National Review Panel

Review of the Serious Incident Experienced by V

November 2011

Review undertaken in respect of a serious incident experienced by a young person known to the child protection system: V

November 2011

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 HSE. When a death or serious incident fitting the criteria above occurs, it is notified through the HSE to the National Director's Office and from there to the National Review Panel. The National Director 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 contained a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. 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 recommendatiions.

- **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. Serious Incident: V

This review is concerned with a young person, here called V who, in the summer of 2010 was involved in a serious accident which he fortunately survived but which is known to have impacted on his current wellbeing. He had been referred to the HSE Children and Family services in October 2008, when aged 15. This referral resulted in social work intervention, including an assessment of his needs. The period of social work intervention was brief stretching from October 2008 to January 2009, although the case was not finally closed until August 2009. The timeline covered by the review is October 2008 to January 2009.

5. Level and Process of Review

This was conducted as a concise review. It was chaired by Michael Bruton with the assistance of Hugh Connor. The methodology adopted was a review of HSE records and interviews with key staff and one family member. The file review involved reading the social work records which, in this case, consisted of one file containing all correspondence and case notes. Interviews were held with the social work team leader and the social worker who had responsibility for V's case. V's father was also interviewed. V and his mother were invited meet the review team to talk about the level of help that they had received in writing or in person. However, as a result of concerns about V's well being neither was able to attend.

The review panel is appreciative of the help and support provided to them by all the people, with whom they met. Each person interviewed was given the opportunity to provide their thoughts and reflections in writing or personally, in order to enhance the Panel members understanding of the facts, issues and context.

6. Terms of Reference

- To examine events leading up to V's accident and determine whether action or inaction on the part of the HSE and HSE funded agencies had been a contributory factor

- To examine the quality of service provided in terms of compliance with:
  - Policy direction
  - Key professional standards of practice

- To prepare a report for the HSE which reaches conclusions, identifies key learning points and makes recommendations.

7. V

V, who lives with his mother, was 16 years of age at the time of the accident. He has contact with his non-resident father who has a history of alcohol misuse. V also has close contact with extended family in the neighbourhood. During the period covered by the review, V was attending secondary school in his locality. He has a large number of friends and enjoys sports.

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

V was the subject of a notification made by An Garda Síochána to the HSE Children and Family services in late 2008. The Gardai had been contacted by a relative of V's, following an argument between V and his mother. The Standard Notification of Suspected Child Abuse form was used. The garda described the reason for referral as 'child/parent relationship' rather than 'child abuse'.

Up to the period preceding the notification, V was regarded as a happy young person who was making good progress at school. However, in 2008 his mother felt he was becoming withdrawn and introverted. Her concern was heightened by the suicide of one of his school colleagues. As a consequence she arranged for V to be referred to Child and Adolescent Mental Health Services (CAMHS). According to the records, CAMHS assessed V but did not find him to be depressed and recommended counselling which he attended once.

9. Services Involved with V in 2008-2009

- The HSE Children and Family's Social Services
- An Garda Síochána who made the referral to the HSE having been called to the family dispute
- Secondary School
- The G.P. who referred him to CAMHS
- CAMHS who had assessed his mental state prior to the referral to Social Services
- A counselling agency which offered him service which V declined to use after an initial visit
- Alcohol Counselling service from whom advice was sought for relatives of someone with a serious alcohol problem

10. Summary of V's needs

At the point of referral to the HSE, V's mother considered that he had some emotional problems. There was some tension between V and his mother at the time, which centred on his relationship and contact with his father. V also began to experience problems at school, leading to deterioration in his attendance, performance and behaviour. His mother was concerned about the negative influence some of his peers might be having upon him.

11. Chronology of contact between V and his family and HSE Children and Family Social Service

Autumn 2008

Responsibility for following up the initial referral to HSE Children and Families services was allocated to a social worker on the team (Social Worker A) who in turn allocated the case to a social work student to carry out an assessment under supervision.

The student social worker subsequently completed a Preliminary Enquiry Form and recorded the fact that V and his family were not previously known to HSE Children and Family Services.

