Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of the death of

Brendan

A young person known to the then HSE

Child and Family Service.

April 2016

1. Introduction

This review has been carried out in accordance with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* issued by the Department of Children and Youth Affairs in December 2014. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Children in care;
- Children known to the Agency's social work department or an Agency-funded service; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.
- In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:
- A child protection issue arises that is likely to be of wider public concern;
- A case gives rise to concerns about interagency working to protect children from harm; or
- The frequency of a particular type of case exceeds normal levels of occurrence.

2. National Review Panel (NRP)

A national review panel was originally established by the HSE (now replaced by the Child and Family Agency) 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 Child and Family Agency. When a death or serious incident fitting the above criteria occurs, it is notified through the Agency to the office of the Director of Quality Assurance and from there to the NRP. The Chairperson of the NRR decides on the eligibility of the case for review, and the level of review to take place.

3. Levels of Review

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, conclusions, key learning points and recommendations. Depending on the nature of the case, one of the following types of review will be conducted.

Major: to be held where contact with the Child and Family Agency 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 two 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: to be held where involvement of the Child and Family Agency 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, key learning points and recommendations.

Concise: to be held where the involvement of Child and Family Agency 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, key learning points and recommendations.

Desktop: 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 one panel member with oversight from the chair. 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, key learning points 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: 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.

This review was carried out by Professor. Helen Buckley, Chair of the NRP and Deirdre Mc Teigue panel member, both of whom are independent of the HSE and had no previous knowledge or involvement with Brendan.

4. Death of young person: Brendan

The young person who is the subject of the review is here called Brendan. He was aged 15 when he died. An inquest found that his death was self inflicted.

5. Level and Process of review

This has been conducted as a desktop review as the then HSE social work department (SWD) had been referred the case only five days before Brendan died. Neither Brendan nor his father had been met by the SWD although efforts were made to contact his father once additional information was conveyed four days after the initial referral. The methodology used was a review of the social work records, consisting of a small file. After Brendan's death, the SWD were involved in a community response to suicide and had contact with Brendan's father. Notes on this process were also available to the review.

6. Terms of Reference.

- To examine the response made to the referral about Brendan by his school.
- To indentify opportunities for learning from the findings of the review.
- To provide a report to the HSE with conclusions and recommendations

7. Details of young person

Because of the very short duration of the involvement of the social work department with this case, there is very little information on file about Brendan. It was known that his parents had separated. His parents had found his behaviour to be very challenging and he had recently moved from his mother's home to live with his father who had also found him difficult to manage. The records indicate that Brendan's behaviour was also causing some concern in school.

8. Services involved with Brendan's family.

- The secondary school Brendan had attended.
- The social work department
- The Gardaí, who looked for Brendan after he had been reported missing during the week before he died, and brought him back to his father.

9. Background and reason for contact with the social work department (SWD).

The files indicate that Brendan's behaviour had been a matter of concern for some time before a referral was made about him to the SWD. He had moved from living with his mother to his father three months previously because of a change of school. His father had contacted the school because of his worries about Brendan's possible involvement with drugs. The school contacted the SWD five days before Brendan's death conveying his father's concerns.

10. Summary of young person's needs.

Brendan died five days after the first referral was received by the SWD. It was known from the referral information that his father had difficulty in managing his behaviour. Further information provided a few days later indicated that problems had been ongoing for several weeks. His needs had not yet been assessed and the SWD made unsuccessful attempts to contact his father on the day before he died, to discuss options for him.

11. Chronology of contact between the HSE SWD and Brendan and his family

The first referral of this family to the SWD was made by the principal of Brendan's school five days before Brendan died. The principal told the intake social worker that Brendan's father had called to the school expressing concern about some carpentry equipment that he had found in Brendan's room, which had been stolen from the school and which he was returning. He had also reported

finding some glue in Brendan's room and was worried that he might have been sniffing it. The school principal told the duty social worker that Brendan had recently moved to the area to live with his father, having previously lived in a different area with his mother, and that he had not settled well. He went on to tell the intake worker that he had found that a sharp blade was missing from the equipment after it was returned. The duty social worker advised the school principal to contact Brendan's father to let him know about the missing blade, and also to inform him that he had made a referral to the SWD. The intake worker also advised the principal that the referral would be placed on a 'priority waiting list' and would be dealt with accordingly. The principal commented that both father and son would be open to support.

