Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death experienced by a young person who had contact with Tusla

Niamh

Executive Summary

June 2019

1. Introduction and background

This review concerns a young woman here called Niamh who died by suicide when she was 15 years old. Niamh was one of a number of children born to her mother Eve with whom she lived for all of her life. Her parents had parted when she was young, and both went on to develop new relationships. Niamh had contact with her father. She came into contact with the services at 14 years old because her behaviour was causing concern; she had an older boyfriend and was found under the influence of drugs and alcohol. She also had some health problems and a history of self-harm. At the time of her referral to Tusla services, she had already been involved with Garda Juvenile Liaison Services for nine months and had been sporadically attending an addiction service on the recommendation of her Juvenile Liaison Officer (JLO). It was noted that her mother was very concerned about her welfare and open to support from services.

In line with her own wishes, Niamh was initially admitted temporarily to voluntary foster care. The social work department (SWD) commenced an initial assessment. She returned home after a short period after a plan had been agreed between herself, her mother and all the services involved with her. The SWD oversaw the plan in operation and it included attendance at an addiction service. The counsellor at the addiction service was unsure about Niamh's motivation to change and believed that she needed residential addiction treatment, but unfortunately no such services were available for girls of her age.

A review of the plan held after Niamh had returned to school noted that she was at risk because of the people with whom she was spending time. She was still linked with the community addiction service and with the Garda Youth Diversion Programme. Niamh subsequently left school without permission and was later arrested for assault. Services, including an allocated Tusla social worker, here called Social Worker 1, continued to support her and for a period she seemed to make progress and engage well. However, she was once again arrested because of drunken behaviour and fighting. Admission to care was again considered but initially it was decided to place her in her father's care. He was agreeable to this plan but annoyed at the lack of previous communication from the SWD and other services about what had been going on with Niamh. There was concern at the time that Niamh's involvement in offences would lead to court appearances and that she was at risk of expulsion from school. There was discussion about referring her to a youth advocacy programme and a psychologist.

Niamh stayed with her father for a few days and then returned to her mother where she appeared to do well for a period of time. She was discharged from the addiction service by

agreement as she was not attending and had not consumed alcohol for several months. She had been linked with the youth advocacy programme and her engagement with it was considered variable. She found it hard to disengage from her friends who were considered a negative influence. She expressed a wish to leave school after her Junior Certificate. A few weeks later, an incident arose where Niamh had apparently taken medication that had not been prescribed for her and had got into trouble at school. The question of care arose again, but her family was not in favour. Although Niamh seemed to settle somewhat, further concerns arose about drug use and she was referred to CAMHS. However, she was not considered eligible for this service. She subsequently withdrew from the youth advocacy service but stayed occasionally involved with a youth service offered as part of the Garda Diversion Programme.

A year after her referral to the SWD, Niamh was still the subject of concern but reluctant to engage with services on a consistent basis. She was keen to attend Youthreach but was still too young for the programme. There appears to have been a gap of three months between social work contacts around this time. Niamh began to express suicidal thoughts and was referred by the addiction service to CAMHS, supported by the SWD. In the meantime she attended the local hospital with her mother for a psychiatric assessment where she was found be having paranoid thoughts but no active suicidal ideation or intent to self-harm. She was put on a waiting list for CAMHS. Over the following weeks, Social Worker 1 had difficulty trying to contact Niamh and her mother but network checks indicated that she was doing fairly well. She had been charged with outstanding offences and was due a court hearing but had not come to recent Garda attention. Sadly, Niamh took her own life three months later.

2. Review Findings and Conclusions

Niamh's death was a tragic loss and the review team extends sympathy to her family who were traumatised by her death, and to the professionals that worked with her. The review has reached the following conclusions:

- Niamh and her family received a consistent, responsive and child centred service from the SWD and particularly from Social Worker 1. Niamh's behaviour began to deteriorate when she entered adolescence and while her family did their best, a formal comprehensive assessment of Niamh's complex needs and her parents' parenting capacity would have helped to build a holistic picture and assist coordination of the many services involved.

