Review undertaken in respect of the death of Nathan,

a young person known to the child protection system.

August 2013

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 eighteenth 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 and began its work in August 2010. The NRP consists of an independent Chairperson, a Deputy Chair, and approximately twenty independent members with 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 receives administrative support from the HSE. When a death or serious incident fitting the above criteria occurs, it is notified through the HSE to the office of the National Director of Children and Family Services and from there to the NRP. 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 contains a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. Depending on the nature of the case, one of the following types of review will be conducted.

Major review: to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex, for example includes multiple placements, and where the level of public concern about the case is high. The review team should consist of at least three panel members including the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a comprehensive report with conclusions and recommendations.

Comprehensive review: to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period. The review team should consist of at least two members with oversight by the chair. The methodology should include a review of records and interviews with staff and family members. The output should be a report with conclusions and recommendations.

Concise review: to be held where the involvement of HSE services is either of a short duration or of low intensity over a longer period. The review team should consist of at least two members including the chair. The methodology should include a review of records, and interviews with a small number of staff and family members. The output should be a report with conclusions and recommendations.

Desktop review: to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent. The review should be conducted by the chair or deputy chair of the NRP. The methodology should include a review of records with the option of consultations with staff and family members for clarification. The output should be a summary report with conclusions and recommendations. If issues arising from the review of records or consultations point to the need for a fuller exploration of the facts, the review will be escalated to the next level.

Internal review: Under *Children First: National Guidance for the Protection and Welfare of Children*, all areas should conduct a review where a child in receipt of services has died. Internal reviews should be sent to the Chair of the National Review Panel. In certain circumstances, e.g. where the death has been from natural causes, or where the death or serious incident has more local than national implications, the internal review, once quality assured by the National Review Panel, may suffice and the NRP will not conduct one.

4. Child Death or Serious Incident

This report concerns the service provided by HSE Children and Family Services to a young person, here known as Nathan, who committed suicide aged 17. Nathan's family had received services from the local social work department (SWD) a number of years ago. His mother asked for assistance specifically in relation to Nathan four years prior to his death, and he had come to attention again a few months before his death because of suicidal behaviour.

5. Nathan

Nathan was one of a number of siblings. He had lived with both his parents before they separated when he was around six years old following a period of domestic violence. Nathan's birth father moved out of the country and died when Nathan was 13. Nathan's mother, here called Rose, began a new relationship with a man here called Donal, who became part of the family. Donal and Rose subsequently married and, by all accounts, Nathan got on well with his stepfather. The younger

siblings lived in the family home. Some of his older siblings lived abroad and some locally. Nathan had been staying with the parent of a friend for around eighteen months before he died. Prior to that time he had frequently stayed away from home overnight with various acquaintances. He visited his mother and stepfather occasionally and had frequent contact with a sibling living nearby.

Nathan was described as a sociable young person who was enthusiastic about sport, especially boxing and football. He was regarded as competent but at school was somewhat indifferent to study. He attended erratically and consequently did not achieve results that were in line with his ability. In the months prior to his death he had dropped out of school and was working part time in the area, though efforts were continuing to get him to continue his education. Although he had not succeeded academically he was not without career ideas and had spoken of possibly joining the army.

Nathan was described variously as 'popular and easygoing', 'charming', and an effective communicator. His outward demeanour seemed to mask some underlying troubles and in 2008 when he was referred to the SWD, there were concerns that his friendly nature coexisted with a state of being 'moody and angry at home'. He was described by someone close to him as prone to 'erratic mood swings' and there were suspicions that he was misusing drugs. Attempts were made to link him and his family to helping services but while his mother and stepfather showed willingness to engage, Nathan tended to lose interest quickly and withdraw. In the time leading up to his death he was causing concern amongst those who knew him well.

6. Level and Process

This is a concise review. It was carried out by Associate Professor Helen Buckley, Chair of the NRP, and Professor Ian O'Donnell, member of the NRP. The timeline upon which the review focuses is the three and a half years between Nathan's referral to the Social Work Department (SWD) and his death. While he was known to the SWD prior to this period this was not on account of any concerns about his own behaviour.

The evidence for the review was obtained from written HSE records (including social work intake forms and a summary report, case notes, and correspondence between the SWD and other services); interviews with HSE staff, each of whom made a written submission; interviews with members of Nathan's family and with a person with whom he had lived for more than a year before

his death and a report of the coroner's inquest. Transparency and equality of treatment was given to all HSE employees involved in this case.

7. Terms of Reference

The review team adopted the following Terms of Reference:

- To examine the service provided to Nathan from the time he was in his early teens when he was referred to the Social Work Department until his death at age 17.
- To identify any deficits in the provision of services to Nathan, as well as examples of good practice.
- To provide a report to the HSE National Director of Children and Family Services.

