National Review Panel

Review undertaken in respect of the death of Karen, a young person known to the child protection system

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 and began its work in August 2010. 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 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, 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 where 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 with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions 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.

- **Recommendation for internal local review** to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.
- HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death

This review concerns the death of Karen, a girl in her early teens who died by suicide. At the time of her death, Karen's case was open to the social work department and there had been ongoing involvement with her and with her family in the months prior to her death.

5. Level and Process

This review is a **concise review** as the involvement of the HSE services in this case was of relatively short duration and low in intensity. The review team consisted of three members: Dr Helen Buckley, Ms Margaret Beaumont and Dr Nicola Carr. Dr Helen Buckley chaired the review.

Based on the case files provided to the review, the review team members compiled a chronology from the date of the original referral to the social work department in 11 years prior to Karen's death. Having read the case files, the review team members identified a number of people including family members, social workers and allied professionals to whom they wished to speak.

Letters outlining the nature and purpose of the review and requesting an interview were sent to the following individuals:

- Mother and father of the young person

- Principal Social Worker, Social Work Department (SWD)
- Team Leader, Social Work Department (SWD)
- Social Worker (allocated to the case at the time of Karen's death)
- Garda Diversion Project Worker
- Family Welfare Conference Coordinator

Members of the review team interviewed the following individuals on dates in autumn 2012:

- Mother and father of the young person
- Principal Social Worker, Social Work Department (SWD)
- Team Leader, Social Work Department (SWD)
- Social Worker
- Garda Diversion Project Worker

The Family Welfare Conference Coordinator was unable to attend for interview at the time other interviews were conducted and subsequently provided a written submission to the review team.

Prior to interview, each participant received written information outlining the purpose and process of the review. Participants were invited to submit a written statement concerning their involvement with the young person prior to interview. No written statements were received.

Each individual interview was recorded and subsequently transcribed. These transcripts form part of the record considered in the review. In addition to this the review team also requested a copy of the Coroner's Report in respect of the young person's death, which it received, and which forms part of the record considered in the review.

6. Terms of Reference

The review was undertaken under the following terms of reference:

- To establish the facts with particular reference to the role(s) played by the HSE and HSE funded agencies prior to the death/serious injury of the young person concerned

- To review the HSE child protection service, in these cases, in the context of compliance with:

- Existing legislation
- Policy directions
- Key professional standards

- To consider issues of interagency and intra-agency cooperation and communication
- To prepare a report for the HSE which

Identifies opportunities for learning from this review

Makes recommendations

7. Karen

Karen, a teenager was the eldest of her siblings. She was living with her parents and siblings at the time of her death. All of the people whom we spoke to for the purposes of this review who knew Karen well describe a spirited and bright young person whose tragic death has profoundly affected them all.

8. List of services involved

The following is a list of the main services involved in this case:

- HSE Social Work Department
- Garda Diversion Project
- Community Psychology Services (HSE)
- Family Welfare Conference Services (HSE)

9. Background

Karen was referred to the SWD on three separate occasions between the ages of 12 and 15. The first referral, from an anonymous caller, related to concerns regarding alleged sexual behaviour by her in public. This allegation was investigated and denied by Karen and the case was closed shortly thereafter. The second referral to the SWD originated from the family GP following a physical altercation between Karen and her mother resulting in injury to her mother. There was a brief intervention by the SWD with the family and the case was closed six months later.

Four months later, a further (third) referral was received by the SWD, this time from Childline and the Gardaí, after Karen herself had made contact alleging an assault on her by her father. This allegation was investigated by the SWD and the Gardaí but no charges were

brought. Further contact was made with the family by the SWD and a social worker met with Karen and her family.

At this time Karen was also attending a Garda Youth Diversion Project (GYDP) and a referral was made by this project to the HSE Family Welfare Conference (FWC) service. While the FWC was being planned, a decision was made by the SWD to close the case because the situation was deemed to have stabilised and sufficient other services were involved. However, this case closure was not actioned as Karen's mother reported ongoing difficulties managing her daughter's behaviour, which culminated in Karen being asked to leave home. Further contact was being arranged with the family in light of these circumstances, and it was during this period that Karen died by suicide.

10. Brief summary of child's needs

Karen needed assistance in dealing with issues of conflict between herself and her parents. She also needed help to stablise her behaviour and to be linked back into school. The social work record notes that both Karen and her parents had sought support from a range of services regarding these issues.

