NATIONAL REVIEW PANEL

Review undertaken in respect of the death of a child known to the child protection system: Dara

June 2013

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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

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 and recommendations. When the HIQA guidance was developed, it was envisaged that the National Review Panel (NRP) may need to review up to two deaths per annum and three to five serious incidents. However, during the first six months of the operation of the NRP, the numbers of notifications considerably exceeded expectations. As a consequence, and in an effort to deal with the demand for reviews, the NRP proposed that reviews should be differentiated into different levels, as follows:

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

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

Concise review: to be held **w**here 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 and consultations with staff and family members for clarification. The output should be a summary report with conclusions. 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. HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death or Serious Incident

This review was carried out in respect of a child here named Dara, who died while living with her parents. She had never been in care, but was known to the social work department in her area where she resided. She was living with her family at the time of her death.

5. Level and Process of Review

This was a concise review as the involvement of the HSE Services in this case was of relatively low intensity over a medium-term period. The review team comprised three members: Ms Leonie Lunny (chair of the review team), Dr Ann McWilliams and Mr John Brosnan. This review covers a period of approximately three years prior to Dara's death.

For the avoidance of doubt, where the review team has described the circumstances of any person mentioned in this report, the review team has based those descriptions on information contained in the relevant records furnished to the review team or on information provided to the review team during interviews conducted as part of this review. The review team is not to be taken as expressing any view on the veracity or otherwise of any such item of information.

The review team read the HSE social work file and compiled a chronology of contacts between Dara's family and HSE Children and Family Services.

The review was delayed due to its initial inability to obtain the written records held by the family support agency. The agency was of the view that its contractual agreement with the family prevented them from sharing written records, and that to do so would breach confidentiality. Legal advice to the National Review Panel confirmed that the contract between the HSE and the agency

did not specify any obligation on the agency's part to share records with the HSE.[1] The review team ultimately secured permission from Dara's parents for written information on them held by the family support agency to be shared. The agency declined to provide copies of the records to the review team for their own use, but allowed them to view the records in the agency. This did not take place until after all but one interview had been completed and delayed the whole process by many months.

A page from the original HSE file which was not included in the review team's file was provided to the team at a late date. It raised the question whether other documents were missing from the file. The review team noted that neither the HSE nor the family support agency had sealed their files immediately following the death of this child.

Seven HSE Children and Family Services personnel were invited and attended for interview. They held the following posts during the period under review: acting HSE general manager, child care manager, team leader A and B,[2] and social worker A, D and E. Other than the child care manager and Social Worker A, each of them took up the invitation extended to all invitees to submit a written statement prior to interview. The clinical director from the local HSE Child and Adolescent Mental Health Services (CAMHS) attended for interview. The review team also interviewed a senior manager, manager and family worker (who attended together) from the "family support agency" and the Principal and Vice Principal of Dara's primary school (who also attended together). The team members met with Dara's parents. Each interview was audio recorded and subsequently transcribed. The transcripts form part of the record considered in the review. Statements were requested and received from Dara's GP, a clinical nurse manager from CAMHS and a HSE family support co-ordinator.

A report was requested from an acting principal social worker who had no direct contact with the family but was in the area at the time referrals were made. No report was received from this worker.

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[1] HSE Children and Family Services has undertaken to modify service level agreements in the future to ensure that records must be shared with the HSE by any service funded by it.

[2] One of the two team leaders - Team Leader A - was assigned as acting principal social worker at times during the review period.

6. Terms of reference

The review was undertaken with the following terms of reference:-

- To establish the roles played by the HSE and HSE funded agencies in relation to Dara prior to her death.
- To review the services provided by the HSE and HSE funded agencies to Dara, in the context of compliance with
  - Existing legislation
  - Policy directions
  - Key professional standards and practice
- To consider issues of interagency and intra agency cooperation and communication
- To prepare a report for the HSE which
  - Identifies opportunities for learning from this review
  - Makes recommendations

7. Dara

Dara was described as a very pleasant, 'lively', 'bubbly' child who 'loved life' but 'was growing up too fast'. She loved animals. She had at least one close friend and was also friendly with her peers at school.

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

Dara's family was referred a number of times to the HSE Children and Family Services prior to the period under review. These referrals related to concerns about her mother's mental health, misuse of alcohol and allegations of domestic violence in the family. During the three years prior to Dara's death, the referrals focused on Dara's poor attendance at school, her vulnerability due to mixing with an older age group, her consumption of alcohol and her self-harm.