The student social worker first visited V's family home three weeks after the initial referral and met V's mother who recounted the background to the argument she had been having with V.

She also described her concern for V's mental and emotional wellbeing during the summer and the fact that she had arranged via the G.P. to have him assessed by CAMHS. V's mother also described deterioration in V's academic performance and behaviour at school, both of which were leading him into trouble. Following this initial meeting, the student social worker had a supervision session with Social Worker A, who suggested making contact with an addiction counsellor to obtain written information for young people whose parents misuse alcohol.

Late 2008

The student social worker made a second visit to V's home three weeks later and again met his mother, but on this occasion also spoke privately to V who had been suspended from school for three days for being disruptive. This suspension appears to have been the result of a number of minor behavioural problems rather than a single significant incident. The record shows that V described his mood as 'better' although no explanation for this was given. The student social worker also offered to arrange an appointment for him with the addiction service to discuss his father's alcohol misuse but this was declined. The file records his statement that "his father's drinking didn't have an impact on him anymore".

Early 2009

As the student social worker's placement ended, responsibility for the case reverted to Social Worker A. The assessment of V's needs was signed off in early 2009 and concluded that a generally positive relationship existed between V and his mother who was believed to be parenting him very appropriately. V was not identified as having any adjustment or emotional problems and as a consequence it was decided that there was no need for urgent intervention and that a 'family support plan' should be developed. The assessment had not addressed V's school difficulties.

The records show that shortly after the assessment was concluded, V's mother contacted Social Worker A to report that V had attempted to leave home on the previous night. In response, Social Worker A made an initial home visit. At this point, V was refusing to go to school. His mother believed he was being negatively influenced by some other pupils. Teachers from his school made an effort to persuade him to return and he eventually did so, but by the end of the month was described as being 'aggressive and in bad form'. His mother was concerned that he might harm himself, and clearly linked his behaviour with events at his school. She told Social Worker A that she was considering sending him to a different school after the summer.

Social Worker A liaised with the Garda who had referred the case, giving him an update on developments and concluded by undertaking to remain in contact with the family with a view to providing support, though the nature of the intended support was unclear. Social Worker A recorded that V responded politely to him but did not seem to be ready to 'open up' at that stage.

There is no further file entry until summer 2009 when the record indicates that the case was closed. The final entry in the file reads; "V and his mother were given some information about

the impact of alcohol on the addict and the concerned people. The issue of schooling was sorted out. I have not had any contact with V and his family for some time. Things going o.k."

12. Analysis of Involvement of HSE Children and Family services with this Case.

12.1 Initial response of the HSE Children and Family Service

The Notification of Suspected Child Abuse made by the Garda, was immediately acknowledged and allocated to a student social worker by Social Worker A within three working days of receipt. An initial visit to the home appears to have been arranged for the following week but was postponed and actually took place three weeks after the initial referral. The first meeting with V took place six weeks after the referral. This represents a long delay in making initial contact particularly with V, especially in the circumstances where the case was referred to a student with a restricted caseload.

Over a period of three months, there were a total of three social work visits to the home during which V was seen twice.

Though the referral was made on a form entitled 'Notification of Suspected Child Abuse', it did not identify one of the child abuse categories, but described the reason for referral in terms of a 'child/parent relationship problem'. Whilst any referral of a child abuse nature would be expected to be seen without delay, the acceptable response time for other types of referral has never been specified; therefore it is unclear whether this had any bearing on the length of time taken before V was seen.

12.2 Assessment

The Initial Assessment was completed by Social Worker A and the student social worker. The written assessment was confined to discussions with V and his mother. There is a note on the file which indicates that the student social worker made contact with V's school, however, no record of any ensuing discussion can be found. At interview with the review team, Social Worker A could not recall this contact. As a result, the assessment did not enhance understanding of the concerns that had been highlighted, which included V's mental and emotional state, the deterioration in his performance, behaviour and attendance at school and his contact with his father. It failed to gather sufficient information to ascertain V's precise needs or whether they were being adequately met. For example, the Gardai had commented that V was one of a number of young men in the area known to be indulging in under-age drinking. This information and its significance if any, was not highlighted in the assessment.