11. Chronology of services provided to Karen and her family

First referral to SWD

The first substantive social work contact with Karen was when she was 12 years old. A phone-call was received by the SWD from an anonymous caller alleging that Karen had been engaged in inappropriate sexual behaviour with other young people in public. This referral was recorded by the duty social worker on a Standard Referral Form (SRF) and categorised as a 'welfare' concern alongside a query regarding lack of parental supervision. Contact was made with Karen's parents via letter and they were invited to attend a meeting with the duty social worker at the SWD. Both parents attended this meeting and the record indicates their view that the referral was malicious, but they agreed to discuss the matter with Karen. Shortly after this meeting Karen's mother telephoned the SWD and said that they had discussed issues of sexual health with Karen and that she denied the allegation. Following this contact, the case was closed, with the social work record noting that there were: "No child protection concerns for now." No social worker had met with Karen on this occasion.

Second referral

The next recorded contact with the SWD was made nearly two years later when Karen was 14. The family's GP sent a letter to the department requesting 'urgent' social work intervention with Karen because of ongoing 'behavioural difficulties' culminating in an assault on her mother. The referral letter reported that as a result of the incident Karen was no longer in the family home and was staying with a relative; however the GP noted that this was not a 'permanent solution'. This referral was received by the duty social worker who categorised it as a 'welfare' concern. The duty social worker carried out a home visit four days after the referral and met with Karen's mother. The social work notes from this meeting record Karen's mother's ongoing difficulties in managing her daughter's behaviour and document physical violence between mother and daughter. At the time of the social work visit Karen had returned home, but the social worker did not meet with her on this occasion.

A subsequent home visit was conducted by the same duty social worker three days later when she met with Karen and her mother and father. At this meeting it was disclosed that Karen's mother had also been physically violent towards her daughter. This matter was discussed. The social worker advised on its unacceptability and suggested alternative techniques for dealing with Karen's behaviour. The file records that Karen had been referred by the GP to a clinical psychologist and was currently on a waiting list. The social worker advised that another social worker would be in touch regarding network checks to be conducted on the other children.

The next recorded contact with the family was a home visit from the duty social worker five months after the first visit. Here the duty social worker (a different worker from the first visit), met with Karen and her mother and father. It was noted that Karen was attending a youth counselling service and that although there were ongoing issues, the situation had considerably improved and there had been no recurrences of violence. The case file indicates that the duty social worker also contacted Karen's school and the Gardaí who reported no concerns. Shortly after this, the case was closed (six months following this second referral). The outcome of the case is recorded as follows: "Dealt with as welfare. Follow up visit conducted; family report improvements."

Third referral

The third and final referral to the SWD was made by ISPCC Childline a few months later following a call to the service from the young person. The Initial Referral Form completed by the duty social worker contains the following short description of the concern:

> Childline received a call from [Karen] advising that her dad threw her against the wall and tried to strangle her, she further advised that her hand hurt, she couldn't move her thumb, she said he had done this before.

A subsequent referral relating to the same incident was received from the Gardaí two days later. The Garda referral had been prompted by a report of the incident from the ISPCC. The Garda standard notification to the HSE noted the following:

> Parents do not cohabit. Father was visiting and speaking to (Karen) about forbidden boyfriend. [Karen] alleges that on [date] she was assaulted by her father. Minor bruise to left thumb. [Karen] rang Childline on [date]. Childline reported matter to Gardaí.

An Initial Assessment Form (IAF) on the case file unsigned and undated categorises the referral as a 'physical' abuse concern. The form repeats the information provided in the Garda Notification referring to 'minor bruising' but does not note the information referring to an alleged strangulation attempt reported by the ISPCC.

The social work case file records that a telephone call was made to the Gardaí on the date that the initial (ISPCC) referral was received by the duty social worker. It notes that contact was made with a Garda Sergeant who stated that another Garda had dealt with the case over the weekend and was due to see the young person again during the week. The file records that the Garda Sergeant reported that Karen was currently staying with a relative and the following note is recorded in the file:

> …case is not immediate and serious from point of view child is staying with (relative) child had a slight cut on her finger.