9. List of services involved

(1) The HSE Children and Family Services had received referrals beginning in the mid-1990s but had limited engagement with the family.

(2) The primary school which Dara attended.

(3) A family support service provided by a voluntary organisation to which Dara had been referred by the primary school. This service had worked with her parents for nine months and had worked with Dara for four months prior to her death.

(4) The Gardaí who made two notifications of suspected child neglect and had contact with the family.

(5) A hospital to which Dara had a crisis admission.

(6) HSE Child and Adolescent Mental Health Service (CAMHS) where an initial assessment had been undertaken.

(7) Educational Welfare Service, to which Dara had been referred by the school.

(8) GP, with whom Dara had limited contact.

(9) HSE Adult Mental Health Services, Dara's mother was a patient of this service.

(10) General hospital where Dara's mother was an inpatient on a number of occasions.

(11) HSE family support coordinator who visited the family on one occasion but whose service was not accepted.

10. Summary of Child's needs throughout the case career

There was no formal assessment of Dara's needs undertaken by either the HSE Children and Family Social Work Service or the family support agency.

10.1 Physical Appearance and Development

Dara is described as of being of average height, of slim and petite build. She presented as a lovely, attractive pleasant young child. Her health was generally good but there was some concern that she was underweight a few months prior to her death. An assessment of her diet and weight had been planned by CAMHS.

10.2 Emotional Needs

There was no formal assessment of the quality of the relationship between Dara and her parents. Dara was exposed to her parents' conflictual marital relationship and her mother's mental health and alcohol problems. Dara showed some evidence of self-awareness about her own vulnerability as she confessed to her family worker some weeks before her death that she was frightened and didn't know what was going to happen to her. Dara revealed that she wore make-up in order to hide herself and she seemed to have a low-self-esteem.

10.3 Educational Needs

Dara attended the local primary school. The school described her educational ability as good but negatively affected by her poor attendance. She had missed the roll call for more than 330 school days over a seven year period which led her to being marked absent, although she sometimes arrived later in the day, often arriving as late as mid-day. Her non-attendance was becoming increasingly problematic and a routine had been established that Dara was expected to check in at the school office every day when she arrived in school. The school reported that they usually phoned her parents in the morning if she did not arrive in class and then she would often arrive later in the day. The school encouraged her to come into school every day even if she was late as they believed that this provided some structure and routine for Dara and they "wanted to see … she was okay." The educational welfare service was involved due to her poor attendance and visited the family home on at least two occasions. Dara also received learning support. She frequently did not complete her homework and did not always complete tasks in school.

The school described her as a bit cheeky at times, but she was not difficult or withdrawn. She related politely to staff but appeared to pay little or no attention to the rules; this was particularly evident in her persistent wearing of make-up to school each day even though she was made to remove it before she could join the class.

10.4 Health Needs

Dara generally appeared to enjoy good health and had limited contact with her GP. There was some concern that she was underweight and this was due to be followed up. She was admitted into hospital six weeks before her death, due to an incident of alcohol misuse. She was seen by a psychiatrist in hospital who formed the impression that she had been depressed for four weeks but more so in the previous two weeks. Dara was assessed as needing urgent follow-up both by the local CAMHS and social work service.

On assessment by her local CAMHS three days later, Dara was assessed as being vulnerable and engaging in risk-taking behaviours such as deliberate self-harming, alcohol misuse, staying out late, looking as an older teenager due to appearance and behaviours. However, she was not found to be clinically depressed at that time.

10.5 Safety and Protection Needs

Social workers who visited the home described it as tidy and comfortable. There did not appear to have been many family routines in place such as a regular rising time, bedtimes or mealtimes. Her parents seemed to have had difficulties setting appropriate boundaries in order to protect her. Dara is reported to have engaged in inappropriate and risky behaviours and liked to spend time with older teenagers, mostly males.

11. Chronology of contact by HSE Children and Family Services

11.1 Pre-Review Period

Dara's family was referred to HSE Children and Family Services on a number of occasions in a period of nine years. The referrals came from a number of different sources. From the files it is difficult to be precise about the exact number of referrals but there were at least five different periods when referrals were received. The referrals related to her mother's mental health and misuse of alcohol, her parents' marital difficulties and allegations of domestic violence by both parents. Social workers met with Dara's parents and there were contacts with the public health nurses, the family GP, a community psychiatric nurse and the Garda Síochána. Social work files were closed when one or both of the parents declined support or did not engage and social workers were satisfied that there were no child protection concerns. At the time of the last referral in this period, a social worker recorded that it was "highly likely that the children are very aware of the stress and tension in the household" and that it was "very difficult to address the issues when the family so adamantly denies them." There were no referrals in the period of three years immediately prior to the period under review.

