Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review undertaken in respect of a death experienced by a young person whose family had contact with HSE/Tusla

David

Executive Summary

June 2019

Introduction and background

This review concerns the death following an assault of a young man, here called David, when he was 16 years of age. He and his siblings had lived with his mother up to her tragic death and had regular contact with their father, who lived nearby. David had been known to Tusla social work services for two years, having been first referred when his mother who had poor mental health and substance abuse issues, was admitted to hospital following an overdose. At that point, David had been expelled from school, had behavioural difficulties and was awaiting a CAMHS appointment. The case was categorised as 'welfare' and although initial records indicate that an initial assessment was to be conducted, a later note on the file recommended closure. Records from the Educational Welfare Service following a referral from David's school indicate that interventions were made by that service and home tuition was approved.

Two years later, the social work department was informed that David's mother had died. Contact was made with the social work department by a family member seeking support for the family. At that point, David's father was unable to care for his children and the extended family was involved, particularly an older sibling who was to be David's primary carer. Records indicate that an initial assessment was to be conducted but when a duty social had a follow up conversation with the same family member, she indicated that support was no longer required. The family member said that David was attending a bereavement counselling service and was due to start in Youthreach. The social work department then closed the file. Staff members informed the reviewers that the volume of referrals was high at the time and that a referral for initial assessment would have remained on a waiting list for some time. Therefore a decision was taken to close it as the family already had supports. Records from the PPFS (Prevention, Partnership and Family Support) service confirm that supports were to be set up for the family. David was described as being out of school, with recent involvement in low level substance abuse and anti-social behaviour which had become serious. He was living with a sibling and also stayed with friends.

Sadly, David died as a result of an assault five weeks after the events described above.

Review Findings

The review found that while the early response to referrals was timely and appropriate, the lack of follow up to the first referral meant that an opportunity to offer supports to the family at this early stage was missed. The response to the second referral was also adequate, but the reviewers are of the view that it would have been better practice for the social work department to seek further information and clarification of the supports available to David and his siblings, particularly in terms

of their day to day care, and it is noted that there was no contact by the social work department with either the children or their parents in response to either referral. It is acknowledged that the basis for a decision not to pursue an assessment at the time of the second referral was influenced by pressure of work in the area. It was not evident in the records that both the PPFS and the social work department were aware of each other's involvement in the case.

Review Conclusions

The review team acknowledges the loss experienced by David's family together with the impact of those involved in their care. It has reached the following conclusions:

- At the time of David's death, community based services had become involved with him and his family. However it appears from records that the initial referral made three years prior to his death might have received more attention at the time, given the vulnerabilities that were identified. It is acknowledged that the same range of community services that exist currently were not available at that stage.
- The SWD response to referrals was prompt though somewhat limited. An initial assessment following receipt of the first referral may have revealed David and his sibling's social, emotional and care needs. An assessment undertaken following his mother's death would have established the capacity of David's older sibling to meet the needs of his younger siblings.
- Greater inter-agency communication would have provided more detailed information regarding David's needs which in turn would have enhanced shared intervention to support him and his family.

Key Learning

This report has attempted to reflect on the David's life and the challenges faced by the staff who worked with his family. The review team considers that there are areas where lessons can be learned.

- Young people experiencing adversity in their lives are likely to feel isolated and confused. Where supportive adults and friends are not available, faulty judgement may negatively affect their behaviour. Research indicates that when experiencing difficulties, young people value the support of social workers, who engage with them,

who listen to them and respond to their expressed concerns[1]. This adds emphasis of the importance of a social worker establishing direct contact with a young person prior to making decisions regarding his/her welfare. Other research confirms this and also suggests that social work support can result in young people's positive adaptation to stressful circumstances at major turning points in their lives. Such support can facilitate engagement with parents, teachers and others directly involved with young people, further enhancing the opportunity for positive outcomes[2].

- *Children First* places the responsibility for addressing concerns relating to the safety of children and coordinating the appropriate response, on the Tusla, Child and Family Agency, Social Work Department. However, it also details the need for all professionals working with children to understand and accept their responsibilities and roles in the promotion of child safety. Thus, the first step for a Tusla professional not directly involved in child protection, having a concern regarding a child's safety or welfare, is to make a report to the Tusla Children and Family Social Work Department. However, *Children First* stresses the importance and value of interagency and interprofessional cooperation in responding to such concerns. This includes the sharing of resources and expertise, ensuring that there is an appropriate and consistent response to a child's needs and to provide for mutual interprofessional support[3]. Achieving this, requires regular scheduled formal and also informal contact between services to share information and ensure that inter-service/agency processes are effective.

Recommendation

- A reporting mechanism should be developed between the child protection services and PPFS so that the outcome of referrals to PPFS is communicated back to the SWD over a defined period of time.

Dr Helen Buckley

Chair, National Review Panel

[1] McEvoy, O., Smith M., (2011) *Listen to Our Voices*, Chapters 3,5+6. DCYA

[2] Deardon, J.(2004) Resilience: a study of risk and protective factors from the perspective of young people with experience of local authority care. *Support for Learning* Vol.19. 4 pp187-193

[3] HSE/Tusla, (2011) .*Children First:* National Guidance for the Protection and Welfare of Children Paras 4.3-4.4 p18