Review undertaken in respect of death of N
A young person known to the child protection system

December 2011

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 and began its work in August 2010. The panel consists of an independent Chairperson, a deputy Chair, and approximately twenty 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 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 contained a detailed chronology of contact by services with the child and family, an analysis thereof, and conclusions, recommendations and an action plan. 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 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
- **Recommendation for internal local review** to be made where the notification refers to a serious incident that has more local than national implications, e.g. where a child has been abused in a particular care setting, where a child is regularly absconding from a placement, or where a specific local service outside Child and Family Social Services is implicated.

HIQA conditionally agreed to this method of classifying cases for a trial period pending the review of the guidance.

4. Child Death N

This case concerns a young person here known as N who died in 2010. The case was notified to the National Review Panel because N had been known to the HSE Children and Family Services during the previous two years.

5. Level and process of Review

This was conducted as a concise review. This involved reading all the social work records which, in this instance, were contained in one file. Interviews were held with the team leader and social workers who had responsibility for N's case. N's parents also accepted our invitation to meet with and share their views of the services provided by the HSE to their son. Each person we met was provided with the opportunity to review their contributions to our understanding of the facts.

The members of the Review Team for the N Case were:-

- Mr Michael Bruton, Independent Management Consultant – Lead Member for National Review Panel in this case
- Mr Hugh Connor, Former Director of Social Work Services in Northern Ireland,

Neither member had any previous professional or managerial involvement in this case. They were totally independent in conducting this review and arriving at their conclusions and recommendations.

6. Terms of Reference

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

- To establish the facts with particular reference to the role played by the HSE and HSE funded agencies during their period of involvement with N
- To review the HSE child protection services in the context of compliance with
    - Relevant regulations and procedures
    - Policy directions
    - Key professional standards
- To consider issues of interagency and intra agency cooperation and communication
- To prepare an independent report for the HSE which
    - Identifies opportunities for learning from this review
    - Makes recommendations

7. Details of family

N was one of three children. He lived with his parents and siblings apart from short periods away from home. The family had never, prior to the July 2007 referral, come to the attention of the child protection system or social work department.

8. Services involved with N

1. The principal service involved in the case was the Social Work Department (SWD) of the HSE Children and Family Service.
2. **Youthreach** who provided N with post school educational opportunities
3. **An Garda Siochana** who were involved arising from suggestions that N was dealing/selling drugs
4. **Juvenile Liaison Officer** who was involved due to N's drug related issues

5. **Youth Service Drugs Worker** – who was involved in counselling N

9. Background

Up to the time his mother contacted the HSE Children and Family Services in late 2007, N had not been in contact with any social services. He was doing well at school, and was regarded as a likeable young person who was easy to get on with. However, during the three years prior to his death, N engaged in some risk taking behaviours which included misuse of drugs and alcohol, He started borrowing money for drugs which ultimately got him into debt. This in turn put him at further risk and on occasions, he was physically threatened and harmed as a consequence. There were also concerns that he was contemplating suicide.

10. Brief summary of young person's needs

N did not have any identified significant health problems and was regarded as a young person with potential. His principal needs related to his drinking and drug usage. There were also concerns about his physical safety following threats made to him by people to whom he owed money for drugs. N's father was frustrated with his relationship with his son. Of particular concern was the fact that N had on one occasion made a suicide attempt, from which he was successfully diverted by a friend.

11. Chronology of involvement with HSE Children and Family Services

2007

Contact between N's family and the HSE Children and Family Services social work department (SWD) was initiated in mid 2007. At this time, N's mother made contact with the SWD to express her concerns about her son's behaviour and mood. The reported concerns included N's drug and alcohol use, his suspension from school and his reluctance to return to school despite having been a bright student. He was also reported to be stealing money, spending periods out of home and not giving his parents accurate information. N's mother told the SWD about the suicide of a friend of her son and how she worried that N might follow his example.

During the period following the initial referral, the social worker here known as Social Worker A made onward referrals to appropriate services, based on information gained from her meetings with N and both his parents. His parents had conveyed concerns about N's school attendance, his excessive spending and his involvement with the local drug culture. It was believed that he was not only using drugs but was engaged in dealing. It came to light that he was also being threatened by people to whom he owed money. Social Worker A met with N and talked to him about the possibility of his attending Youthreach. He responded with some interest to this suggestion and ultimately engaged with the service, attending regularly. Over this period Social Worker A planned to hold a family meeting, but ultimately this did not take place.

Towards the end of this period, a number of worrying matters emerged. N's parents became aware that he had committed a burglary but they declined to report the matter to the Gardai. Shortly afterwards, N's father advised a member of staff at Youthreach that he had, out of frustration, hit N. Youthreach

reported this fact to the SWD, following which Social Worker A met with N's parents to discuss the incident and told them that it would have to be notified to the Gardai. The social worker learned that N had substantial debts and offered to mediate with his creditors; however, this offer was declined by N.

Towards the end of the year, staff at Youthreach informed Social Worker A of N's disclosure to them that he had tried to take his life three weeks earlier. He told them that his friend found him and talked him out of it. N's parents were shocked and upset by this revelation, and found themselves at a loss as to how they might deal with it. The drugs worker with whom the social worker also spoke expressed concern about the issue of N's attempted suicide.

