



**Review undertaken in respect of a death of a young person who  
had contact with Tusla, Child and Family Agency**

**Sophie**

**Executive Summary**

**April 2025**

## **1. Introduction and Background**

This review concerns the death of a young person here called Sophie, who sadly took her own life at the age of 14. Sophie was described as a pleasant and friendly person who was artistic and athletic. After a normal childhood, she had become very troubled in her early teens and had a number of admissions to inpatient mental health services and numerous attempts at self-harm. Up to this point, Sophie had been very close to her family but had withdrawn from them when her mental health difficulties began. Social Workers who visited her home described the atmosphere as loving and caring and her parents as highly committed to her.

The involvement of Tusla child protection and welfare services was brief. Around three months before she died, the mental health team in the inpatient CAMHS unit contacted the Tusla social work department to request community-based services for Sophie on her discharge from her most recent stay in hospital. The mental health team was strongly of the view that a prolonged hospital stay was not going to be beneficial for her but was aware that her parents were finding it very difficult to keep her safe. They advocated a multi-agency approach to the case and a safety plan was verbally agreed. The SWD met with Sophie and her family and put them in contact with a number of services that were considered appropriate. The SWD closed the case on the basis that there was no child protection concerns and her parents were open to availing of services. However, Sophie's disturbed behaviour continued and after a self-harm episode she was readmitted to a residential psychiatric service who re-referred the case to the SWD requesting 'wraparound' community services on her discharge. It was noted that Sophie's parents were finding it impossible to prevent her from leaving the home and harming herself. When contacted by the SWD at that time, her parents were unable to identify a community service that might assist them and were very concerned about the prospect of her discharge.

The Tusla SWD, through senior management, contracted a 15 hour per week package to work on an individual basis for Sophie as well as a further support service, both of which were due to start shortly after her pending discharge. The hospital arranged for Sophie to go home on an overnight visit prior to her discharge with telephone support if required. Sadly, Sophie took her own life on that visit.

## **2. Review Findings**

A number of services was involved with Sophie and her family, chiefly the inpatient and community CAMHS services and the Tusla SWD which connected the family with some community-based services. The review team met with Sophie's parents, the social work staff and senior manager from Tusla, and the psychiatrist who had treated her as an inpatient. Staff from community CAMHS initially agreed to take part in this review but ultimately did not make themselves available for interview so it has not been possible to identify their part in the plan. The review team requested Sophie's mental health records from the community CAMHS service, and they were sent after a considerable delay.

It is not in the remit of the NRP to analyse the quality of the mental health services per se, but the review team can examine and comment on the quality of interagency work which, in this case, encompasses both the community and inpatient CAMHS as well as some support services. The main focus of the review was on the Tusla social work services.

The staff from the social work department responded quickly to the first and second referrals about Sophie. From records and interviews it appears that the SWD developed an empathetic and respectful relationship with the family and were motivated to assist them as much as possible following each referral. However, it is also noted that the SWD's positive assessment of Sophie's parents' capacity was given prominence over the life-threatening nature of Sophie's self-harming behaviour and her parents' self-declared inability to keep her from harming herself whilst at home.

Records and interviews demonstrate that the case was allocated promptly in the SWD when referred and re-referred. There was good management oversight in this case by all Tusla line managers, with evidence of prompt responses for funding requests and the involvement of the Area Manager in negotiations about a specific resource. However, it is the opinion of the reviewers that decisions were made within an agency led framework and in the case of Tusla, continued to follow the parental deficit model.

In the opinion of the reviewers, safety planning in this case was largely abstract and lacking in detail. Under Section 3.1 of the 2020 Joint Protocol for Interagency Collaboration between the HSE and Tusla, "Where a practitioner has concerns or identifies a need for intervention from another HSE service or from Tusla, she/he must liaise with the relevant practitioner and agree a process for interagency engagement and collaboration". There was no evidence that any process was agreed between the CAMHS teams and the Tusla SWD to create a mutual understanding of how a multi-agency approach would work and there was no indication of how collaboration would be achieved or how the various interventions of the two sectors would complement each other, or even evidence that the different services would communicate with each other. In this sense, the term 'multi-agency' is a misnomer.

Throughout this period, Sophie's parents had no sense of a holistic approach however and, whilst appreciative of services, still felt isolated and overwhelmed with the responsibility of protecting their daughter.

All the professional staff involved with Sophie appeared to have been diligent in their approach to working with her, however the review found that there was a lack of agreement about how their aims and objectives would merge. The reviewers were struck by the difference of opinion expressed by each service regarding the reason for Sophie's behaviour and the conviction of both services that the approach they were taking was the correct one and in line with both their remits. It was evident from interviews that CAMHS did not consider Sophie's high-risk behaviour to be symptomatic of a treatable mental health disorder, while the Tusla SWD believed it to be a manifestation of her mental health problems. The SWD made clear its intention to close the case once supports were established. Records and interviews with Tusla staff indicate that a case such as this was not considered to warrant a social work service as the CAMHS service was involved, and Sophie's parents showed commitment and competence with no child protection concerns evident. To the reviewers, this case illustrates yet again that young people with mental health problems that are not classified as mental illness are blocked by policy barriers from getting an adequate service and the cost of this is borne by the young person and their family who in this case were left feeling constantly stressed and frightened of what Sophie might do.