8. Background and Reason for Contact with Child Protection Services

Nathan's family had been involved with the Social Work Department (SWD) when he was a young child due to domestic violence between his parents and some unproven allegations of child neglect. The SWD were also involved with a close family member. When Nathan was in his early teens, his mother, Rose requested help from the SWD. Referrals also came from his school and An Garda Síochána around the same time. The reasons for referral were Nathan's poor school attendance, tendency to stay out overnight, association with an unsuitable peer group who were suspected to be misusing drugs and alcohol, and suspicions that Nathan himself might be misusing substances and self harming. A pattern of intermittent school attendance had begun during the final years of primary school and became more firmly established when Nathan entered secondary school. Nathan appeared to settle for a while, but came to attention again four months before his death because of an episode where he threatened suicide while under the influence of alcohol.

9. List of Services Involved

- Early school leaver's project, which engaged with Nathan at the time he was starting to disengage from school
- Educational welfare service that organised a strategy meeting in his school to try and address attendance issues.

- HSE Children and Family Services. Nathan was referred to the SWD by his mother after he finished with the counselling service to which his school had referred him. He was allocated a social worker (Social Worker 1) and when she went on maternity leave 15 months later, her caseload was allocated to a locum social worker but not activated. When Nathan came to attention four months before he died he was allocated a male social worker (Social Worker 2).

- Psychology services, to which he was referred by Social Worker 1. Rose attended the service , however, Nathan did not.

- Addiction counselling service, where a worker managed to engage Nathan over a period of a few months.

- Counselling service in a local resource centre. Nathan briefly attended.

- GP. Nathan attended his GP for asthma and at his mother's request, for an assessment of his mental health. During the eighteen months before he died Nathan was living in a different area to his GP. Social Worker 2 attempted to link him with a local doctor but Nathan wasn't interested.

- Two referrals were made to two separate advocacy services. Neither were immediately available and Nathan declined to engage with them later when he was offered a service. One of the services offered support to Nathan's mother, Rose, for a period.

10. Brief summary of Nathan's needs throughout his contact with HSE Children and Family Services

Nathan's needs, as identified by his mother and confirmed by the SWD, were for generalised support and guidance in respect of the concerns that led to his referral to the SWD. There was a desire to prevent an escalation of his risky behaviours and to strengthen the relationship between himself and his mother. Possible mental health issues were identified when Nathan was first referred and again when he was found threatening suicide several months before his death. From the accounts

presented to the review team, as well as the evidence in written records, it appeared that Nathan was adept at minimising the seriousness of any difficulties he faced. As one of his family members put it, 'He was very, very good at literally just making you believe anything he said.' A friend commented on his demeanour, after his display of suicidal behaviour, in the following terms: 'You would have thought there was nothing wrong with him in the world.'

From evidence gathered during the review process, it appears to the review team that Nathan had confused and unresolved feelings about his father, who had been absent for several years and whose violent behaviour he would have witnessed. He did not attend his father's funeral but visited his grave three years later. There was likely a sense of loss, even if not clearly articulated, at his father's absence, despite the fact that his father had been abusive towards Rose during Nathan's early childhood.

Nathan's ability to persuade others that he did not need support, together with his determined nature and reluctance to engage fully with professionals, made it difficult to assess and prioritise Nathan's needs let alone to begin to address them.

11. Chronology of service involvement with Nathan and his family

Early childhood

The family's involvement with social services long predated Nathan's birth. Rose had been a victim of domestic abuse in a previous relationship while living abroad. She moved back to Ireland with her then partner and children, including Nathan, when he was an infant. The family were referred to the SWD during Nathan's early childhood because of domestic violence between his parents which persisted over a number of years. Nathan's father moved out of the family home and eventually left the country when Nathan was around seven years old. Concerns about the family abated, though (unfounded) allegations of inadequate parental supervision were received which appear to have stemmed from a local dispute. The case remained open to the SWD for a number of years. Social Worker 1 was the allocated social worker initially. Within a few weeks the family was allocated to another social worker while Social Worker 1 remained working with one particular sibling. Nathan was not the focus of any particular concern at that time.

Early Teens

When Nathan was in his early teens, Rose came to the SWD requesting help because of anxiety that his behaviour was veering out of control. Soon after this referral, Nathan's birth father died but he did not attend the funeral.

