National Review Panel

Review of the death of a young person known to Children and Family Services

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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 (NRP)

A national review panel was established by the HSE in May 2010 and began its work shortly thereafter. 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 consisted 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 was to 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:

1. **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.

2. **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.

3. **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.

4. **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.

5. **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 Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Death of Dermot

This review is concerned with the death of a young person here called Dermot, who died by suicide. The review covers the period between the first referral received by the Social Work Department about Dermot and the occurrence of his death in 2011.

5. Level and process of review

This was conducted as a concise review. The methodology adopted was a review of social work records and some reports from CAMHS, interviews were also held with staff for the purposes of clarification. The review was conducted by Helen Buckley and Bill Lockhart (Chair and Deputy Chair of the NRP). The records consisted of two folders provided by the HSE, containing copies of correspondence, case notes

and reports. In addition interviews were conducted with four social workers (including managers) who had worked with Dermot or had a close working knowledge of him and his family. Contact was made with two members of two separate Child and Mental Health (CAMHS) teams who had knowledge of Dermot. A psychiatric report from one team was included the HSE Social Wok Department files; further psychiatric reports were requested from a second CAMHS team. There was a delay in acquiring these reports as the psychiatrist involved questioned the appropriateness of providing copies of the reports to the National Review Panel.

6. Terms of reference

The review adopted the following terms of reference:

i) To examine the events leading up to Dermot's death and determine whether action or inaction on the part of HSE Child and Family Services had been a contributory factor;

ii) To examine the quality of service provided in the case and the level of compliance with procedures, protocols and standards of good practice;

iii) To provide and objective report to the HSE.

7. Dermot

Dermot was one of a number of siblings who lived with their mother. The social work records contained no information about his father who is believed to have played little part in his life. Dermot was described as friendly, pleasant and quite chatty at times, with some insight into his problems. However, it is also known that he found it difficult to engage with formal services and difficult to talk about his emotions.

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

It is not possible, from the file records, to ascertain much about the early years of Dermot's life. His mother was invited, via her social worker, to contribute to the review but declined the offer. Records pertaining to Dermot cover the four year period that followed the first reports made about him to the SWD.

Dermot attended a local primary school. When he was in fifth class, his teachers became concerned about his poor attendance and problematic behaviour. This resulted in a referral to the SWD. Dermot subsequently transferred to another primary school where he initially settled well, but his attendance subsequently became an issue. The National Education & Welfare Board (NEWB) became involved. Dermot was referred to the Child and Adolescent Mental Health Service (CAMHS) when he was 11 by his GP on the advice of a duty social worker. He refused to attend the appointment that he was offered according to a report by his mother. Around six months later Dermot was found with a cable round his neck by Gardai. He was brought to A+E in a local hospital by his mother and seen by psychiatry. He was then referred again to CAMHS by the hospital. Social work case records indicate that Dermot did not keep the appointment that was offered. Unfortunately there is no record of these referrals on the file sent by CAMHS to the review team. The social work files subsequently report that Dermot's behaviour improved for a period of around two years.

Dermot was admitted to hospital when he was 15; he was accompanied by Gardai, who had responded to a call from a neighbour saying that Dermot was intoxicated, threatening self-harm and being physically abusive to his mother. He was seen by an on-call psychiatric registrar who diagnosed a severe conduct disorder, with a background of attention deficit and hyperactivity disorder (ADHD). The registrar linked Dermot's suicidal ideation to alcohol use. It was also noted that Dermot was grieving for a friend who had died by suicide three years previously; he tended to think about "following" his friend when he was under the influence of alcohol. While initially not interested in attending CAMHS Dermot eventually agreed to attend if given an appointment. He was discharged with a management plan pending his referral to CAMHS. This included contact with the social work team and agreement with it to refer Dermot to a specialist multi-disciplinary adolescent team.