The next note on the social work record indicates that a different social worker returned a call to the deputy school principal four days later, as the duty social worker was dealing with an emergency. The deputy principal told the social worker that his father was now finding Brendan's behaviour difficult and had spoken to the school about this. The social worker told the deputy principal that the SWD would offer Brendan and his father supports and explore services that might assist them. She undertook to phone Brendan's father the same day and to offer him an appointment for the following week. The social worker subsequently tried to phone Brendan's father but her notes say that the phone was 'not connecting'.

A note, written after Brendan's death by the Area Manager, recorded a conversation with the same deputy school principal in which she alleged that when she was speaking to the social worker she had indicated that Brendan was 'running scared' and 'a risk of harm to himself'. However, these comments are not recorded in the social work notes, which appear to have been contemporaneous. Brendan died by suicide the following day.

12. Analysis of the response of the HSE Child and Family Services

As the time span between the first referral to the SWD and Brendan's death was only five days, this review focuses only on the initial responses made to two telephone conversations, the first one between the duty social worker the school principal following his discussion with Brendan's father, and the second one four days later between another social worker (acting for the duty social worker) and the deputy school principal.

During the first telephone conversation, the duty social worker advised the school principal that the case would be 'placed on a priority waiting list', which indicates that the SWD took the referral from the school seriously, although it is not clear what this response implied or what time frame would

operate before any further action would be taken. No other action was taken until the next phone call from the school, which provided some more background information and prompted the social worker to try (unsuccessfully) to contact Brendan's father with a view to arranging a meeting with him to identify some supports for the family. Both conversations were recorded in writing by the individual social workers involved, outlining the substance of the discussion and the intention of the social worker on the second occasion to contact Brendan's father to discuss services that might assist him. There was no mention in either record of the possibility that Brendan might self harm. Notes made following Brendan's death indicate the view of the PSW that the SWD would not have been offering a 'more urgent' response on the basis of the information known at the time.

Brendan's father had, during the week in which the two phone calls were made by the school, attended a talk on suicide which was arranged by the school. It is likely, therefore, that school staff were conscious of the potential for any pupil to take their life. It is not clear, however, how much the threat of suicide rather than a concern about Brendan's behaviour and possible drug use was conveyed by the school management during the conversations with the SWD. If the school was concerned that Brendan would take his own life, this was not the understanding recorded in the social work notes. What is clear is that the additional information provided during the second phone call moved the case from the 'priority waiting list' to one which would receive immediate attention. It was the intention of the social worker to offer an appointment to Brendan's father for the following week to discuss services that might assist, and she recorded her attempts to contact him. It clearly would have been more desirable for them to have been in a position to arrange to meet him immediately rather than the following week.

13. Conclusions

- The review concludes that given the circumstances and very brief time frame involved, no action or inaction on the part of the SWD was directly linked with Brendan's tragic death.
- The review raises the question of what services would be most appropriate to immediately meet the needs of young people whose behaviour is putting them at risk. From the records available in the case, Brendan's father had been having difficulties for several weeks before the school contacted the SWD and it is noted from the records that this referral was made without the father's knowledge. The social work service, while willing to provide advice and information, does not appear to be best placed to provide an immediate response while it is forced to function on the basis of waiting lists and appointments over the following weeks.

Recent statistical data published by Tusla indicates that the situation in this area is not unique.

14. Key Learning

It may be suggested that the Meitheal practice framework currently being introduced might be a more appropriate mechanism for getting early help to families in this type of situation but this would depend on the school and the family having awareness of the range of options available and knowing which was the most appropriate. The learning from this is the importance of school participation in community networks and the need to promote awareness of the different types of responses available to young people so that immediate action can be taken if a young person is judged to be at risk of self harm.

15. Recommendation

Consideration needs to be given, at a national level, to developing an appropriate professional response to young people at risk of harm from their own behaviour when such behaviour is either noted by or reported to a professional. If this is a task that could be addressed by Meitheal, it would be useful to publicise it as such.

Professor Helen Buckley
Chair, National Review Panel