by the psychologist indicate that over the next few months, Jennifer's behaviour was less volatile, but her school attendance and motivation to stay on in school were low. The psychologist made contact with a school completion programme which could offer Jennifer various supports. The psychologist also committed to another set of sessions with Jennifer.

Jennifer had been referred to the local mental health service by her GP and had a consultation with them at this point. Although CAMHS is now increasingly available to young people between 16 and

18 in different parts of the country, it was not available at the time to Jennifer in the area where she resided. As a result, she attended an adult service. SW1 perceived that information from an adult service would not be automatically shared as it would have been between a CAMHS service and the SWD. The consultant psychiatrist concluded that she was not depressed or suicidal at that time and referred her back to her GP and psychologist. However, he cautioned that she may have mental health problems in the future. Jennifer continued to attend psychology appointments, though missed some of them. The psychologist worked with her on identifying how her thoughts and feelings were affecting her behaviour.

Shortly afterwards, the SWD finally decided that as Jennifer's needs were mainly emotional and physical and were being met by the psychology and mental health services as well as her GP with the likelihood of additional counselling from school and family therapy in the future, there was no need for further social work involvement. They intended to close the case as soon as SW1 returned from leave; however this did not actually happen.

Shortly afterwards, having failed a psychology appointment, Jennifer texted SW1, asking her for contact details of a social worker who could help her with housing and financial assistance. At this point, the case wasn't formally closed to the SWD, but SW1 responded to her, advising her how to contact the duty social worker in her local area and empathising with her about the fact that things weren't working out. Jennifer texted back to the effect that she was depressed the entire time saying 'I can't stick it'…'I hate it here... so if I turn 18 they can't help me anymore?' SW1 did not respond to this text message. She told the review team that based on her knowledge of Jennifer, the text did not flag up anything unusual or risky. Jennifer did in fact take SW1's advice and contacted the local SWD duty service for advice about accommodation. The duty record there indicates that she was advised that her call would be returned as the duty worker was busy; the record also noted that she did not appear distressed and was satisfied that her message would be passed on. This call was scheduled for the following day.

The same evening, after close of business, the psychologist received a telephone message from Debbie and called her back. Debbie told the psychologist that Jennifer had a difficult few days; she told the psychologist that the previous weekend, Jennifer had injured herself in temper and had been treated in hospital; she was on 'hunger strike' and was refusing to attend school because of a row with another pupil. The psychologist advised her to get an immediate appointment with the GP and emailed SW1 with an update on this, and also to inform her that Jennifer had missed her recent

psychology appointment. SW1 did not receive the email that day as she was out of the office all afternoon.

Sadly, Jennifer took her own life that evening. Both the psychologist and the social worker spoke to the review team of their reflections in hindsight on the days leading up to Jennifer's death. SW1 found it difficult to believe that Jennifer had really intended her action to be final as she had recently been speaking about plans for the future. At the time that she received the text from Jennifer, SW1 had not been aware of Jennifer's attendance at the hospital with the self inflicted injury. She told the review team that had she known, she might have considered calling a family meeting to discuss it. SW1 also reflected it might have been useful to hold a strategy meeting before closing the case, to which all the services involved with Jennifer might have contributed, although she was not sure if adult mental health services would have attended. However, she doubted whether it would have altered the ultimate outcome; she believed that Jennifer's suicide was an impulsive act, related to 'what was going on at that time, on that evening'

12. Analysis of Involvement of HSE Children and Family Services

12.1 Response to Referrals

During the period under review, the HSE SWD responded promptly to the referrals made in relation to Jennifer, contacted the relevant family members, and linked with other services as appropriate, including the child sexual abuse assessment service.