Just over two weeks later a further incident occurred at Dermot's home where he again engaged in self-harm and assaulted his mother when under the influence of alcohol. When in hospital he was assessed by a registrar on-call from the another CAMHS team who assessed that he was fit for discharge, after drug screening by Paediatric Services in the hospital. The option of attendance at his local CAMHS service was offered to Dermot. A letter was sent to his GP the following day outlining the CAMHS assessment. His mother refused to allow him to come home because of fear of harm that he might do to himself, or to her and his siblings and he went to live with his grandparents for a time. At this time the duty social worker considered a number of intervention options, including residential treatment for drug

and alcohol use and foster care. However, as his grandparents were willing to have him, it was agreed to pursue a referral to a specialist adolescent team in the area. At this time the duty social worker recorded that contact had been made with the local CAMHS team who said Dermot was ready for discharge from a psychiatric point of view, although it understood that he was still on the caseload of the Paediatric Services of the local hospital which had done a urinary drug screen, routine blood tests and other relevant screens.

Dermot stayed with his grandparents for two and a half weeks and then returned to live with his mother and siblings. The reason given by his mother was that his grandparents were elderly and not in good health. There then followed several months of relative calm, as Dermot is recorded in files as having stopped drinking, although his attendance at education was said to be very poor. The case notes record his mother's view that he had learned his lesson after the scare he received by being admitted to hospital. Towards the end of that year there is a record of a professionals meeting being convened by the social worker in the specialist adolescent team. This included representatives from his school, Garda JLO and a Youthreach counsellor. There is no record of the local CAMHS team or SWD being present. Various options were considered such as referral to a family support course and a youth mentoring scheme. In the event his mother did not engage with the family support course and Dermot was admitted to A+E again after another bout of drinking and deliberate self-harm early the following year.

Dermot came to the attention of Gardai over the years for a number of reasons, including threats of suicide, damage to property when under the influence of alcohol, carrying a knife and being found out of home late at night under the influence of alcohol. He was arrested on a number of occasions for his own safety and brought to hospital for psychiatric review when alcohol and/or drugs were implicated. Dermot was also brought before the District Court due to some of the above behaviour and was allocated a Probation & Welfare officer and given bail conditions, including a curfew. He subsequently breached his bail conditions and was remanded to a Children Detention School for a short period when he was 15.

Dermot was ultimately allocated a child protection social worker by the SWD as well as a specialist social worker by the multi-disciplinary service for high risk adolescents run by the HSE. The child protection social worker focused mainly on Dermot's mother and the family and the specialist social worker sought to work more closely with him directly, but also had regular contact with his mother and older sibling.

Dermot found it difficult to engage with statutory services, preferring more informal services such as the school counsellor. His mother expressed concern that he would not talk to anyone about his problems. Dermot met with both his social workers in the weeks before his death and presented as having insight into his difficulties and being motivated to engage with services.

9. Services involved with Dermot

i) School – concerns over attendance and behaviour, school counsellor involved and special school based project involved.

ii) National Education Welfare Board (NEWB) – concerns over attendance and behaviour

iii) An Garda Síochána – concerns about alcohol use, damaging property, suicidal threats and out late at night under the influence.

iv) CAMHS – referral to three CAHMS teams (two on an emergency on-call basis) in relation to suicidal threats and attempts, behavioural problems and use of substances.

v) GP – made referrals to CAMHS in respect of above problems.

vi) District Court – charged with criminal offences, set bail conditions and curfew.

vii) Children Detention school - to which he was remanded for breach of bail conditions.

viii) Probation & Welfare Service – allocated Probation & Welfare Officer in respect of above charges and bail conditions.

ix) Community Drug and Alcohol Service – referred because of alcohol misuse but had not been attending any addiction service at time of his death.

x) HSE Children and Family Services SWD – referrals over a four year period. The case was managed by the duty service most of the time but Dermot was ultimately allocated a child protection social worker

xi) Specialist multi-disciplinary service for adolescents at risk, managed by the HSE.

10. Summary of Dermot's needs during his involvement with HSE Children and Family Services

Dermot exhibited behaviour problems from the time he was eight years old, and his mother needed help in managing them. The social work file records her description of him as a 'very active' child for whom she had difficulties setting boundaries. Dermot also required help to encourage school attendance and manage his behaviour at school from fifth class onwards. He was struggling with class

work and was tending to spend a lot of time with older children. Sustained attempts to support Dermot within the school setting did not really succeed.

Dermot's behavioural problems continued into his teenage years. He threatened and assaulted his mother, causing her to contact the Gardai for her own protection on occasions. It appears that Dermot's intimidation of her impeded her ability to manage his behaviour. The social work files record concerns about her ability to follow through on supports and advice given.