Social Worker 1 met with Rose on a number of occasions to give her advice and support in relation to anger management and discipline and to refer her to other support services. Rose's previous contact with the SWD had not always been positive, but she was clearly motivated to try and engage with them on this occasion in order to get help for Nathan whom she feared was misusing substances and possibly self harming. Social Worker 1 set about coordinating a multi-agency response. At this point, she suggested that Rose speak to the family GP about referring Nathan to the mental health services because Rose suspected he had been self harming. According to the social work record, the GP considered Nathan to be very angry, and suggested counselling rather than a HSE therapeutic service which he felt would take too long. Social Worker 1 referred Nathan to the local psychology service and brought Rose to an introductory meeting. She prepared a genogram of the family for the psychologist which illustrated the different relationships. She made a referral to an advocacy service for young people. Around this time, Rose brought Nathan to a counsellor in the locality whom he briefly attended.

Over the following weeks, Nathan's behaviour deteriorated; he stole money and took his mother's phone and car. He stayed out of home with different people on numerous nights including two separate adults who reputedly had a lot of young people drinking in their homes. He rarely attended school and when there, his behaviour caused concern. His mother was very worried about him and believed he may have been using drugs; she asked the SWD if he could be taken away for assessment. Part of his difficulty at the time was that his family were temporarily residing in a dwelling that was some distance away from their former home and Nathan was separated from his friends.

Rose was reluctant to report Nathan's misdemeanours to An Garda Síochána though Social Worker 1 encouraged her to do so, to let him experience the consequences of his behaviour. She also encouraged Rose to make contact with the Gardaí so that they would pick Nathan up when he was missing from home. At Social Worker 1's suggestion, a local Garda who had a good rapport with Nathan subsequently met with him and advised him about the risks he was taking and the likely consequences.

Although she had a clear picture of the services that were involved and the contact that Nathan and Rose had with each of them, Social Worker 1 had difficulty meeting directly with Nathan. He left the house on the day she was due to call to see him, and she only managed to meet him when she was informed by the Garda that he had been located after going missing and was at the Garda Station. She met him again the next day, but not on any other occasions although she made appointments to see him which he broke. Her case records for this period are lengthy and detail very frequent contact between herself and Nathan's mother and the numerous calls to and meetings with the various services with which she was trying to link Nathan. They also record regular discussions between Social Worker 1 and her team leader, reflecting a high degree of concern and involvement with the case.

Five months after the referral, Social Worker 1 attended a strategy meeting at Nathan's school that had been organised by the Education Welfare Officer. This involved Rose, her husband, the community psychologist and the Early School Leaver's project. The Gardaí sent their apologies. It was agreed that Nathan would return to school with reduced hours to start and that he would continue to meet with the addiction counsellor with whom he had just commenced working.

Discussions took place around this time about the possibility of an out of home placement for Nathan but it was believed by both Social Worker 1 and Rose at the time that such a plan may have more negative than positive outcomes for him. Social Worker 1 strongly encouraged Rose to get Nathan to engage with the youth advocacy service which had by now agreed that he would be offered a worker. However, Nathan had indicated his lack of interest in this. It was agreed that the service would work initially with Rose with the intention of persuading Nathan to get involved and they would try and identify a suitable male worker for him. Around this time, Rose began to express her dissatisfaction with the SWD, saying that that nothing had happened and that she had been given no advice.

In the meantime, Rose had independently contacted an addiction counsellor and attended that service with Nathan for a short period. Social Worker 1 subsequently communicated with the addiction counsellor who gave her information with Rose's consent. Social worker 1 then had ongoing contact with the addiction counsellor and with the with planned advocacy service**.** The addiction counsellor appears to have been the professional who was most able to engage with Nathan, albeit for a brief period. According to accounts given to the review team by Social Worker 1 and confirmed by Rose, Rose had told Nathan that the addiction counsellor was the 'head of social

services' had the authority to place him in care if he didn't attend. It appears that this threat had the effect of motivating Nathan to attend the service and even when he discovered that it had been false, he continued to see her for a short while. In her discussions with Social Worker 1, the addiction counsellor did not report a serious problem with addiction, but suggested that he might benefit from involvement with the psychology service (from which he had withdrawn) and the planned advocacy/support 'wraparound' service. Social Worker 1 had also referred him to a separate mentoring service but there was nobody suitable available in that service to take him on at the time and it was later decided that the service would not have been sufficiently 'in depth' for Nathan.

A discussion between the social work team leader and the principal social worker took place at this time, and it was decided that if Rose declined or failed to encourage Nathan to accept the advocacy service, he should be referred to the Child Protection Notification Team. This reflected concern on the part of social work managers about the possibility of a breakdown in Nathan's relationship with his family.