12.2 Assessment

There were a number of assessments carried out on Jennifer in the period under review. Following the first referral, an Initial Assessment Form was completed by the student social worker. Shortly after, a further and more specialised assessment was carried out in response to Jennifer's disclosures of child sexual abuse. This assessment commenced within a few weeks of referral and appears to have been conducted in a comprehensive manner with all relevant parties interviewed. A completed assessment report was forwarded shortly afterwards and concluded that three credible incidents of sexual abuse involving Jennifer had occurred. Concerns about Jennifer's emotional wellbeing were rightly identified. A number of recommendations were made and included the convening of a Family Welfare Conference (FWC), a parenting course for Jennifer's relative carer, attention to Jennifer's relationship with her father, referral to psychology and finally, the need for the HSE Children and Family Services to address ongoing child protection concerns in relation to the

three alleged perpetrators. The review team considers that the assessments, conclusions and recommendations were appropriate and comprehensive. A further comprehensive review was carried out by the psychology service (Jennifer had been on their waiting list for almost two years at this point), following which a programme of work was agreed to meet Jennifer's many unresolved emotional needs.

12.3 Compliance with Regulations

From evidence on file and the interviews held with staff members, it appears that Children First: National Guidelines for Child Protection and Welfare (2011) was complied with. It is noted that following Jennifer's disclosures of child sexual abuse, a child protection conference was held but not attended by the psychologist, the GP and CAMHS. The child protection conference reached clear decisions including the allocation of an 'outreach worker' to Jennifer's mother. It is noted that there is no evidence that this occurred. It is also noted that the Gardaí had intended to pursue an investigation in respect of an individual who allegedly abused Jennifer but were unable to do so as Jennifer herself decided to let the matter drop. A review child protection conference was held in accordance with the regulations although attendance was limited.

Around this time, a Standard Reporting Form was completed by SW1 on Jennifer's report re CSA when she was 4/5 year old. This incident had been considered as credible in the assessment report completed by the community child centre. The fact that this form was not completed at the time of the incident is of concern to the review team.

12.4 Quality of Practice

12.4.1. Interaction with child and family

12.4.1.1. *Perspective of Jennifer's family*

Jennifer's mother and father and some of her extended family met with the review team and gave their perspective on the interaction that they had with the SWD and other HSE services during the period when Jennifer first went to live with her relative, and later on when she came back to live with her mother, Debbie. They told the review team that they had initially misunderstood the status of Jennifer's placement. The social work record clearly states that Jennifer was placed with her relative carer, Barbara, with the agreement of her parents. This action was not followed up by the HSE with any care application to court; therefore Jennifer was not in the care of the HSE when she went to live with Barbara. However, Jennifer's mother, Debbie, told the reviewers that she believed

she would be arrested if she 'went near' Jennifer when she was first placed. She told the reviewers that she found it difficult to get any information. Her memory was that 'every time we were ringing to find out "what was the story", whether she was coming back, we were kind of getting answering machines, no one actually came and sat and talked to us to tell us what was going on with her'. During that time, she had a letter from the Department of Social Welfare stopping her payments in respect of Jennifer, which added to her conviction that she was 'not allowed' to have her back. Debbie told the reviewers that she was distracted by the serious illness of one of her other children for a period around that time and stopped pursuing Jennifer's return but that around a year later (during which time Jennifer had visited home on occasions for weekends) she and a brother in law approached the social worker 'to demand what was happening with [Jennifer] and when we were going to get her back' and that the social worker had said 'just go and get her', but by that time Jennifer did not want to return home.

The review team did not interview the social workers who were involved at that point as these events had occurred a number of years before the period under review. It appears that by default, Debbie and Jennifer's father were left for almost a year with the impression that Jennifer was in care under a court order when in fact she was not in the care of the HSE but in a private placement. While it is accepted that this was a misperception, it does indicate a poor level of communication between Jennifer's parents and the SWD at the time.

Both parents were very critical of the amount of time that Jennifer was on waiting lists for services, as her father expressed it: 'all they kept saying to me was, we plan to do.... but nothing actually helped her.' Debbie was critical of what she described as the lack of 'flow' and communication between services. She also believed that while Jennifer was living with her relative carer, she was seen by a number of persons whom she thought were psychologists and different doctors without her knowledge and that her consent was never sought. Debbie pointed out that she hadn't later been informed that Jennifer had made a disclosure of child sexual abuse against someone known to Barbara until much later. Jennifer's father was also critical of the fact that he had heard about this allegation from someone he knew rather than 'officially.'