Given V's mother's concern that he might harm himself, a logical action would have been to contact his GP and the CAMHS service and consider their views. V's father should have been engaged in the assessment as a matter of course. The family member who notified her concerns about V to the Gardai, should also have been invited to contribute.

The initial assessment concluded that there was a generally positive relationship between V and his mother whose parenting was regarded as very appropriate. The home environment was considered stable despite the argument that had occurred between V and his mother some weeks before. The assessment indicated that V's mother set appropriate boundaries, knew all his friends, looked after all his basic needs and provided support to V in accessing school and sporting activities. She was considered to be aware of the emotional damage that the adverse effects of his father's alcoholism could have on him. His extended family were also seen as a positive support. The assessment concluded that he got on well with peers and his family.

V was not identified as having any adjustment or emotional problems. During interviews, the review team was told that both Social Worker A and the student social worker believed V's mood and behaviour to be normal and they felt him to be at no greater risk than any other young man with whom they came into contact. It is not clear from the assessment how this conclusion was reached, given the limited information collected and the failure of the assessment to include information from his school or members of his extended family.

As a consequence the following decisions were made

- There was no need for urgent intervention.
- A family support plan should be introduced (though the intended interventions and anticipated outcomes were unspecified).
- Some further work was required to link V with the addiction counselling service before the file could be closed.

The initial assessment was signed off by the social work team leader. As the comments outlined above indicate, the review team considers this assessment to have been inadequate and unfocused. It concluded that family support should be introduced but it did not indicate, in its analysis, what needs this family support would be meeting, and how progress would be evaluated. A good quality assessment should highlight a child or young person's needs, and the capacity of their parents, extended family and community to address these needs. It should formulate objectives, and a plan of intervention to meet them. It should also indicate means by which the interventions would be evaluated. Case closure should only take place when the objectives have been met. The review panel believe that the inadequacy of the assessment contributed to what Social Worker A described as the 'fizzling out' of the case.

12.3 Compliance with Regulations

In general, compliance with Children First in this case was patchy. The Garda notification was acknowledged, but a delay of three weeks before making contact plus a further three weeks before V was seen seems excessively long. It was not clear how the categorisation of this case as 'child welfare' impacted on the response.

Children First stipulates that a case may be closed on the basis that a 'concern no longer exists' (8.23.1 p.82), but in this case, closure occurred because Social Worker A had stopped visiting and had heard nothing further from the mother to raise concerns about V, rather than the risk factors having been resolved. In fact, the family support plan which had been proposed in the

assessment was never developed. However the family was notified by letter that the case was to be closed.

One of the most common complaints made about HSE Children and Family services is a failure to provide feedback to referrers, despite the stipulation in Children First that this should occur. In this case, Social Worker A contacted the Garda who had made the initial report and provided feedback. The review notes this example of good practice.

12.4 Quality of Practice

12.4.1 Interaction with the Child and Family

The assessment found no reason to believe that this young man was in need of protection. In fact it demonstrated many positive features in his life, not least the concern and care demonstrated by his mother and the apparent support he derived from extended family.

The judgment that V was not at risk of abuse from others or at serious risk of self harm was clearly instrumental in shaping the priority which Social Worker A gave to this case.
As a consequence the family was viewed as needing support and a family support plan was to be developed. However, no attempt was made to develop this plan. In fact, contact with the family, in the words of Social Worker A, "fizzled out". Social Worker A had exchanged texts with V's mother for a period and became confident that the mother, if she had concerns, would have sought help. Therefore, given a full case load with many other, more currently pressing cases, contact with this family had not been maintained.

During the period of contact, an emerging problem had been the deterioration in V's performance, attendance and behaviour at school, which saw a pupil originally described as excelling at school, being suspended and then refusing to attend. Despite this, it is unclear how actively the school had been involved in the assessment process, with the student social worker recording contact with the school, but not recording the detail of this conversation. Furthermore, Social Worker A was not able to recall anything in this regard. There was therefore nothing in the assessment summary to show that V's educational experience had been given due consideration.