11.2 Period of Review

<u>11.2.1 Garda Notification/Hospital Referral</u>

This review covers a period of approximately three years prior to Dara's death. The first contact with child protection services during this time was when the Garda Síochána sent a notification of suspected child neglect to HSE Children and Family Services after Dara's parents had engaged in an

argument at a shopping centre. Six weeks later, a hospital sent a referral to the Social Work Department after Dara's mother had an emergency admission due to mental health and alcohol issues. The children were at that point living with relatives. Social Worker A made telephone contact with the Gardaí and the hospital while Dara's mother was still an in-patient. There is no record of further action, however, until fifteen months later when the social work file was retrieved from an "Awaiting Information Drawer" as part of a review of outstanding cases, which, Team Leader A said, had been agreed with the acting principal social worker. Team Leader A directed that the file be closed due to the length of time that had elapsed since the referral came in and no further referral had been received in the interim.

11.2.2 School Referral to Family Support Agency

In the month following the closure of the social work file, Dara's school made a referral to the family support agency stating that she had missed 330 days in seven years. Eight weeks later, the agency offered places to Dara's parents on a parenting group but these were declined and the family went on a waiting list for a family worker. A further eight weeks later, the agency offered two dates for a referral meeting with a family worker but neither was taken up.

11.2.3 School Referral Children and Family Services

Three months after its referral to the family support agency, the school made a referral to HSE Children and Family Services expressing concerns about Dara that included: her keeping older company, her parents not appearing to know where she went or who she was with, wearing heavy make-up to school and poor school attendance. Social Worker A wrote three weeks later offering a home visit to Dara's parents in two months' time. The visit was undertaken by Social Worker B who stressed the importance of supervising Dara, advised her parents that they should maintain contact with her school, and urged them to link with the family support agency which could provide parenting support. Dara was not present at that meeting. On the following day, Social Worker B wrote to Dara's parents advising that the social work file was being closed and repeating the advice given to them at the meeting.

11.2.4 Attendance at the Family Support Agency

Later that month, Dara and her parents attended two referral meetings at the family support agency. While the agency staff said at interview that they did not undertake a formal assessment, they identified significant needs in the family. The conflict between Dara's parents was highlighted as a problem, as well as communication difficulties and poor routines at home. The agency decided

that work should begin with the parents to help support more positive communication at home and assist with parenting skills. Dara's parents agreed to this and it was decided that Dara would be offered an intervention after this work was completed. Dara had indicated at the referral meetings that she would prefer her own space to talk and would prefer individual sessions. The plan as outlined in supervision was that the parents would be offered eight sessions and then individual work would begin with Dara. In the meantime, the agency made a referral for Dara to a local youth service but this was not accepted as she resided outside the catchment area.

The agency worked with Dara's parents for sixteen sessions over a nine month period. A further eight appointments had been offered during this period, and were either missed or cancelled.

The focus of the work for the first five months was on supporting more positive communication and enabling Dara's mother to re-establish her links with the adult mental health service. There was also a focus on the parents' use of alcohol and the impact of this on Dara. During one session, the parents disclosed that Dara had been found intoxicated and that her mother had taken her home and sobered her up. Two months later, Dara's parents requested a direct intervention for Dara from the family support agency. This issue was discussed subsequently in supervision but no service was offered to Dara at that point.

Towards the end of the ten-month period, Dara's school made a second referral to HSE Children and Family Services but this was not accepted by Social Worker A because the concerns raised were regarded as educational in nature.

The penultimate session of the work with Dara's parents was a review of the work with them. The family support agency considered that they had made sufficient progress for work to commence with Dara. The family worker offered her appointments on a weekly basis. Over a four month period, she attended eleven of the total of eighteen appointments offered.

11.2.5 Agency Referrals to HSE Children and Family Services

On the day of Dara's ninth appointment, which she did not attend, her father phoned the family worker saying that she had not gone to school and he was worried about her because he and his wife did not know where she was. The family worker phoned Dara's father the next day. He said that Dara had returned home at 11pm on the previous night and he thought she had been drinking.