12.4.2 Provision of social work service

Once the case was allocated to SW1 when Jennifer was 16, there was evidence of frequent contact between her and Jennifer as well as her family over the following six months. From the beginning,

SW1 appropriately addressed all the key issues identified in the different assessment reports in her meetings with Jennifer and her family. In doing this, she faced a number of challenges given the intra-familial differences of opinion that existed in respect of the child sexual abuse allegations and their implications, the fraught relationship that existed between Debbie and Barbara and the secrecy surrounding Barbara's illness in its earlier stages. It appears from the record and from her interview with the review team that SW1 managed to deal firmly and perceptively with the various sensitivities as they arose, always keeping Jennifer's best interests to the fore and showing appropriate respect for Debbie in her role as Jennifer's main carer. Debbie and her extended family told the reviewers that they found SW1 to be helpful, and supportive. They implied that she was insightful in respect of Jennifer's placement with Barbara and the difficulties and dilemmas it created both for Jennifer and her mother. Other examples of her interventions included setting up various respite arrangements for Jennifer, and clarifying with both her mother and her relative carer how her needs would be best met. She also addressed concerns about the allegedly violent relationship between Jennifer's relative carer and her partner.

Although SW1's contact with Jennifer and her family decreased during the latter period under review, there is evidence that she responded promptly to incidents as they arose; for example, her insistence that Jennifer was reviewed by the mental health team following a crisis admission to hospital, and her response in regard to concerns expressed by the psychologist.

12.4.3 Provision of psychology service

Psychology was the other key HSE service involved with Jennifer and her family for 14 months before she died. She had been referred on two different occasions to this service, and each time, had to wait a considerable time before anyone was available to see her. During her latter involvement with the service, Jennifer attended 13 appointments but cancelled or did not attend an additional ten others. From the evidence available to the review team, once the psychology service was made available to Jennifer, it was consistent and of a high standard. The very detailed notes kept by her psychologist show that she was very committed to Jennifer's general welfare as well as her emotional state and was available to her despite Jennifer's erratic attendance. Her interview with the review team confirmed this. The psychologist focused largely on individual work with Jennifer but included her mother appropriately at intervals. She also advocated with other services on Jennifer and her mother's behalf. She offered Jennifer additional sessions when the first planned sessions were completed. Shortly before Jennifer's death, it had been suggested that her future counselling should be school based, to avoid her having to miss school time in her Leaving Certificate

year. Both the psychologist and SW1 believed that joint work with Jennifer and her mother was the next appropriate step and review team see no reason to question their view.

12.4.4. Child and family focus of services

From the records and meetings between staff and the review team, there is evidence that both SW1 and the psychologist managed to develop very good relationships with Jennifer and her mother. Both professionals met with Jennifer on her own on many occasions; there is evidence that they prioritised her needs at all times even when this meant disagreeing with her, or incurring her mother or her relative carer's displeasure. Jennifer had the mobile phone numbers of both her social worker and psychologist. Both of them felt that she would have been confident enough to contact them if she needed to. It was evident that both of them had identified many of Jennifer's positive characteristics and they displayed considerable empathy towards her both in recordings and in their meetings with the review team.

Jennifer's mother commented to the review team that she and Jennifer's father had been legally married, therefore were both Jennifer's legal guardians and remained so. They were critical of the fact that a number of medical and mental health services saw Jennifer at different times without seeking their consent.

12.4.5 Provision of mental health services:

Both Jennifer's parents, but Debbie in particular, found it difficult to access the mental health services that they believed Jennifer needed. Debbie was worried because there was a family history of mental illness and believed that Jennifer needed more than the psychology service she was getting (a point not disputed by the psychology service). She described how she tried 'going everywhere trying to get my own help for her… I didn't even know where to start'. She and her extended family found it hard to accept that the various mental health services that Jennifer had attended had said there was nothing wrong with her, feeling that professionals 'kind of always ignored me, even though I knew her outside and in'. She described how, the week prior to Jennifer's death, she had been on the phone to various services 'begging, begging' for help, she had wanted to have Jennifer 'sectioned' and had been advised to go to her GP; but had only been able to secure an appointment with her GP on the day after Jennifer had died.