Rose subsequently had a number of meetings with an advocate from the youth advocacy service which appeared to be helpful and it was intended that as soon as a male advocate was recruited and Nathan could be persuaded to engage, work would commence. Soon afterwards she indicated to Social Worker 1 that she may send Nathan away to live with a family member who apparently had a positive influence on him and the file records that Social Worker 1 advised her to try the advocacy service first prior to making plans. In the meantime Nathan's behaviour improved somewhat, he was more cooperative and attended school more regularly for a while, though this pattern once again deteriorated within weeks. Social Worker 1 lessened her contact. She told the review team that this was because the Youth Advocacy Service had become involved. Within a few weeks Social Worker 1 heard that Nathan had gone away with a sibling to a relative in the UK. This coincided with Rose withdrawing from the advocacy service.

However, Social Worker 1 became aware soon afterwards that Nathan had not gone away, and she told the review team that her efforts to contact Rose by letter to establish what was happening were unsuccessful. The advocacy service agreed to try and liaise with the family to encourage Nathan's engagement, but they were equally unsuccessful.

Nathan returned to school in the locality and his attendance improved, but he continued to miss about 40% of days. Social Worker 1 monitored his situation through his school until the end of that year, which was fifteen months since Rose had made the referral. She asked the advocacy service to

make another effort to engage him, but at this point there had been such a long gap since his referral that the process required to be renegotiated. Nathan was almost fifteen at this point.

Social Worker 1 went on maternity leave shortly afterwards and returned to a different post in the area.

Mid to late teens and departure from the family home.

There are no social work records covering the period when Nathan was between 15 and 17. The review team was also told that recruitment difficulties meant that it was difficult to adequately cover for staff on maternity leave. Social Worker 1's maternity leave was covered, though not from the start. Although Nathan's case was still open, the locum social worker did not engage with the family. The review team was informed that this was because no further concerns were reported to the SWD during this time. However, the lack of new referrals or reported concerns did not mean that Nathan had settled; in reality, it meant that Rose had stopped making contact. It later transpired that Nathan's relationship with his mother came under serious strain during that period, and that he gradually moved into the household of a friend's family when he was around fifteen and a half. This household was headed by a single parent, here called Camilla. Camilla told the review team that Nathan used to stay overnight from time to time but gradually moved in, saying that he didn't get on with his mother. She allowed him to stay because she was not prepared to turn him out onto the street and was quite happy to have him there. There was no contact between Camilla and Rose at that time. While living with Camilla, Nathan would go home to his mother and stepfather now and again, sometimes staying a few days. He also had a lot of contact with a close family member in the neighbourhood. Camilla told us that she too tried to get him back to school, but after a renewed effort, he eventually dropped out again. He had a part time job in the area. Camilla described him as popular and polite and said that she enjoyed having him live in her household. From her description, he seemed to regard her as a maternal figure, calling her 'mum' rather than by her name though she described her relationship with him as 'more of a friend … helping a friend'.

From all accounts, Nathan's behaviour stabilised while he was living with Camilla and her family. He was not attending school, but otherwise was not in any overt difficulty. He was regarded as a hard worker by his part time employers and those in the neighbourhood that knew him, and had not been in any contact with An Garda Síochána for a number of months.

Later teens

A few months before he died, Nathan went to the UK to visit some family members and to see his father's grave. Shortly after he came back to Camilla's home, he made what appeared to be a suicidal gesture whilst under the influence of alcohol and was 'talked down' by a passerby. Camilla told the review team that she believed the visit to the UK had unsettled him and stirred up memories of his past and his father. She felt he got over it quickly following the incident and was 'perfect' again.

The incident was referred to the SWD by a member of the community. A male social worker, here called Social Worker 2, made contact with Nathan and visited him in Camilla's house. It had been decided that a male might be more appropriate at this time and have more success in engaging Nathan. Nathan was willing to talk to Social Worker 2 but asked for Camilla to sit in on the conversation; he dismissed his suicidal gesture as 'emotions having got out of hand' and a result of having been upset about visiting his father's grave for the first time, having drink taken and having had a row with some friends. Social Worker 2 had undergone training in suicide prevention and spoke in what appears to the review team to have been a direct and sensitive manner to Nathan about what had occurred. The social worker had already spoken to the local GP who had pointed out that while he was not Nathan's GP, he was willing to see him with regard to the incident. However, Nathan was unwilling to follow this through, nor was he interested in a suicide prevention service that was suggested to him. Social Worker 2 did not consider Nathan to be suicidal at that time but did feel that his 'issues' were not going to go away and required to be addressed. It was the opinion of Social Worker 2 that with Nathan's history of reluctance to engage with services, the priority should be to build a trusting relationship with him in an effort to persuade him to ultimately avail of mental health services. Nathan asked the social worker not to contact his mother at the time as she had recently been unwell, and his wishes were respected. The file shows that after a second meeting with Nathan, Social Worker 2 sent a letter to Rose asking her to contact him, to which she did not respond. Rose told the review team that she never received this letter; however, the review team found a copy of it in the social work file. According to Social Worker 2, the focus changed from a mental health concern to one about Nathan's welfare and the circumstances which had led to his living with someone outside his family. Social Worker 2 considered that Camilla was a warm and protective carer and that Nathan who had previously showed such reluctance to avail of services had 'developed a kind of independent attitude' and identified his own supports in terms of living with Camilla. Social Worker 2 initiated efforts to secure an arrangement whereby Camilla would be paid an allowance for caring for Nathan.