Concerned about these developments, the family support agency arranged a family review meeting for the following week involving Dara and her parents.

At the review meeting, Dara's parents raised further concerns about her. They said she had been skipping school, coming in late and spending time with an older peer group who had been engaging in risk-taking behaviour. Both the family worker and her manager observed that Dara did not look well at the meeting. She was wearing heavy make-up, appeared thin and looked tired.

Following the review meeting, the agency sent a referral to HSE Children and Family Services about Dara's presentation as an older teenager, her underweight appearance, low self-esteem, school's concerns about her attitude and behaviour; her use of alcohol and possible sexual activities; and her parents' concerns that they felt unable to manage her and that her safety was at risk. The referral expressed the view of the family support agency that Dara's family urgently required "an intervention to address the child protection concerns as highlighted" It also raised a specific concern as to Dara's safety over the summer months when she would have longer periods of time during which she would not be under parental supervision. Duty Social Worker A replied two days later that it was not intended to pursue the referral as there did not appear to be any specific child protection concerns in relation to Dara.

Four days later, Team Leader B learned of Dara's case at a meeting with the manager from the family support agency. Team Leader B had been assigned to the duty social work team for just over a month having previously served as duty team leader in another area. On return to the office, Team Leader B reviewed Dara's file noting that there had been "7 previous referrals" and that Dara had not been seen. Team Leader B decided that her case needed to be allocated to a social worker and a full initial assessment undertaken. However, Team Leader B told the review team that it had not been possible to allocate the case at that time because of other more immediate demands on the duty team pending the assignment of additional social workers from an agency.

Three weeks after its initial referral was declined, the family support agency sent a second referral to HSE Children and Family Services after Dara had attended a scheduled appointment with the family worker. Dara was accompanied by her father who was very worried about her. The referral advised that Dara had been drinking heavily during the week, was feeling extremely stressed at home and was engaging in self-harm. Social Worker B told the family worker on the following day that the agency's concerns would be brought to the attention of Team Leader B.

11.2.6 Hospital Admission

Within a week of Dara's latest session with the family worker, a hospital made a referral to HSE Children and Family Services about her crisis admission by ambulance late at night. At the hospital, Dara admitted to drinking beer and vodka on the night and to having been drinking heavily for the previous two weeks. She had fresh laceration marks on her left arm and admitted cutting herself on four recent occasions. Dara said she had been very upset because she was not allowed to see Boyfriend A anymore. The relationship had ended after Dara's father, concerned about their age difference, had visited the boy's home and spoken with his family.

The impression of the psychiatrist on call was that Dara had been depressed for about four weeks but more so in the previous two weeks. He believed that Dara should be kept in hospital overnight for follow-up by the multidisciplinary deliberate self-harm team but she was discharged by her parents against medical advice. Three days after Dara's discharge from hospital, she attended a follow-up appointment at her local HSE Child and Adolescent Mental Health Services. The Services diagnosed that she did not have a psychiatric illness and did not present as a risk to herself or others. A further appointment was offered for two weeks hence.

The family support agency was concerned about Dara's immediate safety during the week of her hospital discharge and made contact with HSE Children and Family Services. One concern expressed by the family support agency specified the high quantity of alcohol being consumed by Dara on a regular basis. When Social Worker C visited the family home on the Friday afternoon and did not receive a response, she spoke with the team leader who arranged for the Gardaí to visit over the weekend. The Gardaí visited the family home, saw Dara, and had no concerns to report.

11.2.7 Allocation of Dara's Case

There were a number of developments in the following week. On the Monday, two newly-qualified agency social workers, D and E, were assigned to the duty social work team. On Tuesday, Dara attended a session with the family worker. This was the fourteenth appointment offered to Dara and the eighth she attended. She was accompanied by her new boyfriend, Boyfriend B. Dara said he had helped her out on the night of her admission to hospital and had helped her to stop drinking alcohol. She identified him as a positive influence. On the Wednesday, Team Leader B allocated Dara's case to Social Worker D and recorded a three-point action plan to: meet with the family and Dara, liaise with all agencies, and set up a meeting with all agencies to formulate a plan. On the same day, the Gardaí, who attended Dara's home on the night of her emergency admission to hospital, sent a notification of suspected child neglect to HSE Children and Family Services.

On the Friday of the same week, Social Worker D wrote to Dara's parents offering a home visit for the following Thursday. This was rescheduled for a further four days later at the request of Dara's father.