From the perspective of the reviewers, Jennifer received an excellent psychology service and it is noted that an appointment had been available to her on the day before she died but other mental

health services provided to her appear to have been fragmented, in the sense that they always seemed to consist of once-off appointments. Mental health services also seemed difficult to access, particularly at a time of crisis. Although still only 17, Jennifer's last mental health appointment was with an adult service. While the SWD would have communicated regularly with a CAMHS service and been able to obtain reports from them, SW1 felt that information sharing and communication norms were different when the service involved was for adults. Neither the social worker nor the psychologist were aware of the outcome of Jennifer's contact with the mental health service prior to her death. The psychologist had written to both Jennifer's GP and the mental health service but received no response.

Commenting on the accessibility of services for young people in crisis, the psychology service made the point to the review team that it functions as a uni-disciplinary team and in certain cases, would benefit from another opinion on a case by a psychiatrist or an experienced psychiatric nurse.

12.5 Management

12.5.1 Decision to close the case to the SWD

At a particular point, it was decided in the SWD that the case would be closed; Jennifer and her family were informed of this as was the psychologist. It was initially to be transferred to another area following Jennifer's move there, in the knowledge that it would probably be waitlisted for allocation. Ultimately it was decided to close it. The intention to close it was signalled to Jennifer and her family some months before her death, but was in fact still open when she died. The SWTL told the review team that it was still open because the administrative action necessary to close the case had not been completed

SW1 told the review team that she believed that the plan for the SWD to close the case was appropriate at the time that the decision was made. This view was supported by her team leader. Both SW1 and the team leader considered that Jennifer was, at this point, linked in to all the relevant services such as her GP, psychology and the mental health services. Jennifer's mother was managing her educational needs, there were no outstanding child protection concerns and there appeared to be no further need for social work intervention. The reviewers are of the opinion that while this assumption was a rational one, it was based on a premise that the other health and mental health services be accessible, would remain involved, work in collaboration and would be able between them to provide a reasonably cohesive response to Jennifer's needs. However, in reality the chances of this happening would have been limited very quickly by the completion of the

sessions by the psychologist. Additionally, as Jennifer's parents pointed out, waiting lists featured very frequently in the family's experience of mental health and counselling services, none of which were easily or quickly accessible. The possibility that Jennifer would receive a comprehensive or longer term response to her emotional needs, particularly if a crisis arose, was in fact quite fragile. It could quite rightly be asserted that it is not the responsibility of a SWD to oversee the provision of mental health services when no child protection concerns exist in respect of a young person; however, this case highlights the potential for fragmentation when no service takes key responsibility for a young person's welfare. The review team notes from information provided in interviews that while the SWD was cautious and considered about how their involvement would end, the psychologist, who was the other professional most closely involved with Jennifer was unsure if the case had been closed a few months after the social worker had informed her of their intention. It is also noted that the SWD was unaware that the psychologist was due to finish her sessions with Jennifer at the same time as the case was closing.

12.5.2 Supervision

During the period under review there was evidence of supervision of the case involving the allocated social worker and her team leader. The SWTL told the review team that SW1 had formal supervision every month but this did not mean that every case was discussed on a monthly basis. In addition to this, there would have been regular checking in with each other. This was confirmed by SW1. There was also evidence of supervision of the allocated psychologist and her principal and some peer supervision.

12.5.3 Child protection meetings and conferences

There were two child protection conferences and a FWC and a review FWC during the period under review. It appears that the child protection conferences were well organised and that the plans made at them were put into action and reviewed. SW1 and the SWTL told the panel that they believed that the FWC was a positive experience for Jennifer as it was well attended by her maternal extended family and she would have been aware of the support they were prepared to offer. The family had a somewhat different perception and a different recollection of events. They claimed that a letter from Jennifer's relative carer (who had since died) had been read out, after which Jennifer became very upset. The SWTL said that the letter had been referenced and summarised but not read out as to do so would have been considered inappropriate.

12.5.4 Interagency Collaboration

There was evidence of good interagency collaboration between certain services. This was confirmed through attendance at two child protection case conference meetings and two family welfare conference meetings.

There was also evidence of generally good communication between the psychology department and the SWD, and between the psychologist and other agencies such as schools and An Garda Síochána. The psychologist also had contact with the GP, CAMHS and with educational services. However, as noted above, the SWD and the psychology service appeared to be unclear as to the status of each service's involvement with Jennifer just prior to her death.