Social Worker 2 also considered linking Nathan with Youthreach as it was becoming clear that mainstream school was not a suitable option for him. For logistical reasons, Youthreach was not a readily available solution and Nathan was not keen on it, but it was still being considered when he died. In the meantime, Social Worker 2 made contact with a close relative of Nathan's who knew him very well and who painted a somewhat different picture of him, describing him as moody and prone to 'mad behaviour'. This relative was adamant that Nathan required psychiatric help but the social worker found it difficult to convey that it could not be forced on him. Social Worker 2 asked the relative to encourage Rose to link with the SWD to discuss Nathan's situation but the relative did not think this was a realistic possibility.

A few weeks later, Nathan went away for a few days. He had been bothered about his relationship with his girlfriend in the previous few days. Camilla noticed that some money was missing from her house and guessed that Nathan, one of the few people who knew where it was, had taken it (a charge he denied). He returned to the area and went to his relative's house, where he was reported to have been in good spirits. Some hours later he was found attempting to take his life and tragically, he subsequently died. He had sent texts to some of his friends which, in hindsight, could have been subtly revealing his intentions

12. Analysis of the services offered to Nathan and his family

12.1 Initial response of the SWD to referrals concerning Nathan

When Nathan was referred to the SWD by Rose, Social Worker 1, who knew the family and had worked with them in the past was allocated the case. As outlined in the earlier sections, she attempted to connect Nathan with a range of services. Her involvement in the case lasted fifteen months, but she only managed to meet Nathan twice in close succession.

When Nathan was referred again over three years later, the duty social worker responded quickly. It was established that Nathan had not been seen by health or mental health staff for a number of years and had not come to the attention of An Garda Síochána in the meantime. The social work team leader took the opportunity to allocate a male social worker with the expectation that Nathan might find it easier to talk to a man. Social Worker 2 responded appropriately to the referral, saw Nathan as soon as he could get his agreement and directly and sensitively addressed the alleged suicide attempt. He attempted to refer Nathan to medical and mental health services but Nathan declined.

12.2 Assessment

At first Nathan's needs were assessed through communications with his mother rather than directly with himself. When he was spoken to, he expressed the view that he neither needed nor desired support. Rose's motivation to work with the SWD did not endure because she felt that progress was slow and that her concerns were not being taken seriously. The poor engagement between the family and the SWD therefore made it difficult to assess Nathan's needs on a holistic level; though as reported above, the addiction counsellor used the opportunity available to her to identify what she considered would be a useful service. Nathan was nonetheless considered to be at risk, to the point where out of home care and notification to the Child Protection Management Team were briefly contemplated.

Two contrasting pictures of Nathan were perceived by those that knew him. To most outsiders, he appeared to be cheerful and happy. His family, however, found him to be 'deep', moody and erratic. His close relative expressed serious concern about his mental health following his suicidal behaviour. Social worker 2 tried to link him with mental health services although he did not appear suicidal on meeting. This was affirmed by Camilla, the person in whose house he was living at the time, who felt that he had completely recovered from whatever was bothering him at the time. There were no grounds for compelling a mental health assessment against his will. It is not possible to comment on whether or not more could have been done in this regard, such was Nathan's avoidance of engagement with formal services.

12.3 Compliance with Regulations

The immediate response of the SWD to the referral about Nathan when he was 13 complied with Children First. However the fact that the case was neither activated nor closed following Social Worker 1 going on maternity leave suggests that it slipped through the net between the time he was 14 and 17.