There is no record or note of whether medical assistance had been sought in respect of this incident and at this point the young person had not been seen by a social worker. The case file records that three days later an unannounced home visit was carried out by the duty social worker but that no one was at home and a message was left for Karen's mother to contact the SWD. Karen's mother contacted the SWD the following day and the case file provides a record of her account of the incident, including an acknowledgment that Karen's father did allegedly 'push her a bit'. The case file also reports that the duty social worker told Karen's mother that she:

> …would need to meet with (Karen) to hear her side of the story, and speak to (father) re inappropriateness of pushing.

At this point it was agreed that a home visit would be conducted by the social worker the following week to meet with Karen, and both her parents. The case file further records that three days following the initial referral, despite attempts, direct contact had not yet been made with the Garda investigating the incident.

The home visit was conducted by another duty social worker nine days following receipt of the initial referral. However, on this occasion neither Karen nor her father was present as arranged. The case record notes that Karen's absence was because her mother did not want to take her out of school. The reason for Karen's father's absence is not recorded. The case note records Karen's mother's account of the incident, and reports that Karen's mother acknowledged that her daughter had been allegedly 'dragged up the stairs' by her father and 'pinned to the bed' in the course of a dispute regarding an older boyfriend. The case record concludes by noting an agreement to meet the following week with all parties to help resolve the situation.

This home visit was arranged for the following week, but the case record notes that the day before the scheduled visit, Karen's mother contacted the SWD to reschedule for a week later as Karen had to attend a meeting at the GYDP. A home visit was subsequently carried out in which the duty social worker met with Karen and her mother. Karen's father was absent on this occasion as a result of court proceedings concerning alleged drug-related offending. This home visit is the first record of a social worker meeting with the young person in respect of this referral. This occurred more than three weeks after an incident concerning a physical assault was reported to the SWD.

It is not clear from the case record if Karen was seen separately by the duty social worker. The social worker met by the review team for the purpose of the review did not carry out the home visit. She was the last worker who dealt with the case, but she had not had the opportunity to meet Karen. The case file notes Karen's account of the incident where she reports being 'dragged' up the stairs and to her bedroom and her father putting 'pressure on her neck' to the extent that 'she couldn't breathe'. The case note concludes with the social worker recording her intention to call the following week to arrange an appointment with Karen's father pending the outcome of his court appearance.

The social work file records that three days after this home visit telephone contact was made with Karen's mother by a duty social worker (again another worker), who reported that the final court outcome had not been decided and Karen's father was due in court three weeks later. She was anticipating he would receive a prison sentence. It was noted that Karen's mother reported that 'everything was well' and that Karen 'was in much better form'.

Another duty social worker made contact with Karen's mother via telephone three days later as pre-arranged. According to the record, Karen's mother reported that things had improved at home and that they were still awaiting the outcome of Karen's father's court case. Karen's mother also reported that she found the previous duty social worker's home visit and intervention to be helpful.

The next recorded contact with the family was a telephone call to the SWD from Karen's mother a month later, in which Karen's mother reported ongoing difficulties with Karen including missing school, staying away from home and 'threatening to contact Childline'. Karen's mother also reported that Karen said that she wanted to live in a 'home' (i.e. a children's home). On this occasion the file record notes that the duty social worker discussed these issues with Karen's mother and advised that she would follow-up by discussing the case with the duty team leader.

There is no further record of social work involvement or any action taken until two months later, when a file note records that the team leader advised the duty social worker to seek an update on the case. One week later, the duty social worker, (again another worker), telephoned Karen's mother. Karen's mother advised that 'things weren't great' at home, but that Karen was involved and regularly attending a Garda Youth Diversion Project, where she was undertaking one-to-one work and had been referred to anger management and mediation. Karen's mother reported that Karen and her father were not speaking to each other, but there had been no further incidents between them.

Garda Youth Diversion Project involvement

Karen's mother provided the details of the person Karen was working with in the GYDP and the duty social worker followed up with a phone-call to this worker. This worker confirmed that Karen had been attending the project for one year, and that a referral had been made to HSE Family Welfare Conference (FWC) services for intervention with the family. The GYDP worker advised that the family were currently engaging 'but that if this stops or the FWC

process does not proceed for any reason / not reach a resolution of the issues, the next step would be a referral to child protection.' The duty social worker advised that she would discuss allocation of the case with the duty team leader, but that her 'impression is that services are being provided to deal with the issues identified.' The file record notes the plan to discuss the case with the duty team leader and to follow up on any decision with Karen's mother and the GYDP worker.