Social Worker A recorded, following his conversation with the Liaison Garda that "mother is still concerned about V's state of mind and I shall remain in contact with this family and see how I can support them". This was just a few days after V's mother contacted the social worker to report that V had attempted to leave, and was having problems with peers at school. In fact there is no further entry in the file of any contact with V or his family, although Social Worker A told the review team that some text messages were exchanged.
The next entry on the file records the case closure some eight months later. As the previous section points out, this was completed without ascertaining whether or not the concern about V had abated, or without consulting him or his mother.

Social Worker A told us that the reason why the case "fizzled out" was the pressure of his workload. He also told us however, that the workload that he was carrying at that time was no greater than that of his colleagues, nor was it different from the workload that he routinely carried. He told us that at any point in time, there could be about five cases on his workload which are being monitored albeit that this case appeared to be dormant.

V's mother felt he was becoming increasingly withdrawn and introverted, and she associated this change with the suicide of one of his school colleagues. Whilst the student social worker sought to probe this issue, no other concern was identified in terms of the possibility of V self harming. His mother's concern was further fuelled by a worrying deterioration in his performance, attendance and behaviour at school. This review panel believes that this deterioration should have been considered as a possible risk factor.

12.4.2 Child and Family Focus

Gaining the trust and involvement of teenagers in discussing problems or concerns is often difficult. Nonetheless, the student social worker used a child centred approach by speaking to V privately and engaging him to certain, albeit limited, extent.

After the student's placement terminated, Social Worker A resumed full responsibility for the case. There is a comment in the social work record, written by Social Worker A indicating that it was difficult to engage V in talking about himself. It reads: "whilst polite, it is clear that V is not ready to open up to me at this stage". Social Worker A talked about this to the review team, recalling the conversation with V and explaining the reasoning behind his conclusion. However, this was the first time that Social Worker A had met V and in the opinion of the review team, more time could have been invested in efforts to engage V before coming to such a conclusion.

Given the family history of alcohol abuse, it was suggested to V that he should attend an addiction service to learn more about problem drinking and the impact it can have on a family. Social Worker A told us, however, that neither V nor his mother were keen to discuss the topic of V's father's alcohol misuse. As a result, staff sought relevant literature to give to him, which they hoped might help V develop some understanding and a coping strategy. While the review team believes that this was a good idea, its lack of success was not addressed by the provision of any alternative strategy, such as, for example, seeking support for V through his school.

During her conversation with Social Worker A, V's mother expressed disquiet about her son's withdrawal and growing introversion. There appears to have been no support offered to her as to how she might cope better with his behaviour. Social Worker A told us that the issue of V's mental and emotional state had been dealt with by the G.P. and the CAMHS service and was therefore not an issue upon which they had concentrated. It was suggested by Social Worker A that V's mood and his deteriorating performance, attendance and behaviour at school might have been connected with problems in school, which he was having at the time. Yet no contact was made with his school to address this. Additionally, the review team believe that there would

have been merit in seeking consent for contact with, both the CAMHS and counselling services for both information and direction.

12.4.3 Recording

The standard of recording on the file was generally good, but the review has noted two omissions. One is the record of the student social worker's contact with V's school, and the other is the non recording of text messages exchanged between Social Worker A and V's mother.

12.5 Management

12.5.1 Allocation

The allocation of the case to a student with weekly supervision provided by Social Worker A appears to have been a logical step. However, as the previous section has outlined, the nature of the assessment conducted in this case and the delay in making contact with both V and his mother did not meet the standards which could reasonably be expected from a student under supervision. If cases are to be allocated to student social workers, it is the responsibility of the agency, and particularly of the practice teacher, to ensure that standards are met.

12.5.2 Inter-Agency Meetings or Conferences

There were no inter-agency meetings held in respect of V. A meeting that included CAMHS and representation from the school could have added considerably to a comprehensive assessment of V's needs, and also enabled the school- related issues that were troubling him at the time to be clarified. It could also have been used to consider what additional social or emotional support the school might be able to offer, which may not have put extra pressure on the caseload carried by the social work department.

12.5.3 Supervision

The review was informed by both Social Worker A and the social work team leader that there would normally have been monthly to six weekly supervision of Social Worker A's caseload. This session would normally not allow a detailed discussion of every case and the focus was usually on the more challenging and risky cases but every case would have been mentioned.