Dermot also had emotional needs. He had, by his own admission, problems with alcohol misuse that led to self harm and suicidal behaviour. He seems to have been significantly affected by the death of a friend by suicide three years before his own death. More recently Dermot lost another friend in a road traffic accident and this caused him great upset. His alcohol use and threats of suicide appear to have escalated after this event, resulting in destructive behaviour.

11. Chronology of contact between Dermot and his family and HSE Children and Family Services.

In total, twelve reports regarding Dermot were received by the duty team in the SWD from the time he was eleven years old to his death in his mid-teens. The majority of these reports came from the Gardai, the A&E Departments of local hospitals and one came from his primary school.

11 years old

Dermot and his family first became known to the Children and Family Services when a referral concerning his behaviour was received by the duty social worker from the deputy principal of his primary school. Dermot was 11 at this time and in the 5th class. The referral stated that his attendance had been irregular and his behaviour problematic in recent months. It also mentioned that he spent a lot of his time in the company of young people in mid to late teens and raised the possibility that he may have been introduced to substance misuse. The referral stated that Dermot was in danger of becoming unmanageable if preventative action was not taken and added that Dermot's mother had sought help from the school in managing his behaviour. The referral record from the duty social worker also stated that the National Education & Welfare Board had written to the SWD reporting concerns about Dermot's very negative behaviour towards his mother, including physical assaults.

A screening/ preliminary enquiry report was prepared. This involved obtaining consent from his mother to obtain reports from other agencies, e.g. GP, and school. The SWD opened a file and the duty social worker made contact with Dermot, his mother, the school and his GP. Initially Dermot was reluctant to meet the social worker and his behaviour and attendance at school continued to deteriorate. The GP was asked by the duty social worker to make a referral to the Child and Adolescent Mental Health Services (CAMHS) which was believed to be the most appropriate service at the time. No record of this referral appears on the file supplied by his local CAMHS team. It appears from social work records that Dermot did not attend the appointment offered. His circumstances then seemed to improve and his mother noted no concerns about his behaviour at home or school. His new school placement appeared to better suit his needs and the school made good reports about him. He engaged in soccer with training and matches during the week and at weekends. He was also linked with a counsellor in the school and given extra support. The SWD closed the file at that point.

Age 12 - 13

A notification was received by the SWD from the Gardai the following year about an incident, describing how Dermot *"was discovered on (date) with a cable around his neck"*. The notification went on to recount that Dermot subsequently assaulted his mother 'quite severely' and was brought by her to a psychiatrist in A+E in a local hospital.

The SWD re-opened the file at this point and the duty social work service checked in with Dermot's mother from time to time. By early the following year the SWD considered that his situation had improved sufficiently for it to close the file.

Mid- teens

By mid-summer of that year two more notifications from the Gardaí were received by the duty social worker about Dermot's behaviour. They were very similar to previous notifications and included self-harm, assault on his mother and heavy drinking. On the first occasion Dermot was seen by a duty psychiatrist from a nearby CAMHS team. He was discharged from hospital and a report was prepared and sent to the SWD. He then re-presented at the A&E Department of a local hospital and was admitted to the paediatric ward. He was seen the next day by another duty psychiatrist from yet another CAMHS team, and care and welfare issues were again identified as significant in his presentation. The psychiatric report on file in respect of this incident highlighted Dermot's misuse of alcohol and noted his

tendency to engage in episodes of deliberate self-harm when he was intoxicated. It diagnosed what it termed as a possible 'disturbance of activity and attention and conduct disorder'. A management plan included in the psychiatric reports recommended that Dermot be drug screened by the paediatric team, that there should be liaison with the SWD, that the report of an A&E assessment three years previously be obtained, that he was fit for discharge from a psychiatric perspective. The plan proposed that his case should remain open with his CAMHS team and that his case should be discussed at a multidisciplinary team meeting again. He was offered an out-patient follow-up appointment with CAMHS for two weeks later but failed to attend.