- This case is poignant in its depiction of a young person clearly in distress and seeking help regarding her mental health. Niamh was twice referred to the hospital for emergency psychiatric assessment and was eventually placed on a waiting list for CAMHS. She had still not received an appointment when she died by suicide three months later. It is noted that a residential addiction service was recommended by her addiction counsellor but that no such service exists for girls.

- Whilst there was evidence of Niamh and her parents being consulted by the SWD on many occasions, Niamh repeatedly voiced her wish to leave her school and to attend a Youthreach programme. Being unsettled in her school placement impacted on Niamh, her family and the school community. It is unclear if any other alternatives were actually available given that Youthreach was unlikely to be an option due to her young age. Ultimately, Niamh refused to return to her school and was not engaged in education for several months prior to her death which would have heightened her vulnerability.

3. Key Learning Points

This report has attempted to communicate the complexities of a vulnerable young person, and to highlight the challenges faced by those staff who worked with her and her family.

- Fundamental to good practice is the need to complete a comprehensive assessment of the child and family in a timely manner but this is also an ongoing process. Assessments should take account of presenting factors such as substance abuse, mental health, behavioural and educational issues for the young person. The impact of these multiple factors must be viewed in tandem with an assessment of parenting capacity especially in the context of compromised physical health and other relevant factors.[1]

- The impact of the lack of a suitable school placement on Niamh's wellbeing, particularly in the final months leading up to her death, cannot be underestimated. Education affects all aspects of the development of young people and offers a daily routine and structure (Jackson and McParlin, 2006)[2]. The lack of an appropriate educational placement can affect a young person's sense of stability and security necessary to reach their potential in adolescence.

- Research on engaging fathers shows that professional attitudes are important in terms of promoting engagement. The mother is often the focus of social work interventions and a

[1] Schene, P. (2005) *Comprehensive Family Assessment, Guidelines for Child Welfare*: 4-6
[2] Jackson, S. and McParlin, P. (2006) *Education of Children in care. The Psychologist* 19(2): 90-93

father can be excluded on the basis of traditional assumptions about gender roles. The involvement of fathers can impact positively on risk assessment and management in the child welfare process[3].

- When a case is designated child welfare, but a key issue is the young person's repeated patterns of high risk behaviour, there needs to be a consistent overview in the management of the case by the SWD to ensure an appropriate response at all times. This includes an ongoing assessment of risk that will facilitate professionals and families in making informed judgements at critical junctures particularly when the young person is ambivalent or disengaging from services which may in turn increase their vulnerability. This is a challenging area of practice. A consistent overview should also include regular supervision for the social worker throughout the duration of the case in order to ensure a quality service. Supervision provides a structured opportunity to discuss work, review practice and progress, and plan for future development (Tusla, 2011)[4].

- Young people may have a complex number of needs and therefore, it may be difficult for them to access the appropriate service at the most opportune time. For example, there may be a lack of residential treatment services for young people who misuse substances and delays in accessing mental health services. This may result in them being responded to within the existing framework of services. However, these services may be limited and/or crisis driven.

- The services involved with Niamh, including the youth advocacy programme, the drug and alcohol service, the Garda diversion programme, the JLO service and the GP, sought to offer Niamh a service that was responsive to her needs. As time went on Niamh's engagement with a variety of agencies ceased. She may have been overwhelmed with the number of services involved. The identification of one key agency that could provide Niamh with a trusting working relationship may have provided an anchoring for both the family and the services involved.

[3] Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. and Tolman, R. (2012), *Engaging fathers in child welfare services: a narrative review of recent research evidence. Child & Family Social Work*, 17: 160–169.

[4] Tusla (2011) *Child Protection and Welfare Practice Handbook.*

4. Recommendation

It is outside the remit of Tusla to address the gaps in mental health services for young people that currently exist. This review recommends that the matter is drawn to the attention of the Department of Health and the HSE in order to reinforce the need to provide services for young people whose clinical diagnosis does not fit within eligibility guidelines operated by CAMHS. The review also notes that there were no residential addiction services for girls and recommends that this matter is also brought to the attention of the HSE.

Dr Helen Buckley

Chair, National Review Panel.