The review team noted the fact that Nathan left home at 15 and went to live in a household away from his family. While Camilla considered herself to be more of a friend to him than an alternative carer, Nathan appears to have perceived her as a maternal figure and her home was his main dwelling place. This placement conformed to the definition of 'private foster care' outlined in Part IV of the Children Act 2001 i.e. 'any arrangement or undertaking whereby a child is for more than 14 days in the full time care, for reward or otherwise, of a person other than his parent or guardian'. The SWD were unaware of his living arrangements until they were alerted after his suicidal

behaviour. At that point Social Worker 2 assessed Camilla as a warm and protective carer and this is not disputed by the review. Indeed it appears that she provided him with not only bed and board but a considerable amount of emotional support. However, it is the opinion of the review team that a more in-depth examination of the suitability of the placement should have taken place as soon as the SWD were notified about it. Under Section 23T (2) of the Children Act 2001, where the HSE has received notice in respect of a private arrangement 'an authorised person on entering the premises shall investigate the care and attention that the child is receiving and the condition of the premises with a view to ensuring that the person undertaking the arrangement is complying with his or her duty to take all reasonable measures to safeguard the child's health, safety and welfare'. Nathan's history of vulnerability, his specific needs and the fact that he had been considered to be at sufficient risk to consider forwarding his name to the CPNMT meant that his situation needed careful consideration. In the opinion of the review team, this would have warranted more than a meeting with the carer and should have elicited at a minimum, routine checks. By 'checks' we intend a Garda check and written references in respect of the person providing private foster care. The review team was informed that the SWD had checked that the family was not known to them. However, this is not considered to have been sufficient.

12.4 Quality of practice

12.4.1 Interaction with the young person and family

Social Worker 1 acknowledged that the relationship between the SWD and Nathan's family had been historically poor, but she attempted to maintain a level of contact and observation after his referral. During the 15 months of Social Worker 1's involvement, there was frequent and well documented activity in the case, much of which involved liaison with services including the advocacy programme with which neither Nathan nor his mother ultimately wished to engage. The case notes are largely concerned with discussions that took place with the various services about the family's needs, and telephone discussions with Rose. There is a useful genogram. The case notes are lengthy and provide an overview of the different services that were contacted on Nathan's behalf and the range of options that was being considered for him. The person with whom Nathan engaged for the longest was the addiction counsellor. He had been misled by his mother into thinking that she could take him into care if he refused to see her, but even after he realised that this was not true, he engaged with her for a brief period. While she did not feel he had an addiction problem, she used the opportunity to assess which services would be the most appropriate for him. The willingness of the

addiction counsellor to look beyond his alcohol and drug use to assess his welfare needs is commendable.

As Rose grew disenchanted with the services, interaction with the family became even less frequent and when Social Worker 1 went on maternity leave there was no contact at all for two years. The case became active again when Nathan was found threatening suicide.

Social Worker 2's involvement was confined to two meetings with Nathan, the first one following his suicidal behaviour which was minimised by Nathan himself. Social Worker 2 did not feel that Nathan was suicidal at that particular point but offered to refer him to a suicide prevention service and spoke to Camilla's GP with a view to setting up an appointment. Social Worker 2 also contacted Nathan's school and became aware that he had not attended for a number of months and was ambivalent, sometimes wanting to continue but tending to set his sights too high so that frustration was inevitable. Social worker 2 told the review team that, given Nathan's history and current reluctance to engage with services, building trust became a priority at that point, and following a second meeting, that the focus of work shifted from the incident towards supporting Camilla's care of Nathan. While this was an appropriate course of action, the review notes that the measures taken to formalise the placement did not go beyond contacting the Department of Social Protection for financial assistance. As outlined above, it is the opinion of the review team that at the very least, Garda checks on Camilla should have been carried out, and references taken up.

12.4.2 Child and family focus

The difficulties establishing rapport and a meaningful sense of connection with a young teenager who wants neither, should not be underestimated, but there is no sense from the records that the SWD got to know Nathan as a person, and consequently, the practice could not be said to be genuinely child centred. Following the first referral, there was little direct contact with Nathan, and it took five months before a face to face meeting took place between himself and Social Worker 1, followed by a single subsequent encounter. Social Worker 1 met more often with Rose and on occasion with Nathan's stepfather, Donal. It seems to have been accepted by the SWD at an early point that Nathan was difficult to engage by them and ultimately, no service worked directly with him. It is difficult to say from this distance if more efforts could have been made and it was acknowledged by those who knew Nathan in personal as well as professional capacities that he was a persuasive young man who was skilled at concealing his true feelings. Social Worker 1 informed the review team that the five month delay that elapsed before she met him was partially due to the

fact that he failed appointments with her and had been referred to other services, and partially due to Christmas holidays and sick leave.

However it could be reasonably inferred that there was too great a delay between the initial referral from a distressed parent and the allocated social worker actually meeting Nathan, albeit that she had put him in touch with numerous other services (none of which managed to engage him). Likewise, once Nathan had withdrawn from the addiction counsellor and Rose had withdrawn from services and had not replied to the social worker's letter, no further efforts were made to contact Nathan directly. It was known that he had not gone away as planned at this stage. As already outlined, the fact that no further referrals were made about him did not, in reality, mean that all was well.