11.2.8 Home Visit

Social workers D and E met with the family in their home. Each of the family members was present for at least some of the visit. In the course of a long and comprehensive interview, the two social workers explored the various concerns that had been raised in the referrals to the duty social work team. Dara said that she had not drunk alcohol in the previous two weeks; her mother said that Dara's self-harming had stopped at the time she began seeing her new Boyfriend B.

Three days later, a HSE family support co-ordinator, who had been contacted by the family support agency, called to Dara's home to offer support in getting Dara to school. This service was declined by Dara's mother and Dara.

11.2.9 Professionals' Meeting

A week after the home visit, Social Worker D was assigned to another team and Team Leader B allocated Dara's case to Social Worker E. Three days later, Social Worker E represented HSE Children and Family Services at a meeting of professionals hosted by the family support agency. Also present were the manager and family worker from the family support agency and two representatives of the local CAMHS. The professionals shared their information/perspectives on Dara's case including the fact that Dara was seeing Boyfriend B and that there was a suggestion that he was much older than her. The professionals agreed further contacts with Dara and her family before meeting again in four weeks. It was intended to have a representative of HSE adult mental health services at the next meeting.

Following the meeting, Social Worker E briefed Team Leader B. They agreed an action plan that envisioned:

- A further home visit by Social Worker E to discuss Dara's relationship with Boyfriend B, including his name and age; support for Dara; and her mother's engagement with HSE Adult Mental Health Services.
- Contact with HSE adult Mental Health services, the family GP and a HSE family support coordinator who had visited Dara's home after contact from the family support agency.

- Consideration of a supervision order and referral to a family welfare conference or child protection case conference.
- Preparation of an initial assessment.

Social Worker E spoke with Dara's father by phone and agreed a home visit for eleven days later; the earliest date on which he could be present.

Dara attended for a one-to-one session with the family worker five days later. She presented in a positive mood but somewhat closed in her responses. Dara said she had broken up with Boyfriend B and that he had taken it badly and she was worried about him. She said that she had been drinking again that week but felt she was more in control.

HSE Children and Family Services was informed of Dara's death on the eve of the intended home visit.

12. Analysis of involvement of HSE Children and Family Services

12.1 Response to Referrals

The review team was informed that there was a high number of referrals and a range of management and staffing issues during the review period. The review team acknowledges that these pressures resulted in the duty team adopting a crisis management approach that involved a high threshold for response and delays in responding to referrals that did not demand immediate attention. This analysis must be considered in this context. At the beginning of the review period, the Garda Síochána had sent a notification of suspected child neglect in respect of Dara and her sibling and a general hospital had made a referral about six weeks later after a crisis presentation by Dara's mother. Although Social worker A made initial contacts with Gardaí and hospital staff, the social work file remained inactive i.e. no action further action was initiated by the SWD and no further referrals were made concerning the family during the following fifteen months while the file remained in an 'Awaiting Information Drawer'. It was then closed by Team Leader A as part of a review agreed with the acting principal social worker. This response is considered by the review team to be inadequate. Lack of contact or failure of families to engage are not positive indicators of a child's safety or welfare and should not be used as justifications for no further action.

The first referral specifically relating to Dara was from her school to the family support agency. The agency decided to work first with Dara's parents. The review team was satisfied that some of the presenting issues, such as the conflict between Dara's parents, communications difficulties and poor routines at home, were addressed. However, the review team was concerned that a specific intervention for Dara was not put in place until seventeen months after the date of the school's referral. During this time, Dara's school made two referrals to HSE Children and Family Services. The response to the first of those was a home visit by Social Worker B that elicited positive undertakings from Dara's parents to address the school's concerns and engage with the family support agency. Dara was not seen by the social worker. The second referral was not pursued by HSE Children and Family Services because the concerns it raised were regarded, appropriately, as educational in nature.

Three months later, Dara was referred by the family support agency to HSE Children and Family Services. This was about two months after she began individual sessions with the family worker. The written response by Social Worker A indicated that the referral was not being pursued because there did not appear to be any child protection concerns. This response failed to appreciate the significant risks to a child that were outlined in the letter. The response was set aside within days as Team Leader B noted that there had been seven previous referrals but the child had not been seen. At interview with the review team, Team Leader B said that existing caseloads prevented allocation of Dara's case before additional social workers became available to the duty team. There were other cases that demanded more immediate attention but nonetheless Team Leader B categorised it as high priority for allocation. While this resulted in a delay in addressing Dara's needs, the review team was satisfied that Team Leader B acted properly in allocating cases on a priority basis and noted that Dara's case was allocated promptly on the assignment of additional agency social workers to the duty team.