The SWD re-opened the file and prepared another standard screening report. According to the social work file, Dermot's mother was indicating at this time that she was no longer able or willing to accept Dermot home and attempts were being made to find a placement in out of home care for him. Preparation of the report included at least one home visit to his grandparent's house where Dermot was now staying on a temporary basis. His grandparents reported his behaviour as good. They had conveyed to him their expectation that he would come home in the evenings and refrain from drinking. It was made clear to Dermot by his grandparents that if he broke this rule he could no longer stay with them. The file was closed a few weeks later as the SWD believed that there were no child protection concerns. Contact was made with the specialist adolescent service and it agreed to continue offering a support service to Dermot. He stayed with his grandparents for two and a half weeks and then returned to live with his mother. His mother is recorded as saying that his grandparents were elderly and that Dermot's behaviour appeared to have settled.

The social work duty file indicates that a social worker from the HSE specialist adolescent service has been meeting with Dermot at least once per week at this time. This service also convened a professionals' meeting by late autumn attended by education and Gardai JLO representatives. It agreed that Dermot's mother should be encouraged to attend a family support course, but after initial interest she did not attend. A referral was also to be made for Dermot to a mentoring scheme run by a voluntary organisation. Dermot's behaviour deteriorated again before this could be put in place.

Next year

Further notifications were received from Gardai in each of the first three months of the following year. Each outlined concern about Dermot's aggressive, abusive and self destructive behaviour whilst

intoxicated. Following a particular incident, the A&E Department of a local hospital referred him to an on-call Child and Adolescent Registrar who diagnosed "deliberate self-harm in the context of alcohol misuse". Crisis management was discussed with his mother, she and Dermot were made aware of the Out-of -Hours Psychiatric Service and a letter was sent to his GP. On the other occasion he had been found after midnight in the street intoxicated and not wearing any shirt or shoes. Gardai had returned him to the care of his mother. This led to his file being opened again by the SWD. It remained open until his death some three months later.

Up to this point, the case had been managed by the duty social work team. This meant that each notification was dealt with by one of a number of social workers on duty at the time. Six weeks before Dermot died, the case was allocated to one specific social worker, here called Social Worker 1. She began the process of getting to know Dermot and his mother and making contact with other agencies involved with him including the NEWB, school counsellor, Probation & Welfare officer, and Gardai. Social Worker 1 also visited Dermot and his mother. On her initial visit she formed the impression that Dermot was friendly, chatty and was willing to engage. Likewise his mother appeared to be co-operative. Dermot was on strict bail conditions at that time and his mother reported that he had been adhering to them. He was keen to get his charges dealt with. His mother said that Dermot had seen CCTV footage of an incident from which criminal charges arose and felt that he was 'mortified' by it.
Some three weeks later his social worker received a call from colleagues in the specialist adolescent service to say that one of Dermot's close friends had been killed in an accident. The social worker was informed that Dermot had been at the funeral and appeared very upset. The informant said that she had visited the dead boy's mother who had informed her that Dermot had made a suicide attempt in the previous week.

It was agreed between the social workers that the social worker from the specialist adolescent service, here called Social Worker 2, would visit Dermot as she had been working with him since the previous autumn. The two social workers undertook to liaise after the visit. An email was received by Social Worker1 two days later from Social Worker 2 informing her that Dermot had been in court the previous day, having been arrested for an assault. He had been drinking a lot since he received the tragic news of his friend being killed. He had been released from court on strict bail conditions. According to the social work file, his mother had been aware of the suicide attempt and another self-harming incident and was concerned that he wanted to "*do something to himself*". She spoke of "*keeping an extra eye on him*" and

felt that it was impossible to get him to talk to anyone. She thought that it might have been better if he had received a custodial sentence to help him clear his head and get away from the impact that his friend's death was having on all the young people locally. Social Worker 2 spoke with Dermot who assured her that he would not take his own life, for his mother's sake. The social worker discussed various risk factors with him, particularly alcohol consumption. It is reported in the case notes that Dermot found it difficult to speak with Social Worker 2 and gave abrupt answers.

In discussion with Social Worker 1, Social Worker 2 undertook to meet Dermot regularly, and also highlighted the importance of coordination between the services, given the number of professionals involved with Dermot and his family and the apparent high risk behaviour of some of the children. Social Worker 1 had proposed a professionals' meeting and this was agreed.

