



**Review undertaken in respect of the death of a young person who
died while in care**

Dylan

Executive Summary

July 2016

Introduction and background

Dylan was in the care of the Child and Family Agency, in a residential unit, when he died just before his 17th birthday. He had been in care for only a few months at this point. He had lived mainly with his mother prior to his admission to care, with periods in the care of his stepfather. Dylan's mother had a drug problem from the time he was quite young and both he and his siblings had been reported to the social work department (SWD) because of concerns about neglect and poor school attendance as well as the age inappropriate responsibilities that Dylan was carrying. A number of different practitioners became involved with Dylan and his family at that time. When he was in his first year in secondary school and following a crisis in his family home which culminated in Dylan being placed in emergency care for a short period, he moved to live with his stepfather who had separated from his mother a few years earlier. His stepfather's extended family also offered him support and he appeared to settle down well although his social worker was concerned about the impact on him of exposure to his mother's drug use. The case was closed to the SWD shortly afterwards, as concerns had abated, but Dylan moved back to stay with his mother a few months later. A child protection conference was held at that point and a child protection plan was developed but not actually implemented. Dylan's mother was very resistant to social work intervention and this appeared to deter efforts to work with herself and Dylan. Approximately a year later, Dylan re-entered the care system with his mother's consent following a row he had with her. After an initially unsettled period he was placed in a residential unit in line with his own wishes and plans were initiated to get him back into education. Sadly, he was found dead in the unit a few weeks later. The coroner reported that high levels of toxicity were found in his system.

Findings and conclusions

The review did not find any evidence that action or inaction on the part of the Child and Family Agency contributed to Dylan's very sad and untimely death but did find evidence of practice weaknesses. In summary, it found that while the initial responses made to reports about Dylan were prompt and appropriate, the case began to drift at the time he left his stepfather's care. The review noted some missed opportunities; Dylan's needs were not assessed until he entered the care system for the second time which meant that the impact of his adverse home situation was not given

sufficient attention or analysis ; his placement with his stepfather had no legal basis, his welfare was unknown for a long period when he returned to live with his mother; a large number of social workers were involved but did not manage to develop a relationship with Dylan; a child protection plan made at the time was not implemented and there was insufficient use made of inter-agency meetings. There were gaps in management and supervision as well as adherence to policies at this time, attributed by staff to a high turnover of social workers and pressure of work which led to 'firefighting'. It is noted that Dylan received an improved service when he re-entered care and that his views and wishes were taken into consideration.

Key learning points

The review highlighted a number of key learning points which are elaborated in detail in the full report and summarised here as follows:

- It goes without saying that assessment is the basis for effective intervention
- It is important that non engagement between families and social work services is taken seriously as a significant obstacle which must be addressed carefully. It is suggested that practitioners should familiarise themselves with family histories and try to understand parental motivation to avoid contact. It is also suggested that workers should reflect on the situation from a child's perspective and actively strive to overcome barriers.
- Assigning the classification of 'welfare' (as opposed to 'child protection') to a case sometimes has implications for the type of follow up that the case receives. In general, the categorisation of the case is less important than the extent to which the child or young person's needs are ascertained and addressed. However, if the categorisation of a referral as 'welfare' is likely to result in an inadequate response to the child's situation, it should not be applied without very careful consideration of the probable consequences and an understanding of the limitation it may impose.
- Supervision is a case management tool which prevents drift and ensures that plans which are agreed at child protection conferences are implemented and followed up. As well as systematically monitoring progress, it should set and maintain high standards.

Recommendations

The inquest jury made the following recommendation, 'Where there is a minor involved and where [young people] are perceived to be under the influence of alcohol or drugs, we would recommend they be visually checked on a regular basis and a record made of each check.' This review suggests including this recommendation in any guidance produced for residential care managers.

Dr. Helen Buckley,

Chair