There were two further referrals in the month during which Dara's case was on the waiting list for allocation to a social worker. The first was a child protection notification from the family support agency raising further concerns about Dara's drinking, self-harm and family circumstances. A week later, another referral from a hospital advised of Dara's crisis admission after ingestion of alcohol and laceration marks on her left arm. Following her discharge from hospital, the family support agency requested a safety plan be put in place. The HSE Children and Family Services responded promptly in organising a home visit but, as there was no response, the social worker appropriately requested the Gardaí to call over the weekend.

The review team saw first steps towards organisation of a strategic, multi-agency response for Dara with the allocation of her case to a newly arrived social worker and the preparation by the team leader of an appropriate action plan. This led to a home visit that was comprehensive in nature. Ten days later, there was a professionals meeting hosted by the family support agency. At interview, the social workers and other professionals believed that these had been positive developments in response to Dara's situation. The review team concurs with this view.

Following the meeting, Team Leader B prepared a plan identifying clear actions to be taken by the HSE Children and Family Services. The first action item on the list was a further meeting with Dara's parents. The review team considered that these were appropriate steps in organising a response to Dara's situation.

12.2 Assessment

The family support agency received a referral from the school approximately a year and a half into the review period. There was a six-month delay in allocation due to a high level of demand and the family's inability to attend. Although Dara was seen with her parents on two occasions in the initial stages, no formal assessment of her needs appears to have been carried out. A further ten months passed before Dara was eventually seen.

It was the opinion of the review team that, given the unique circumstances of individual children and families, the absence of formal or comprehensive assessment of a child's needs challenges the ability of the service to operate in an evidence based and child focused manner. An effective assessment promotes the likelihood that interventions will be tailored to the specific issues that require to be addressed.

An assessment of risk in relation to Dara's mental health was undertaken when Dara was hospitalised and this was followed by a further assessment by CAMHS three days later. This response was appropriate and timely.

The review team considered that the meeting of professionals hosted by the family support agency contributed useful information in terms of completing both an initial and comprehensive assessment in the future.

The HSE did not undertake an initial or a comprehensive assessment. An initial assessment was to be completed following allocation of the case to a HSE social worker but Dara was deceased before

it could be carried out. The delay in carrying out at least an initial assessment is considered an inadequate response.

12.3 Compliance with regulations

The version of Children First that was operating at the time stated in 8.10.1 that all child protection concerns must be followed up as soon as possible and Chapter 9 provided a protocol for joint Garda/HSE working in investigating reports of child abuse.

In this case, there were two notifications of suspected child abuse (neglect) from the Garda Síochána to HSE Children and Family Services. There was a six-week time lag in the HSE response to the first Garda notification. The response appears to have ended at initial enquiries made by a duty social worker with the notifying Garda.

The second Garda notification related to the circumstances of Dara's crisis admission to hospital. HSE Children and Family Services arranged for the Gardaí to visit Dara's home after her discharge from hospital but there is no evidence of collaboration between the services in regard to the notification which was sent by the Garda Síochána in the following week.

A child care manager told the review team that Children First was not formally implemented in the area by HSE Children and Family Services but that local policies and procedures were operated in line with Children First. The review team was informed that there were no records held in the child care manager's office detailing any follow-up by that office in this case. The review team considers that the procedures in the child care manager's office in respect of this case were inadequate.

12.4 Quality of Practice

12.4.1 Interaction with child and family

The principal service involved with Dara and her family was the family support agency. It is noted that Dara and her parents missed over one third of the appointments offered to them. Missed appointments are disruptive of therapy and wasteful of resources. A question could be raised about the efficacy of office based, as opposed to home based, appointments when a family clearly lacks motivation and there is a high risk of 'no shows'.

The review team noted that there was a long delay before the family support agency offered a direct service to Dara. Her parents had requested this service midway through their ten month

attendance at the family support agency. This was discussed in supervision but it was decided that the service would not be offered to Dara until her parents completed their parenting programme. There was evidence of a good working relationship being established with Dara in her sessions with the family worker. The review team noted that there was a considerable delay in carrying out a review of work with Dara's parents.