Dermot was then arrested by Gardai for breach of bail conditions and remanded in custody for four days. The SWD only heard of this action indirectly when Social Worker 1 rang the Gardai to inquire about a court appearance. He was then released on bail a few days later. He returned home and took his life the next evening.

12. Analysis of involvement of Health Board/HSE Children and Family and Aftercare Services with Dermot

12.1 Initial response:

The initial referral about Dermot from his school to the SWD was handled appropriately. A screening was carried out and consent was obtained by the duty social worker to make contact with his GP, school and NEWB. Both Dermot and his mother were visited by a duty social worker and, after a slow start his behaviour and school attendance appeared to improve and the file closed.

However, a further eleven referrals came into the HSE over the following four years and it was only six weeks before Dermot died that his case was actually allocated to a social worker. It must be acknowledged that the decision not to allocate the case did not prevent Dermot and his family from receiving support from the HSE; both the duty team and the specialist adolescent team had significant inputs during that time. What it hindered, however, was the completion of a full child protection and welfare assessment. The frequency of notifications concerning Dermot should also have elicited a

response from the SWD. The Principal Social Worker (PSW) for the area, in an email communication to the reviewers, commented that, in hindsight: *"there should be some way of generating concern when cases are re-referred with the same presenting concerns. In this case whilst there was multi-disciplinary involvement, the fact that this file did not, until just before Dermot's death, move past the duty team meant that there was no professionals meeting and there were at least three different social workers thus leading to a lack of continuity"*.

The PSW indicated that caseloads in the area were excessively high which prevented social workers from routinely reviewing old case notes, an action which may have facilitated them to revise their assessments. Instead, an initial assessment was conducted each time, without in-depth analysis of factors pertaining to his behaviour.

12.2 Assessment

It is of concern that Dermot was referred to the SWD a number of times over a four year period for essentially the same reasons, without any full assessment having been undertaken of his needs, or of his mother's capacity to meet them. Dermot misused alcohol; his behaviour was challenging and he had mental health needs; he also had difficulty engaging with education and he had involvement with the criminal justice system. Such a combination of problems would require comprehensive and on-going assessment, including professional meetings and/or family group conferencing. While the lack of assessment did not prevent Dermot or his family from receiving services, the lack of a coordinated response meant that he tended to fall between them.

12.3 Compliance with regulations

12.3.1 Early protective action

Children First: National Guidance for Child Protection & Welfare requires Children and Family Services to respond to reports made to it. Early protective action in this case appears to have been appropriate and timely. The duty team of the SWD reacted speedily and undertook an initial assessment. However, the repetitive nature of notifications in this case would have warranted escalation of its status at an earlier stage to one which required a fuller assessment and earlier allocation.

12. 4 Quality of practice

12.4.1 Interaction with child and family

The SWD made strenuous and sustained efforts to engage with Dermot and his family. However, as noted above, failure to escalate the case beyond the duty team at an earlier stage resulted in a lack of continuity with different social workers visiting the family and conducting repeated initial assessments. The involvement of the SWD appears to have been appreciated by Dermot's mother. An earlier allocation of the case to the Intake Team may have led to more consistency and a better understanding of family dynamics. It is, however, acknowledged that the early decision to refer the Dermot to the specialist adolescent team, who had a protected caseload and a range of interdisciplinary skills, may have compensated for the delay in allocating a child protection social worker. The input from the specialist adolescent team appears, from interviews with the social work staff, to have been appreciated by the family.

12.4.2. Child and Family Focus

Interviews with social workers, management and file records demonstrate a strong child and family focus. This could have been improved had there been an earlier comprehensive assessment and a clear intervention plan. According to the evidence presented to the review by the records and interviews with staff, Dermot was very shaken by the death of his friend. Social workers 1 and 2 recognised his vulnerability at this time and responded very appropriately.

12.4.3 Quality of Record Keeping

The quality of record keeping was consistently good. There are good records of family and interagency contact.

12.5 Management

12.5.1 Allocation

A key factor was the failure to allocate the case until just a few weeks before Dermot died. Social Worker 1, who ultimately took on the case, was well qualified with more than five years post qualifying experience. She had undertaken training on Children First and also had training in both Safetalk[1] and ASIST[2].