A few days before her death, Jennifer was treated for a self inflicted injury, sustained in temper, in the Emergency Department of the local hospital. Although she was under 18, this did not elicit a referral or communication from the hospital to the SWD.

It appears that in the absence of this information, SW1 was unaware of the stress being experienced by Jennifer and her mother prior to Jennifer's death; she told the review team that had she known of these issues she might have responded differently to Jennifer's text to her and considered holding a strategy meeting and inviting the adult mental health services. However, she qualified this with her view that it would probably not have altered the outcome of what she believed was Jennifer's impulsive act of self harm.

12.5.5 Recording

There was evidence of good recording in the psychology file with detailed contemporaneous records of sessions with Jennifer and her family. There were also records of emails and letters as well as meetings. There was an indication of good recording in the social work file for most of the period under review. There was also evidence of good recording in the child care manager's office.

13. Conclusions

The review team notes the grief and shock that has been experienced by all of Jennifer's immediate and extended family and the people who worked with her, and extends sympathy to all of them. It has found that Jennifer was loved and cared for by her family and her extended family including the relative with whom she lived for a number of years. The review has also seen evidence that Jennifer was liked and respected by the professionals who worked with her and that she received a good standard of service from social work and psychology during the last eighteen months of her life.

The review has concluded that neither action nor inaction by the services involved with Jennifer contributed to her death. However, it has noted the long waiting list for psychology services, the fragmented nature of the different mental health and counselling services, and has identified a gap whereby young people who experience emotional difficulties including suicidal ideation but are not formally diagnosed with a mental illness on initial examination find it difficult to get appropriate services on time.

14. Key Learning Points

- **Gap between service users' expectations and understanding of the child protection system and the actuality of the service provision.**

The review has noted some gaps in Debbie's understanding of the child protection system. She initially misunderstood the nature of Jennifer's placement with a relative carer, which was actually informal and of a voluntary nature. The review team was unable to investigate precisely what transpired at that time, but it appears that Debbie thought that Jennifer was under a care order, when in fact she was not in care at all. The review has also commented on the lack of a final decision as to the closing of the case and the uncertainty that this created for the family, who told the review team that they believed that the SWD had terminated their involvement. Research has shown that misunderstandings are commonly experienced by parents who are often under stress when they come into contact with services, and highlights the need for staff to consistently clarify the rationale behind child protection actions and ensure that families understand the purpose and anticipated outcome of any interventions, plans or changes of plan.

- **Good practice example of managing tensions in relative placements – evidence of the issues and of the social worker's management of them**

The review has noted the way that SW1 managed the tensions that prevailed between Jennifer's family and Barbara, her relative carer, and cites this as an example of good practice. She was able to prioritise Jennifer's welfare, and respond to her wishes whilst showing respect for both her mother and her carer in their different roles.

- **Mental health services**

The review has commended what appears to have been a very dedicated service provided to Jennifer by her psychologist. However, it has noted that each time she was referred to psychology,

she had to wait a considerable time before the service commenced. It has also noted that when Jennifer attended multi-disciplinary mental health services, she was assessed as not suffering from a mental health problem. Both Jennifer's mother and the psychology staff were of the opinion that Jennifer had emotional difficulties that required more than a uni-disciplinary psychology service. Her mother told the review team that she desperately and unsuccessfully sought a service for Jennifer during the last week of her life; she told us that she was advised that Jennifer would have to be referred by her GP and was unable to get a prompt appointment. The case portrays a distressing picture whereby young people who have deep emotional problems and may be suicidal can find the pathway to services very slow and cumbersome and the services very narrow in their orientation. The review team believe that it is very important that the gap between the sort of needs experienced by young people in crisis and the provision of mental health services is recognised, and that the limitations of a uni-disciplinary psychology service are acknowledged.

15. Recommendation

- In view of the worrying rate of suicide amongst young people in Ireland, including those in contact with child protection services, it is recommended that the Child and Family Agency reviews the provision of multi-disciplinary mental health services to young people in crisis and facilitates speedier and less cumbersome access.

Dr. Helen Buckley

Chair, National Review Panel

Date: 19th August 2014