There was very limited interaction between the HSE Child and Family Services and Dara's family. Only two interviews took place in the period under review. The first took place three months after the referral from the school. The review was informed that the reason for the delay was due to the large number of referrals on hand and the lack of resources available to respond within a more acceptable timeframe. There was some discussion prior to the visit about Dara's participation in this meeting but it was suggested that she should attend school given that her attendance was causing concern.

On this visit, Social Worker B appeared to address the concerns appropriately and agreed an adequate plan with Dara's parents in that they said they would be vigilant in supervising their daughter's whereabouts and ensure her attendance at school and at the family support agency. However, further information gleaned during the interview indicated that Dara was drinking alcohol and smoking even though she was still a young child. No contact was made with the school or with the family support agency to follow up these matters, which were indicative of inappropriate and risky behaviour; nor was Dara's perspective on the issues sought. The review team regards these deficits as breaches of good child centred practice.

The second interview took place following the arrival of Social Workers D and E who were recently qualified. This was the first time that Dara had been seen by a HSE social worker, although she was not interviewed alone. All the members of the family were seen for at least part of the time and the review team considered that all the pertinent issues were addressed.

12.4.2 Recording

There was some evidence of good recording in the HSE files in that the two home visits were recorded in some detail and Social Worker E wrote a detailed record of the professionals' meeting. However, there was no agreed procedure at that meeting for minute taking.

There was also evidence of poor recording. For example, following the referral from the family support agency prior to Dara's hospital admission, the intake record completed by a Social Worker A omits several key risk factors that were present in the referral letter.

There was evidence of structured recording in the family support agency in both the individual case notes and the supervision notes. It was noted by the review team that there was no record in the case notes of the quantity of alcohol consumed by Dara as outlined in correspondence to the HSE.

12.5 Management

The picture that emerged from interviews with staff from HSE Children and Family Services was one of a service under very serious pressure. Factors believed to have contributed to this situation were a very large increase in referral numbers due to demographic changes in the area and serious issues about staffing. A general manager, a child care manager, an acting principal social worker and a team leader who had worked in the area all highlighted the issues of staff shortages, vacant posts left unfilled and posts filled on an acting-up basis throughout the period under review. The posts of child care manager and principal social worker were not filled permanently for most of the period covered by this review. One person was appointed as acting principal social worker and acting child care manager and, for a part of this period, they also fulfilled their role as team leader, and helped with duty on occasion. At interviews, the review team was informed that information about pressure on the duty system, unallocated cases, staff vacancies and acting up positions was conveyed to senior management.

12.5.1 Duty

The duty team consisted of two teams of four workers each. One team of four handled referrals and did the initial assessment and the other four undertook further work if required. Eventually, if required, these cases were passed to the long-term team. It was reported that there was a high rate of referral to the duty team. According to Team Leader A, it was not unknown for the duty team to have cases awaiting allocation for over two years. Team Leader B said that at one point the duty team had 690 cases involving individual children open to them and they were getting seven referrals a day. The difficulties appeared to be the high volume of work, insufficient staff and blockages that did not permit the allocation of cases to the long term team. The two team leaders described very similar situations at interview. Both of them spoke of stacks of files in a filing cabinet and in boxes awaiting a response.

Dara and her family experienced the consequences of this understaffed, overburdened and blocked duty system. The system resulted in the social work file being left in a drawer for fifteen months at one point and, on another occasion, a delay of three months in undertaking a home visit to the family. There were occasions when a referral was not considered appropriate and where files were closed by a duty worker without discussion with the team leader.

The duty team did not have any formal assessment system for new referrals. Team Leader A said she relied on the judgement of a very experienced team of workers. The review team considered that the absence of an assessment system for new referrals resulted in Dara receiving an inadequate service. When Team Leader B was appointed she found that there was no clear assessment process or framework and she worked with the team to develop an agreed approach.

12.5.2 Supervision

Team Leader A told the review team that she provided supervision to the duty team. However, the first record of supervision made available to the review team was the initial direction provided by Team Leader B some months before Dara died. Following a meeting with the family support agency, Team Leader B set out an action plan that was updated on the assignment of Social Workers D and E to the duty team and following the professionals' meeting.

There was evidence of regular supervision in the family support agency, although the review team noted evidence of an inconsistency in one record which does not correspond with the case notes and record of attendance.