One week later the documents relating to the FWC referral (initiated by the GYDP worker) were received by the SWD and according to the social work record, the case was discussed with the duty team leader and a decision was made to close it. This decision was communicated to Karen's mother, whom, the file note records had met with the FWC coordinator on the previous day and was 'happy with this plan'.

The GYDP worker contacted the social work department two weeks after this decision was communicated to say that she was concerned about the case closure, as there remained issues of concern regarding Karen's behaviour. These included the fact that she was now not going to school and was staying out late, resulting in her mother contacting the Gardaí.

Final contact with SWD

Within a few days of this contact, Karen's mother also contacted the SWD to report deterioration in the situation at home. She recounted further conflict between Karen and her father, absence from school and the fact that Karen was staying away from home overnight without permission. Karen's mother reported that Karen's behaviour, including a further physical altercation between Karen and her father had led her to ask her daughter to leave the home unless she was willing to abide by the family's rules. Karen subsequently left the house**.**

The duty social worker (again another worker) who took this phone-call asked Karen's mother to consider allowing her daughter to return home if she came back to the house. A meeting with the social worker 'to mediate' between mother and daughter was suggested for the following day.

On the following day, contact was made with Karen's mother to arrange the meeting, at this point it was reported that Karen had stayed in a friend's house overnight but had since gone missing. Contact was made with the GYDP worker by the duty social worker. She reported that she had met with Karen the previous day and she had been upset. The GYDP worker

had arranged to meet Karen the following day, but she had uncharacteristically failed to attend the meeting. At this point, the Gardaí were actively looking for Karen.

Karen was found later that evening by her father having died by suicide. The review team was told that the earlier plan to close the case had been revised, and that it was to be allocated to a newly appointed social worker. Unfortunately Karen had died before this could happen.

Family Welfare Conference Service (HSE)

A referral was made to the HSE Family Welfare Conference service by the GYDP worker a month prior to Karen's death. The referral form notes Karen's deteriorating relationship with her parents, and particular concerns regarding Karen's adherence to boundaries.

According to the case file, within three weeks of this referral the FWC Coordinator met with Karen's mother, father and Karen separately to discuss the process of the family welfare conference. Despite the ongoing difficulties, all parties agreed to participate in the process. However, within a further three weeks of these initial meetings the home situation had further deteriorated as outlined in the chronology above. The FWC coordinator was advised of this situation by Karen's mother, who made several phone-calls to the service in this period to report the deteriorating situation and to seek advice. The file notes from the FWC Coordinator record that it was agreed with Karen's mother that further meetings regarding the conference process would not be appropriate until the situation had calmed down. It was noted that Karen's mother was advised to contact the social work department regarding the ongoing difficulties (which the social work case files indicate that she did).

Karen died within a month of the referral to the FWC service and before the family welfare conference process proceeded any further.

Community Psychology Services (HSE)

Three referrals were made to the HSE Community Psychology Services when Karen was 11, 13 and 14 in relation to her reported behavioural difficulties. The first of these referrals originated from the family GP. The social work case files records that Karen attended at least two appointments with psychology services when she was 14 and reported these as being beneficial. The case file indicates that Karen's case was closed on two occasions because the behavioural difficulties 'had been resolved at the time of closure.'

A further referral was made to psychology services by the GYDP worker in the week of Karen's death, specifically in relation to 'anger management'. In response to this referral the psychology services advised by letter that: 'Due to increasing demands on the service there is a considerable wait for the first appointment.'