The dearth of services for young people with mental health difficulties and suicidal ideation and intention was highlighted to the reviewers by both services and the policy aspect of it is outside the control of individual area management. The reviewers recognise it as a recurring problem which requires attention at national level between the HSE and Tusla.

### **3. Conclusions**

3.1. Sophie's death was shocking and distressing for everyone who knew her. Sadly, she had made numerous self-harm and suicide attempts over the previous six to nine months and had expressed a clear intention to take her life. The review has found that staff in both the community and inpatient mental health services and Tusla social work department separately did their best to support and assist her and her family. It has also found that her parents were unstinting in their efforts to protect Sophie from harm but most of the time found themselves to be isolated and on edge, excluded from decisions, burdened with responsibility, and constantly worried that Sophie would take her own life.

The reviewers have found in this case that despite the adoption of the Signs of Safety framework for practice, the Tusla SWD has continued to use a parental deficit model for judging the eligibility of a

case for further intervention. This tendency is undoubtedly linked to capacity in the SWD but means that the scaling applied to a case from this perspective may underestimate the level of risk actually present and leads to decisions, such as for example, that no further assessment is required.

3.2. Although both the HSE mental health and Tusla social work services involved with Sophie were acting within their own policy remits, the case illustrated a fundamental and deep-rooted mismatch between the policies of the different strands of the mental health service and child protection and welfare services with regard to the management of young people with mental health difficulties who exhibit self-harming behaviour. The orientation of both services appears to have been service based rather than child and family centred, a recurring tendency that is made worse by shortages and pressures in each service which give rise to gate-keeping. This disparity has fundamental implications for the likely effectiveness of a safety plan, which must be based on a realistic appraisal of what is required, what services are available and who will coordinate them.

3.3. The NRP does not have a remit to evaluate the work of the mental health services but it can comment on the interface between CAMHS and Tusla which was characterised in this case by an expectation on the part of CAMHS that was not shared by Tusla nor particularly well communicated to it. The lack of mutual agreement, clear communication, and coordination between CAMHS and Tusla services has been highlighted many times to the National Review Panel, with a recurring pattern whereby CAMHS supports a model according to which inpatient care is detrimental in the longer term, and young people with mental health difficulties who exhibit high risk behaviours will do better in their communities with supports. The expectation is that the community supports will be sourced by Tusla and that community CAMHS teams will provide mental health support. However, the successful operation of such a model would critically depend on agreement and coordination at a number of levels between the HSE and Tusla (national, area based and local) which has not been evident to date. It would also require the establishment of channels of communication and absolute clarity about what is meant by community support including the Meitheal programme as well as a mutual understanding about the extent and limits of what each service is capable of providing. These factors were absent in this case and should be clearly laid down in a revised Joint Protocol.

3.4. It is acknowledged that the events described in this review took place in a relatively condensed period of time which coincided with high and low level Covid restrictions. The findings of this review should be understood in that context.

## **4. Learning points**

4.1 Signs of Safety was introduced in order to achieve a stronger and child centred focus on safety of scarce resources. To repeat a learning point from previous reviews, this review highlights the need for Tusla to revise guidance individual children and young people regardless of the cause of the risk to which they are subject. Yet, as this and earlier reports have indicated, SWDs tend to take an approach based on parental harm when assigning for assessment and initial screening carried out under Signs of Safety in cases where young people are subject to significant risk due to self-harm.

4.2 In this case, the approach by CAMHS was based on the concept of a Life Worth Living, which is based on DBT (Dialectical Behaviour Therapy) principles. It was explained by the CAMHS psychiatrists as using community supports to move away from suicidal thoughts, keeping a young person busy and engaged to minimise opportunities to self-harm. There is a need for mutual discussion, training, and planning between CAMHS and Tusla about how this concept can be implemented at a conjoint level. This will require a national policy pathway and must be addressed in a revised version of the Joint Protocol.

## **5. Recommendations**

15.1 The DCEDIY and the Department of Health need to take urgent action on the basis of accumulated evidence of the policy blocks preventing coordinated work between Tusla and CAMHS.

- (a) An in-depth overview should be jointly commissioned between the HSE and Tusla of the number of reviews and reports which recurrently highlight the unmet needs of the specific cohort of children and young people at the margins of CAMHS and Tusla.
- (b) The conclusions from the report and overview should form the basis for discussion between Tusla, the DCEDIY, HSE and the Department of Health and lead to policy re-evaluation.
- (c) The 2020 Joint Protocol for Interagency Collaboration between the Health Service Executive and Tusla needs urgent revision, to clarify coordination and leadership in cases assessed by Tusla as 'high welfare' and to ensure that operational procedures reflect the paramountcy principle with the needs of the child or young person as a primary driver of decisions and planning.
- (d) Allied with the above recommendations, there needs to be intensive communication, preferably through joint training, between CAMHS and Tusla with regard to clinical and community-based programmes that can operate along agreed lines to assist families and young people who self-harm and/or suffer from mental health disorders. As this recommendation cannot be progressed without the consent and active agreement of the HSE it is suggested that Tusla should engage the HSE to bring this forward.

15.2 Tusla needs to take the necessary steps (e.g. training, revised guidance) to continue to move social work departments away from a parental harm model of assessment towards full adoption of the principles of Signs of Safety which will assist practitioners to more accurately measure and scale levels of risk to children and young people regardless of the cause.

**Dr Helen Buckley**

**Chair, National Review Panel**