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

Executive Summary

August 2014

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This was conducted as a concise review. The review team comprised of Dr. Helen Buckley and Dr. Ann McWilliams. The methods used were a review of social work and psychology files, and interviews with social work staff, psychology staff, Jennifer's parents and some of Jennifer's extended family. The review team acknowledges the deep sense of shock and distress experienced by Jennifer's family and by people who worked with her and extends its sympathy to all who knew her.

Background

Jennifer took her own life shortly before her 18th birthday. She was living with her mother at the time, and had spent a number of years in a private fostering arrangement with a family member and a very brief period in the care of the HSE.

Jennifer's parents separated when she was very young. Her mother had some parenting difficulties and the local HSE social work department (SWD) became briefly involved. At nine years old, Jennifer went to live with a relative with the agreement of both her parents. As she was not in care, social work involvement ceased. Jennifer's mother told the review team that she did not realise that Jennifer was in a voluntary and informal placement and by the time she understood that she could take Jennifer back, she had settled and did not want to leave her relative. While living with her relative, Jennifer had frequent contact with her mother and siblings, less with her father but remained in touch.

During the first few years living with her relative, Jennifer exhibited some behavioural problems and was referred by her GP to the HSE psychology service. She waited two years for her first appointment at 12 years old. She had, at different times, disclosed three separate incidents of sexual abuse allegedly perpetrated by different individuals. At the time, some doubt was expressed by the adults in her life as to whether or not these incidents had really occurred and they were not fully investigated until she was 16 years old. When she was eventually assessed by a HSE child sexual abuse assessment service, the allegations were confirmed. In the meantime, aspects of her behaviour, including alcohol use, were causing concern. By her mid-teens, she had been attending counselling because of her sexual abuse and was once again referred to psychology; she began to

receive this service after another long waiting period. Once her case was taken on, she received an excellent service from the psychologist. At the same time, a HSE Children and Families social worker was allocated to her. This social worker worked saw her frequently and provided very good support to her over a long period. Around this time, the relative who had been caring for her became terminally ill and subsequently died; Jennifer found this extremely difficult, particularly as there had been tension between her own family and her relative. She went back to live with her mother. While she was well cared for, her moods tended to fluctuate and all the professionals working with her, including her school, were concerned about her emotional vulnerability. She had a very brief placement in voluntary foster care but returned home quickly. She was seen by the Child and Adult Mental Health service, which identified her as unhappy but not depressed or suicidal. She was later referred to an adult mental health service as she was over 16; the psychiatrist concluded that she was not depressed or suicidal but could experience mental health problems in the future. She continued to attend psychology services and the social work department decided to close the case as she was now living in a different area and her needs were largely emotional and health related and were being met by other services. The case had not been fully closed by the time that Jennifer died.

Jennifer's mother told the review team that she had tried to get a mental health service for Jennifer the week before she died; but by the time she got a GP appointment to make the referral it was too late. Jennifer had attended a local hospital a few days before she took her life, for an episode of self-harm. The SWD had been unaware of this event.

Findings

The review team 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 over 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.

Key Learning Points

- The review has noted some gaps in Jennifer's mother's understanding of the child protection system. 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.

- The review has noted that each time Jennifer 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. 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.

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