The review has noted the tension that existed between Rose and the SWD, partly stemming from a previous mistrust of the services. It has noted the efforts of Social Worker 1 in particular to try and keep channels of communication open, her acknowledgment of Rose's concern for Nathan, and her awareness about the fragility of the relationship between Rose and the SWD which unfortunately deteriorated over the months. The review has also noted that Social Worker 2 was compromised by Nathan's insistence that information about his suicidal behaviour would not be passed to his mother. When Social Worker 2 ultimately attempted to contact her, the letter went unanswered. He did have contact with a close relative of Nathan's and attempted, through this person, to contact Nathan's mother with no success, but did not make any further direct attempts. This was in a context where a young person who was still under age had been living away from home and had made what seemed like a credible suicide attempt. The difficulty in engaging Nathan's family and maintaining their commitment to stay involved is fully acknowledged by the review team. However, we have also noted the frustration on the part of the family who felt that their concern about Nathan's mental health was unheard. There was undoubtedly a gap between the family's perceptions and expectations of what could be done for Nathan and the ability of all of the services to engage him.

12.4.3. Quality of recording

Recording by Social Worker 1 was excellent. The notes were typed, signed and dated; they appeared to be contemporaneous and recorded frequent contact with the various services involved at different times as well as discussions between Social Worker 1 and her team leader. Notes by Social Worker 2 were also comprehensive and were dated and signed.

12.5 Management

12.5.1 Allocation

The case was allocated immediately following Rose's referral and investigation of the available options began promptly. For two years there was a break in continuity when Social Worker 1 went on maternity leave. Her case load was allocated to a locum, but in the absence of any new concerns being reported, it was assumed no social work intervention was required. When Nathan was re-referred after his suicidal behaviour, the case was swiftly re-allocated.

There is an obvious question about why a case to which so much attention had been directed remained open and inactive for so long after Social Worker 1 went on maternity leave. Had a decision been made to close the case, it is possible that Nathan's move from home would have been highlighted as final checks were made.

There appeared to be ongoing management oversight of the case while it was active; records and interviews suggest a well-organised and well supported team of social work professionals who worked cohesively.

12.5.2. Supervision

The files did not contain supervision notes, and the team leader explained to the review team that it was not practice at the time to include them (this has since changed). The social work case notes record frequent discussion and updating between the social worker and team leader as well as evidence of consultation between the team leader and the principal social worker. The team leader confirmed that supervision took place monthly.

12.5.3. Inter-agency collaboration

From the information provided to the review, inter-agency relationships in the area appeared to be generally very good with a high level of communication. However, it was striking that within this context, the SWD, where his case remained open, was not aware that Nathan was living away from his family in another household. For example, during this time his school was aware that the person with whom he was living had no parental authority and this fact may also have been known to other services in the area. The review team finds it surprising that given the previous level of communication that this information did not reach the SWD.

12.5.4 Case conferences and inter-agency meetings

A strategy meeting was called by the Education Welfare Officer and attended by education, social work and psychology staff as well as Nathan's parents. The social worker attended meetings with Nathan's parents and the psychologist and had contact, including meetings, with the addiction counsellor and the youth advocacy project staff. However, no child protection conference was called. At one point, Nathan's situation was considered to be critical enough to consider referral to the Child Protection Management Team if he did not avail of the advocacy service. Despite the fact that he did not avail of it, this did not occur. In the opinion of the review team a multi-disciplinary child protection conference which involved the entire network of professionals concerned with the case, including Nathan's GP and the Gardaí, would have provided an opportunity to overview the case. It may also have highlighted the fact that despite Social Worker 1's efforts, nobody was actually working with Nathan.

13. Conclusions

The review acknowledges the shock and sadness expressed by all the professionals involved with Nathan in response to his untimely death, and it also acknowledges the profound grief of his family and of Camilla, who took care of him in the months prior to his death.

On the basis of the evidence available to it, the review has reached the following conclusions:

- Action or inaction on the part of the Children and Family Services was not directly linked with Nathan's death by suicide.
- The response to the initial request for services by Nathan's mother was prompt and the range of services offered to Nathan and his family were appropriate.
- Social Worker 1 attempted to link Nathan with a range of services and recorded her work at all stages.
- While there were intra-familial tensions, Nathan's family's actions in the years prior to his death demonstrated concern and commitment on their part.
- While Nathan's reluctance to engage with professionals is acknowledged, the review concludes that his situation was largely addressed through discussions with his mother and professionals in different services and that direct contact with him was minimal. Despite the existence of a range of services for young people in the area, no service worked directly with him for longer than a few weeks.