12. Analysis of the involvement of services

12.1 Social work response to initial referral

Three separate referrals were made to the SWD over a period of three years in respect of this young person. On each occasion the referral was processed by the duty social work service and an Initial Assessment Form (IAF) containing information on the family composition, presenting issues (i.e. reason for the referral) and the immediate action taken was completed. In respect of the first referral, an anonymous call to the SWD alleging inappropriate sexual behaviour, a letter was sent to Karen's parents within two days inviting them to attend the SWD, which they duly did. In respect of this referral the social work response was prompt and the issues raised, which were categorised as 'welfare', did not necessitate a further response. Nonetheless it is notable that a social worker did not meet with the young person in respect of whom the referral was made. The second referral to the SWD was made by the family GP who reported that Karen was 'violent and abusive towards her mother'. The DSW carried out a home visit four days after this referral was received and met with Karen's mother. Three days later a further home visit was conducted by the DSW, who on this occasion met with Karen and both her parents. On this occasion the response to the referral was relatively prompt. However, it is not clear from the case record if the young person was seen individually by the DSW. The third and final referral to the SWD was made by ISPCC Childline when Karen was 14 following a call to the service from the young person. As outlined in the chronology, this call concerned an allegation of physical abuse by Karen against her father. The social worker made two attempts to meet with Karen following the referral both of which were unsuccessful because Karen did not attend for different reasons. Ultimately the first social work contact directly with Karen was three weeks after the incident, and it is not clear from the case record if Karen was seen alone by the worker. There is no record of any medical assessment being sought in relation to the alleged abuse. Although charges were not brought against Karen's father in respect of it Karen's account of the incident when she met with the social worker was congruent with her initial self-report to Childline. No social worker met with Karen's father regarding this incident. It is recorded that he did not attend for a home visit appointment because of ongoing court proceedings.

The main point of contact with the SWD was with Karen's mother, who met with social workers on two separate home visits and who contacted the SWD via telephone to report difficulties in managing her daughter's behaviour. The review team is of the view that this was a concerning incident and should have been responded to with more assertive attempts both to see Karen on her own and to have her medically examined at the appropriate time.

12.2. Assessment

On each occasion that this case was referred to the SWD an Initial Assessment Form (IAF) was completed. The information contained in these assessment forms is minimal. The standard IAFs used in this HSE area contain details on the young person's name, address, family composition, presenting issue and immediate action taken. A further page notes whether network checks have been conducted, the outcome of the initial assessment and the recommendations for the case. The information contained within the forms is typically sparse – partly a function of the structure of the form with small text boxes in which to record the information. For example in respect of the second referral in this case the following is noted regarding the 'outcome of the initial assessment': 'Dealt with as welfare. Follow-up visit conducted – family report improvements.' The following section on 'recommendations for case' contains one word: 'Closure'.

Apart from the IAF, there is no other structured assessment on file and it is therefore difficult to see how the issues in this case are holistically assessed particularly when the case is dealt with on duty and different social workers are involved at various points. This is not

to say that there is no assessment in the case, the file notes containing information on the home visits for example are detailed and as such include the social worker's assessment of the situation. However, the absence of a structured in-depth assessment, which importantly would require a consideration of the young person's perspective, mitigates against a full consideration of the issues. In other words there is little sense how social work intervention moves beyond the surface of the issues presented.

12. 3 Quality of Practice

<u>12.3.1 Interaction with the Child and Family</u>

Each time this case was referred to the SWD it was dealt with by duty social workers. From the point of the third referral until Karen's death, a time-span of five months four different

DSWs dealt with the case. In interview for the purposes of the review, Karen's parents reflected on their experiences of contact with the SWD, and in particular the fact that the case remained unallocated. Karen's mother remarked:

> …we were at the point like where things were crucial for us like and we still had no social worker appointed. But my thing was that we had (named social worker) coming out to us twice and we had already told out story to her and I didn't feel comfortable, you know, saying it to someone else. Then I had two young girls, I think they were only fresh out of college, that come down to check, you know, a random day. There was two girls. And then after that it was (named social worker). So that's one, two, three, four; that's four social workers I had discussed different things with.

From the perspective of Karen's parents the involvement of multiple workers was a source of frustration and mitigated against proper engagement with the family, and Karen's father noted.

> It would have been better if it was just left to one person to deal with rather than all these different people coming out like, so it just felt like there was nothing actually getting done like, yet there were loads of people coming out to us…

12.3.2 Child and Family Focus

Throughout the period of the SWD's involvement with the family, social workers met with the young person on three separate occasions; twice in relation to the second referral (from the GP) and once in relation to the referral from the ISPCC/Gardaí. On each of these occasions Karen was seen with one or both her parents. It is not clear from the case records whether any social worker met with Karen on her own. As outlined above, the review team believes this to be a weakness, particularly given the nature of the alleged assault on her by her father.