[1] Safetalk is a training course that enables people to identify persons with thoughts of suicide and connect them to suicide first aid resources.
[2] ASIST (Applied Suicide Intervention Sills Training) is a two day skills based interactive workshop which trains participants to recognise and respond to suicidal risk.

12.5.2 Inter-agency meetings or cases conferences

In the autumn before Dermot died Social Worker 2 convened a professional's meeting with education and Gardai JLO. There is no record of CAMHS representatives or SWD representatives being present at the meeting. Social worker 1 was in the process of arranging a professionals meeting when Dermot died.

12.5.3 Supervision

Both Social Worker 1 and Social Worker 2 informed the review that they receive regular supervision and support from their respective team leaders. Dermot was not seen as a high priority in the case load of Social Worker 1, (given the high number of cases on the case load) but he was discussed at supervision and this is recorded on the HSE files. In the case of Social Worker 2 Dermot was considered to be a priority case in the weeks before his death, given the risk factors at that time.

12.5.4 Policy

The review was told by the PSW that the HSE area in which Dermot lived is busy with a lot of fast moving crisis driven cases. Dermot was not seen as a priority and, in the words of one of the social workers, *'was not well known around the office.'* The duty team leader chairs a weekly allocations meeting. There is normally what was described as a 'working list' in respect of thirty five to forty cases involving children and the team leader allocates these to social workers. A waiting list system has been introduced to help deal with work pressures and in late 2011 an extra team leader was employed. On reviewing the files after Dermot's death management acknowledged that the number of separate referrals concerning him had been of concern. However, they did not form the view that additional intervention from the Social Work Department could have saved his life. Nonetheless, the review considers that a pattern of repeated referrals should elicit a particular response, and notes the absence of any policy in this respect.

12.5.5 Inter-professional and inter-agency cooperation

Overall, the level of inter-professional and inter-agency cooperation was of a good standard. In particular there is evidence in the files of good co-operation between Social worker 1 and Social worker 2 who knew Dermot and his family through his involvement in the specialist adolescent team. In fact it would be accurate to say that the case was co-worked.

There was evidence of appropriate information sharing, with two exceptions. One was an apparent oversight on the part of one of the CAMHS teams who failed to provide the Social Work Department

with copies of psychiatric reports. A second shortcoming was the failure of Gardai to directly notify the Social Work Department that Dermot had been arrested and remanded to custody and then released on bail.

There is no evidence of any direct face to face contact between the SWD and any of the CAMHS teams involved with Dermot. Such a meeting may have been helpful.

13. Conclusions

- The remit of this review is confined to the child protection services provided by the HSE. However, the breadth and severity of some of Dermot's problems, which included suicidal ideation, significant alcohol misuse, a diagnosed behavioural disorder and criminal behaviour brought them beyond the range of Children and Family Services. While the review has identified some policy and practice deficits in respect of this case, it does not find that any action or inaction on the part of the HSE Children and Family Services contributed to Dermot's death.

- The analysis of the service offered to Dermot and his family has found that the SWD generally complied with policies and procedures. The fact that a pattern of repeated referrals did not trigger a comprehensive assessment is seen as a weakness, and the review concludes that this omission precluded the coordination of some of the services with which Dermot and his family were engaged. It also delayed the ultimate allocation of the case to a social worker from the Children and Family Services and thereby compromised social work assessment and intervention. However, the review acknowledges that the significant role played by the social worker from the HSE specialist adolescent service went some way to compensate for this.

- Whilst the level of communication between services was generally satisfactory, the review found some shortcomings, specifically in respect of information sharing between CAMHS and the SWD, and between the Gardai and the social work staff involved with Dermot.

- Notwithstanding the deficits that were identified, the review found examples of good practice in Children and Family Services. In the context of limited resources and high caseloads, staff who were interviewed presented as committed, conscientious, well trained and child centred.

Likewise, management demonstrated compassion, reflection and support, with a good understanding of the pressures and resource limitations they are facing.

- The fact that the HSE Children and Family Service was functioning in a context that was, by the account of the staff, overstretched and under pressure, undoubtedly affected the manner in which the different referrals were approached. The findings from this report must be understood in that context.