- When Nathan's social worker went on maternity leave, the case remained open but inactive. The lack of further referrals resulted in an assumption that Nathan's situation had remained stable when in fact he had prematurely left home following a strained relationship with his family.
- Nathan independently moved to live in the household of a parent of one of his friends; he was still a minor at the time and this arrangement represented a private foster placement as defined in Section IV of the Children Act 2001. The SWD should have responded to it as such. In light of Nathan's history and acknowledged vulnerability, the review team believes that the SWD should have taken more steps than it did to establish the appropriateness of the placement to his needs. It is not considered that failure to do so had any bearing on the tragic outcome for Nathan, but it would be remiss of the review to overlook this omission on the part of the Social Work Department.

14. Key Learning Points

No direct link has been found between practice in this case and Nathan's very sad death. However the review has noted a number of points that are worth reflecting upon.

14.1 Child safety

In this case, Nathan was offered a number of services which he declined or quickly dismissed. At the same time, his behaviour appeared to deteriorate when he was fourteen to a point where he was regularly stealing, mitching from school and staying away from home overnight. His mother was clearly expressing her inability to manage him and it appeared that nobody in his life was able to exert the sort of authoritative parenting that he required. In hindsight, it appears that a lot of responsibility was left to his mother who, although supported by her partner and a number of practitioners, clearly had difficulty in enforcing boundaries or modifying his behaviour. Notwithstanding the difficulties experienced by the SWD in engaging him, a young person of his age required intervention and it would seem that at the very least, a child protection conference could have been held to consider how his safety needs might be addressed. There were a number of services for adolescents in the area; Nathan was clearly a resourceful young person and a sharing of ideas may have proved creative.

It is notable that when Nathan's whereabouts became known to the SWD after his suicidal behaviour, no Garda checks or assessment was carried out on the person who had, under the law,

become his private foster carer. As Social Worker 2 pointed out, Nathan found his own resource in the community. However, for all anybody knew, he could have been in very risky circumstances at this time.

14.2 Activation of cases in the absence of the key worker

The review has noted the staffing difficulties in the area and the problem this created when Social Worker 1 went on maternity leave and while we are sympathetic to this, it necessary to point out good practice norms. The learning here is that the absence of new referrals in respect of an open case should not be taken as grounds for assuming that the child or young person concerned is safe and well. Open cases should be pro-actively as well as reactively managed. The actions required in closing a case would possibly have brought his circumstances to light.

14.3 Child centeredness

The review has already referred to the fact that no service worked directly with Nathan for any significant period and has acknowledged that he deliberately avoided engagement. It is not uncommon to find young people uncommunicative, particularly if they are troubled by past events or have suffered trauma. It is also not unreasonable to work on the basis that certain professionals are better placed to elicit the trust of a young person and in this case the proposal for a youth advocate to work with Nathan was a rational and constructive response. However, the fact that despite the presence of a number of services for young people in the area, nobody actually worked directly with Nathan when he was in his early teens can only be described as inadequate. The fact that no service was directly linked with Nathan meant that once Social Worker 1 became unavailable, concern about him virtually evaporated until he came to attention again.

This fact does not appear to have been highlighted or have elicited a great deal of concern while the case was open. A member of staff who was interviewed by the review team suggested that training should be available on the topic of working with young people who are difficult to engage. It is also necessary for social work teams to be constantly aware of the challenges involved in such cases and to make conscious efforts to find innovative ways of overcoming them. For instance, a deliberate decision was made the second time around to allocate a male social worker to Nathan and in fact, Social Worker 2 managed to have two meetings with him fairly quickly after taking on the case.

14.4 Working with families

There is a lot of evidence on file and from interviews about the efforts made by Social Worker 1 and other professionals to use opportunities to work with Rose and her husband while they were open to it. There was clearly a gap between the expectations of the family and the service that could be

provided. Later there was a gap between the expectations of Nathan's close relative and what the service was able to provide. It is worth considering how services can attempt to mediate with service users to reach a mutual understanding in spite of the predictable tensions that so often prevail.

The review has noted that Rose was not contacted by the SWD until three months after Nathan's death, despite their involvement at the time.

14.5 Teenage suicide

Ireland has the fourth highest youth suicide rate in the EU. The cohort of young people most at risk are those linked with the child protection, youth justice systems and mental health systems. Social work team members told the review of their determination to have training in suicide prevention for all staff on their team. The review endorses this intention and sees this as a learning point for not just this area but all services working in child protection and welfare.

15. Recommendation

Given the worrying level of youth suicide, in-service training on an accredited suicide prevention programme should be provided as a matter of course to social workers.

Signed: Date:

Dr. Helen Buckley

Chairperson, National Review Panel