12.5.3 Interagency collaboration,

The evidence from the records and interviews was that for most of the period under review there was poor interagency collaboration between the HSE and the family support agency. The origin of this may have related to different interpretations of the necessity for intervention and the threshold of risk. The family support agency was very frustrated by this but may not have been aware of the volume of referrals to the duty team and the poor staffing situation. The review team believes that there were also different expectations held by each organisation about the other and a lack of mutual agreement about responsibilities.

There was one interagency meeting. This meeting was called by the family support agency and attended by representatives of three agencies. The family was not invited to attend this meeting and the review team considers that this was appropriate at that point. Newly appointed Social

Worker E attended on behalf of the HSE. This social worker appeared to cope well but it must have been quite a challenge for a newly qualified worker to represent the child protection interests of the HSE at such a meeting. Team Leader B was unable to attend due to court commitments.

13. Conclusions

This review of the role of the HSE and HSE funded services has highlighted a number of shortcomings in practice and structures. While no action or inaction on the part of the HSE contributed to the death of this child it is important to set out the deficits in service.

- The review team concluded that there was a lack of individual focus on Dara by both the HSE Children and Family Services and the family support agency until some months before her death. This is linked with the absence of formal assessment of her needs by either the family support service or the HSE.

- The review team was impressed by the support provided to Dara by the staff at her school, who demonstrated a high level of concern about her, and were willing to go to great lengths to maintain her attendance.
- The review team was given convincing evidence of the limited capacity within which the statutory social work service was operating at the time that Dara and her family were referred to them partly due to the changing demographics in the area. There were significant staffing issues in the area that impacted on this case. The review team had the impression of workers being totally overburdened and concluded that this contributed to the significant delay in responding to referrals about Dara and her family at various times. It is likely that it also influenced the ill-considered rationale applied to the closure of the initial referral in the period under review and the high thresholds applied to subsequent reports.

- The review team concurred with the view expressed at interview by social workers and other professionals that Dara's case was not one requiring a high priority response in the period immediately prior to her death as Dara was not seen to be in any imminent danger and the first steps had been taken towards the organisation of a strategic multi agency response to meet her needs.

- Notwithstanding the above constraints on the service, the review team also noted the absence of any written policy at national, regional or local level in relation to prioritization, allocation or initial assessment of cases in the intake team.

- Management weaknesses at a local level were evident in the case, for example, there was no record in the child care manager's office of any follow-up by that office to the two child protection notifications from the Garda Síochána.

- Management at regional level in this area also appeared weak and was demonstrated by the culture over a number of years of acting up positions, vacancies left unfilled, fulfilling multiple roles, i.e. social work team leader acting as principal social worker and as child care manager in addition to carrying, for a period, the responsibilities of the team leader post.

- Inter-agency relationships appeared to be strained between the statutory social work service and the family support service. These centred mainly on the mismatch between the child protection concerns being notified by the family support service and the thresholds being applied by the statutory service. Towards the end of the period under review there were indications of an improved working relationship between the HSE and the family support agency.

14. Key Learning Points

One of the key learning points to emerge from this review is the importance of focusing on the child who is the centre of concern and ascertaining her needs at the earliest possible stage, using an effective method of assessment.

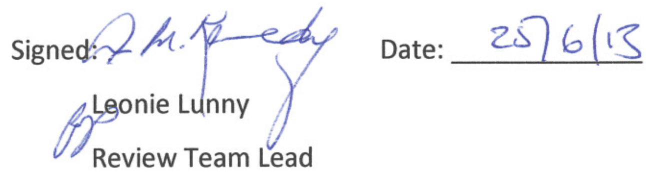
This case provided an example of the potential role of schools in supporting a vulnerable child. The school staff were consistently supportive to Dara.

The number of missed appointments with the family support service highlights an important issue and demonstrates that where service users are reluctant to engage with either family support or statutory child protection services, some motivational strategies will need to be used. These may include a more flexible and mutually agreed method of service delivery.

15. Recommendations

- In the current context, where it is envisaged that community organisations will play a stronger role in child protection and welfare service delivery alongside statutory services, it will be important to have protocols in respect of mutual expectations. These should consider and agree the thresholds at which the statutory services will become involved.

- Increased demand and pressure on resources make it imperative that management at national level provide policy and guidance on assessing and prioritizing cases to ensure the best possible outcome for children and their families.



Signed: Date: 25/6/13

Leonie Lunny

Review Team Lead

Signed: Date: 25-06-2013

Dr Helen Buckley

Chair, National Review Panel