12. 4 Management

12.4.1 Case Allocation and Duty System

The difficulties and pressures of operating the duty social work system were reflected in interviews with staff for the purpose of this review. At the time of interview the manager of the duty social work team reflected that there were 204 children currently on the duty system 'awaiting allocation'. Furthermore:

> …the lists are growing all the time. The pressure on staff is growing all the time… So, obviously, (Karen's) case I suppose she was at home with her parents it didn't put

> her in the very high risk level. We were aware that there had been difficulties in the home and they were dealt with…I suppose the difficulty was there wasn't one allocated worker to build a relationship with the family. (Team Leader)

Within the duty system, given the high volume of cases, the social work team leader noted that there was a 'need to prioritise' and it was the 'life or limb cases' that get an immediate home visit. One of the net results of the current system is that cases remain within the duty-system for relatively long-periods of time, because there is insufficient capacity within the area to allocate the cases. As the Team Leader explained:

> So you just get this roll-over effect. It is not working and I think all of us in there will acknowledge that it's not working.

The principal social worker (PSW) interviewed for the purpose of this review also noted that within the overall context of cases dealt with by the SWD Karen's case would be considered relatively low threshold:

> Where I would view it would be in terms of effectively a welfare case that verged at times certainly on child protection angles, particularly when there were concerns in relation to physical violence and those sorts of altercations.

And that the reality was that in this context, the case would not move from the duty system towards allocation:

> I suppose what is also evident is that at the time unless there were urgent issues presenting we weren't in a position to allocate the case consistently so we were more dependent on, I suppose, duty concerns coming to us and then following up on them on the basis of their seriousness rather than, I suppose, being able to allocate the case outright.

Nevertheless, in interview the team leader acknowledged that there were aspects of Karen's case that were 'troubling', and as such she had made the decision to allocate the case shortly before Karen's death, as a result of the appointment of a member of staff on a short-term contract. As she stated:

> It was never one that I was happy with anyway and, you know, I think when it is an assault by a man in particular because obviously she wasn't physically strong or whatever…That was why [a decision was ultimately made to allocate the case], it was like just go out and see if we can get a handle on this.

12.4.2 Interagency Working

At the time of Karen's death a number of services were or had been involved with the family. Karen had self-referred to the GYDP and she attended this regularly. The GYDP had in turn referred Karen and her family to the HSE FWC service. It is evident from the case-file and from interviews conducted for the purposes of this review that there was communication between the SWD and these agencies and, not unreasonably, the involvement of other services acted as a reassurance for the SWD. As the team leader explained:

> So I suppose, unfortunately, the case was unallocated from [dates] but we knew that the GDYP was involved and also a Family Welfare Conference was being set up. So, it wasn't that the family was completely without a service, we knew that somebody was going in there …

The referral to the HSE FWC service was made by the GYDP and preliminary meetings in preparation for the conference had taken place with Karen and her parents. Unfortunately, the FWC Coordinator was not available to meet with the review team due to sick leave. However, the file records from the FWC indicate that the referral was received six weeks prior to the young person's death and the family had been willing to engage with the conference process. Furthermore there had been communication between the SWD and the FWC regarding this referral.

13. Conclusions

This review of the role of the HSE and HSE funded agencies prior to the death of this young person has highlighted a number of issues in respect of this case. Firstly, it is important to note that a number of agencies were involved with Karen and her family at the time of her death, and there had been some positive interventions and engagement. However, the review team notes a number of shortcomings in relation to the child protection and welfare dimensions of the case. These include:

- The delay in a duty social worker seeing the young person following a referral for physical assault;
- The lack of in-depth social work assessments in the case;
- The fact that the case was managed in the duty system for several months and as a result multiple social workers engaged with the family.

These issues must be placed in the context of an under-staffed SWD dealing with complex caseloads, where the rate of child protection referrals exceeds the capacity of the service to adequately deal with them. Viewed through this prism cases which are perceived to be relatively low threshold – i.e. more 'welfare' than 'life and limb' are afforded less priority. The capacity of over-burdened child protection systems to deal with referrals which exceed the staff required to deal with them is a critical issue in this case. The need to respond in a timely fashion to reports of abuse is a core task of a functioning child protection and welfare service.