Social Worker A also told the review that under the practice teaching contract with the university, a student would receive supervision each week.

There were therefore regular opportunities for this case to be reviewed. There was no record on the file of any supervision discussion between the student and Social Worker A or Social Worker A and the team leader although we have no reason to doubt this did occur.

The review was informed that the team leader was unaware that this case was inactive, i.e. that contact with V and his mother was not being maintained. In supervision sessions with Social Worker A, the case had been included in the caseload weighting system and was therefore considered active. However, the team leader could not recall specifically discussing the case. The team leader was carrying a small caseload and It was not normal practice to look at the files, either routinely or selectively to assist in the supervisory process. This was acknowledged by the team leader as a managerial shortcoming.

The team leader told us that throughout this time there was considerable pressure of work within the team, with constant efforts being made to prevent a waiting list developing. Clearly in these circumstances, effective supervision of workloads is imperative to ensure that new work is quickly and effectively allocated and existing work is being professionally discharged. The failure of Social Worker A to follow through on an agreed course of action, and the team leader's failure to recognise this, gives rise to concerns as to how case loads were supervised and prioritised.

12.5.4. Policy

A young person at V's school had committed suicide in the previous year, and this fact, together with his mood at the time, had caused his mother to worry that he may harm himself.

The growing problem of young people self harming or taking their own lives, has been a major policy issue for the past decade. As a consequence, *'Reach Out, A National Strategy for Action on Suicide Prevention'*[1] was produced in 2005. This policy document outlines a multi-sectoral approach to prevent suicide and self harm based on cooperation and joint working between Health, Education, other statutory bodies, and the community and voluntary sectors. One outcome of this policy is that expertise and resources have been deployed into schools, to deliver a Social Personal & Health Education Module (SPHE) for all secondary school pupils. Counsellors have also been employed to assist Principals deal with pupils in the aftermath of a suicide.

It seems logical that when the suicide of a young person occurs in an area, that this policy should be implemented as a preventive measure, and also to help young people come to terms with the trauma that naturally affects them when a peer takes his or her own life. When we discussed this with Social Worker A and the team leader, the review team found that both were somewhat vague both about the policy and how they might utilise it. Given the growing number of young people potentially at risk of self harm and the very high probability that some of the young people known to Children and Family Services may fall into this category, it is important that staff know how to access additional support from schools for the young people with whom they are working

12.5.5 Inter-professional and inter-agency collaboration

There was little inter-agency work in this case. Contacts with the Gardai complied with the procedural requirements set out in Children First. In practice this amounted to three phone calls. One of the major issues for V was schooling. The Initial Assessment Form records that the student social worker made contact with the school but there is no case record to verify this and no record of what was discussed. In this situation we would have regarded contact with the school as necessary. No contact was made with CAMHS or V's GP despite a history of involvement with them and his current low mood. Opportunities to complete an adequate

[1] This document is available for download at http://www.dohc.ie/publications/pdf/reach_out.pdf?direct=1

assessment or to develop a holistic plan to help V and his mother were possibly missed by this lack of collaborative working.

13. Findings

V. was involved in a serious accident in the summer of 2010, which is known to have had a significant impact on his current wellbeing at the time and for some time afterwards. The review has made the point that the case was closed one year earlier without consideration of whether the initial concerns had abated, or whether V's needs had been met at that time. All that is known is that his behaviour and low mood were a cause of concern at the point of referral. The assessment, which this review considers to have been inadequate, concluded that this young man was not at risk from himself or others. However, he was clearly troubled about certain issues in his family context as well as problems at school. While he was reluctant to engage with services at the time, his mother could have benefited from support and guidance.