14. Key Learning Points.

Any death by suicide is likely to be tragic but is particularly distressing when it is a young person. It is rarely an isolated event but hugely impacts on the family, friends and wider community. The review acknowledges the profound effect that Dermot's suicide had, not only on the people closest to him but on all the professionals who were involved with him. This sad event has provoked a great deal of reflection on the nature and quality of service delivery in the area, as well as openness to learning in order to improve practice and policy. The review has identified a number of key learning points, which are detailed below.

- Dermot was the subject of notification to the Social Work Department on twelve occasions from a range of different agencies in the four year period leading up to his death. Reviewed together, the referrals paint a picture of a young person on a negative trajectory, with a diagnosed behaviour disorder and suicidal tendencies, complicated by alcohol misuse and problems at school. His mother's capacity to manage his behaviour was sorely tried. While Dermot was involved with numerous agencies, a lack of strategic planning and coordination meant that the service delivery was somewhat fragmented and reactive to individual events. In hindsight, the frequency with which Dermot refused to attend appointments and resisted a number of offers of help also becomes clear. A more in-depth assessment might have led to the identification of a lead agency and a comprehensive intervention plan that might have been acceptable to him. Repeated referrals of a similar nature should provoke a more in-depth assessment; such a pattern will only be recognised if there is a determined effort within a SWD to look for it, and its identification should routinely trigger a comprehensive assessment.

- Dermot's resistance to formal services was also evident. He made a satisfactory, albeit sometimes reluctant, connection with his school counsellor and the social worker from the specialist adolescent service. A more coordinated and strategic approach to the case could have identified which service could have taken the most appropriate lead in this case.

- The potential for a young person to self harm or commit suicide presents challenges to all the services, some of which are more experienced and better equipped to respond. While the review does not claim that Dermot's suicide was predictable, a number of risk factors were present, not least of which were his alcohol misuse and his associated suicidal ideation. Admissions to custody or institutions and then the immediate period after release are known to be high risk times for suicide[3]. The death by suicide of a friend was another key risk factor in Dermot's suicidal behaviour.

- Awareness of the most common factors associated with youth suicide should form a core element in practice with vulnerable young people. It is noted that Social Worker 1 had been trained to identify and respond to suicide risks. Awareness and training will not always prevent suicide, but it may be effective in certain cases. Training in techniques such as "motivational interviewing" may have help staff to connect directly with young people and thus gain an increased understanding of the issues facing them.

- It was acknowledged by a psychiatrist during the process of the review that psychiatrists and members of CAMHS teams would benefit from training in family therapy in view of their observation that suicidal and other dangerous adolescent behaviour impacts on the whole family.

- The HSE Social Work Department is to be commended for providing support to Dermot's mother and siblings and co-ordinating an inter-agency response to his death. Particular attention was being paid to Dermot's siblings and the increased distress and risk they are likely to be experiencing. In understanding of the risk of 'copycat' suicides, a community response to teenage suicides was initiated in the area. There was a community meeting and the HSE agreed

[3] Roberts, A.R and Bender, K (2006) Juvenile offender suicide: prevalence, risk factors, assessment, and crisis intervention protocols. International Journal Of Emergency Mental Health, Volume 8, Issue 4, Pages: 255-265.

to provide Safetalk training in the area. GP's were also contacted as were secondary schools in order to raise awareness and vigilance. The HSE are to be commended for coordinating the community response, along with Gardai and local youth agencies.

15. Recommendations

1. Social work departments should routinely review referrals. The identification of recurrent referrals in respect of the same child and family should trigger a comprehensive assessment.
2. While it is not within the remit of this review to make recommendations in respect of the practices or policies of CAMHS or An Garda Síochána, some potentially serious shortcomings in communication on the part of these organisations were identified. It is recommended that the HSE/ Children and Family Support Agency negotiate protocols on information sharing with all relevant children's services. This is in accord with section 4.3.6 "Partnership Working – Exchange of Information" of Children First (Department of Children and Youth Affairs, 2011).

Signed: Bill Lockhart Date: 6, December, 12

Dr Bill Lockhart

Deputy Chair

Signed: Helen Buckley Date: 17 - 12 - 2012

Dr Helen Buckley

Chair