Where there was engagement by the SWD with the family, this on the whole, was viewed positively, but dealing with multiple workers was a source of frustration and meant that it was difficult for any one worker to move beyond the surface presenting issues. This fact is reflected in the cursory structured assessments (IAFs) completed in respect of each referral. It should be noted that the absence of more in-depth structured assessment tools is not unique to this HSE area and this has, in fact, been the norm nationally. However, here the review team finds that this problem is compounded by an over-burdened duty system, which mitigates against any further in-depth assessment or consideration of the case.
Most critically there was limited engagement by the SWD with the young person in respect of whom the referrals were made. Notwithstanding the involvement of other services with the family the fact remains that the child protection concern which resulted in the third referral was not adequately investigated.

14. Key Learning Points

The review highlights the following points for reflection:

- The need to meet with young people in order to conduct an adequate assessment is highlighted in a range of key learning from previous inquiries (Broadhurst et al, 2010).[1] When an allegation is made against a parent it is of critical importance that the social worker meets with the young person on their own to ensure that the young person's perspective is heard. An adequate assessment of the presenting concerns cannot be made without carrying out this fundamental task. The Children First Practice Handbook which emphasises the importance of meeting with children

[1] Broadhurst, K., White, C.; Fish, S.; Munro, E.; Fletcher, K. & Lincoln, H. (2010) *Ten Pitfalls and how to Avoid Them. What Research Tells Us.* London: NSPCC

and young people separately and ascertaining their perspective in relation to child protection and welfare concerns, should be adhered to in this regard.

- We do not know how Karen perceived the child protection and welfare system. We do know, however, that she was not seen by a social worker until three weeks after her call to ISPCC Childline. A central finding of a range of research exploring young people's help-seeking behaviour notes that responsiveness to concerns raised is key as is establishing trust via a relationship with an individual worker (Buckley et al, 2008; Jobe and Gorin, 2010)[2].

- Care should be taken to ensure that child protection and welfare systems and practices are responsive to the specific needs of teenagers. Some research has demonstrated that social work services can underestimate the child protection and welfare needs of teenagers, because of difficulties with engagement or through an over-optimistic view of young people's resilience (e.g. Hicks and Stein, 2010).[3] In this case, the young person' age at the time of referral (early teens) to the social work department may have influenced the low priority afforded to this case from the outset. This suggests that more attention should be paid by social work services to the specific needs of adolescents and the manner in which services respond to these young peoples' needs.

- The central importance of adequate assessment is emphasised in a range of research literature and inquiries into child deaths (Broadhurst et al, 2010; Bunting and Reid 2005)[4]. Key elements of best practice include gathering and assessing information from a range of sources and recognising the dynamic nature of young people's life circumstances. In the opinion of the review team, the Initial Assessment Form (IAF) is not fit for purpose in this respect. Moreover, the absence of a more

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[2] Buckley, H.. Whelan, S., Carr, N. & Murphy, C. (2008) *Service Users' Perceptions of the Irish Child Protection System*. Dublin: Office of the Minister for Children and Youth Affairs; Jobe, A. & Gorin, S. (2010) 'If kids don't feel safe they don't do anything': young people's views on seeking an receiving help from Children's Social Services in England.' *Child and Family Social Work,* doi: 10.1111/j.1365-2206.2012.00862.x

[3] Hicks, L. & Stein, M. (2010) *Neglect Matters. A multi-agency guide for professionals working together on behalf of teenagers.* London

[4] Bunting, L. & Reid, C. (2005) 'Reviewing child deaths: learning from the American experience.' *Child Abuse Review,* 14,2: 82-96

comprehensive standardised structured assessment tool further mitigates against good practice in this area.

- A range of research on service users' interactions with the child protection and welfare system notes that perceptions of the system and willingness to engage are mediated through contact with individual workers (Buckley et al, 2010).[5] The retention of cases on the duty system resulting in interactions with multiple social workers and a lack of a consistent 'face' of the service mitigates against engagement beyond the surface of presenting issues.

15. Recommendation

- The Child and Family Agency should review the adequacy of the current Initial Assessment Forms (IAF) and agree and implement a standardised assessment tool (both initial and comprehensive) on a national basis.

Dr Helen Buckley

Chair, National Review Panel

August 2014

[5] Buckley, H., Carr, N. & Whelan, S. (2010) 'Like walking on egg-shells': service user views and expectations of the child protection system.' *Child and Family Social Work,* 16, 1: 101-110