A family support plan, which amongst other things, was presumably intended to enable her to cope with the anxieties and challenges being presented by V's behaviour and mood, was proposed but not developed. Although she was aware of who to contact if she required urgent assistance, the failure of the service to follow through on an undertaking could have undermined her confidence in the system. The case was closed in mid 2009 without evaluation of V's circumstances at the time, the rationale for closure being that no further incidents had come to the attention of HSE Children and Family services. On the basis of these findings, the report reaches the following conclusions:

- It is not possible for the review to express a view as to whether action or inaction on the part of HSE Children and Family services contributed to his involvement in the accident, as there is little or no information available to the review panel, as to the events in his life following the last contact by the social worker in early 2009. Whilst there was no overt evidence that concerns about V had abated at the time the case had closed, nor was there any evidence, that the inaction of the Children and Families Services was a causal factor in this accident.

- The assessment process was partial and incomplete. It could have been improved by involving a wider group of people such as V's father, extended family members, CAMHS and the school in particular. This would have made it more comprehensive and created the context for the development of a focussed family support plan.

- The review team was told by both Social Worker A and the social work team leader that there would have been monthly to six weekly supervision of Social Worker A's caseload. This session did not allow a detailed discussion of every case and the focus was usually on the more challenging and risky cases, but every case would have been mentioned.

- Social Worker A also told us that as part of his contract with the university to supervise students, he was required to provide the student with supervision each week. There were therefore regular opportunities for this case to be reviewed. We note however

- that there is no record on the file of any supervision discussion between the student and Social Worker A or Social Worker A and the team leader, although we do not doubt that the case did come up in discussions.

- The review team was concerned that the case could "fizzle out" without the team leader becoming aware that there was no meaningful contact for several months. We regard the failure of Social Worker A to develop a family support plan as poor practice.

- In terms of key standards of practice, the review notes patchy compliance with Children First. It has been established by recent reviews that Children First has not been consistently implemented across the country and that it has subsequently been revised, but minimum standards of responding, assessment, case planning, case closure and recording (including the recording of text messages) should have been in operation and were lacking in this case. The review has commented extensively on the poor quality of assessment.

14. Key learning points

A number of key learning points are evident from the review:

- There is some confusion as to the criteria used and the response offered by the HSE Children and Family Services when a case that is referred to the services is classified as 'child welfare'. It is not clear whether child welfare cases receive the same level of assessment or intervention or whether the same level of timeliness in response is expected. This is an issue that requires clarification at both local and national level.

- Notwithstanding the previous point, a key learning point arising from this review is the fact that an assessment of a child welfare concern requires consultation with all the professionals and family members present in a child's life

- Following from the previous point, it is reiterated that a good quality assessment can assist in identifying a child's needs and the locations in which these needs may be addressed, such as school. It can assist in formulating objectives and a multi-disciplinary plan, and it can indicate when closure is appropriate. It could also assist managers in supervising and reviewing individual cases. This case demonstrates how an inadequate assessment can result in the building blocks for effective intervention not being put in place

- The review also notes an absence of engagement with V's father and his extended family. Good practice requires that fathers are included, and in this case V's relationship and interaction with his father was an important issue. The tendency to marginalise fathers is well evidenced in social work and child protection literature[2]; practitioners and line managers need to be aware of the potential for it to occur, especially when fathers are non-resident

15. Recommendations:

I. Thresholds for responding to child welfare reports should be developed and made explicit to all agencies, who work with Children and Family Services. If the rate of referral to the area exceeds the capacity of staff to respond, some consideration needs to be given to developing alternative methods of managing child welfare referrals, such as Differential Response.

II. Attention should be focussed on the LHO's Assessment Guidance and how this may be more fully incorporated into practice to ensure that assessments are comprehensive and inclusive

III. The HSE National Supervision Policy issued in 2009 should be audited for compliance.

IV. Minimum standards should be set in relation to responding, assessment, case planning, case closure and recording (including the recording of text messages)

V. Staff should receive training to improve their knowledge in relation to a "Reach Out" policy so that they can work more closely with schools when someone on their caseload is considered to be at risk of self harm or suicide.

Signed: Helen Buckley

Professor Helen Buckley
Chairperson National Review Panel

Date: 14 - 12 - 2011

[2] Ferguson, H. & Hogan, F. (2004) *Strengthening Families through Fathers,* Dublin: Department of Social and Family Affairs http://www.fsa.ie/fileadmin/user_upload/Files/foreword.pdf