Shortly afterwards, N and his parents tried to arrange for N's admission to a residential centre for treatment of his drug problem. They attended an interview, and N was offered a place. However, he subsequently turned it down. A short time later, N was suspended from Youthreach for a day for reasons connected with his drug use. During the following few days, he moved back home from a house that he had temporarily shared with other young people. His behaviour on his return home was considered to have improved, as had his communication with other family members

2008

There followed a four month gap in social work involvement. In early 2008, the Youthreach manager contacted the Social Work Department to let them know that N was being discharged from the scheme, and he reported serious concerns, including the fact that a number of random attacks had been made on N by people known to him. The Youthreach manager suggested a meeting between himself, the Gardai and the social workers to discuss the problem. However, nothing arose from this suggestion. A subsequent letter from Youthreach to the social work manager, following an incident when a man came to centre and threatened to harm N, stated that Youthreach had "massive concerns for N's safety and welfare". The letter went on to report that N was "scared and under threat from a number of people.. We [Youthreach] would also be very concerned about suicide as N appears very alone and down at the moment..." The Youthreach manager suggested that N should be referred to a counselling centre for support. He also signalled that Youthreach would take him back in the autumn as long as he was no longer involved with drugs. The initial response of the SWD was to encourage the family to engage in counselling. However, when it became clear that the most pressing difficulty was N's drug use, referral to the HSE addiction service was considered to be more appropriate.

In early autumn 2008, Social Worker A had a telephone conversation with N's mother and learned from her that N was back home and once again attending Youthreach. However, his mother reported that he still stayed away from home from time to time, and on these occasions they would have no idea of his whereabouts. Social Worker A informed N's mother that she was going to close the case and invited her to get in touch if she, her husband or N needed to talk to a social worker. Youthreach rang Social Worker A some days later to say new concerns had been expressed by N's mother which she had not shared with the social worker. The decision to close the case was deferred pending further information.

In late 2008, the social worker was in the Youthreach premises on other business. She met N who came over without hesitation and shook hands with her. He was very chatty and reported that things were 'great'; he looked well and seemed happy. Social Worker A later spoke to the Youthreach Manager and asked him if things were as good as they seemed. He was somewhat hesitant and said they would still have some concerns from time to time. No further contact between N and HSE Children and Family Services is recorded on the file.

12. Analysis of involvement

12.1 Initial response of HSE to this case

There were two distinct phases in the SWD's response to the initial referral of concerns about N. The first phase was from mid to late 2007. During this period, Social Worker A, following the referral by N's mother, made a prompt referral on behalf of N to a drugs counselling service. She also took the important step of linking N with the Youthreach service, following which N was successful in securing a place. During this period it became clear that N was heavily in debt as a result of his involvement with drugs. At one stage N's social worker offered to mediate with the person demanding repayment of monies by N, an offer that was declined. In the meantime, N's parents had sourced a treatment service which was prepared to accept N, but he subsequently declined the offer of a place. An ongoing supportive service was offered to N's parents by the social worker in conjunction with the services of Youthreach and the drugs worker associated with the youth service. The initial assessment undertaken by the social worker was well presented. It made clear observations in relation to the positive aspects of N's family and their support of him.

The second phase of involvement which occurred from the spring of 2008 to the date of case closure in the autumn of 2008 was triggered by a report from Youthreach to the social worker following complaints that N had allegedly been dealing and using drugs in the centre. As outlined in the chronology above, the Youthreach manager proposed an interagency meeting to discuss the difficulties, which did not occur, and he subsequently communicated other concerns to the SWD in writing. Given the significant threats to N, the opportunity to have a potentially useful structured interagency meeting to consider the facts and plan appropriately was missed. The failure to hold a case conference is considered by the review team to represent a lacuna.

12.2 Assessment

As outlined above, the concerns reported by N's mother to the SWD included his drug and alcohol use, his suspension from school and his reluctance to return to school despite his being a bright student, stealing money, being out of home and not giving his parents accurate information. N's mother also referred to the suicide of a friend of her son and felt that this was a threat hanging over them. The maternal concerns expressed regarding the impact of N's behaviour on his younger siblings were never fully assessed.

Given the issues of school behaviour and absence from home, it is unclear why no formal contact was made with N's school or the Gardai. The initial assessment noted a child welfare concern as 'child/parent relationship'. The social work notes record that services were offered in the following priority: Youthreach; social work interventions; drugs project worker; Garda Síochána/JLO. N was quickly referred to Youthreach and the drugs project worker by Social Worker A.

Social Worker A met directly with N some days after her initial meeting with his mother. The concerns about N's staying out of home, the reasons for his drinking were not explored, nor was there any assessment of the impact on N of his friend's suicide.

There is no evidence of any risk assessment in respect of N's attempt at suicide, or of his suicidal thoughts, nor is there any record that referral to specialised services was considered. A more dynamic assessment process incorporating the views of N's former school, Youthreach, and his parents would

have clearly identified the benefits of an interagency meeting. The absence of this was inconsistent with good practice.

Over the entire period of contact between N and HSE Child and Family Services a range of significant issues relating to N's care were identified including:

- N's refusal to return to school despite being a bright and successful Junior Cert student
- His use of alcohol, including spirits, at an early age
- His drug usage and strong belief by those who observed him on a daily basis that he was dealing
- His large indebtedness – at one time in excess of €6,000
- Stealing from his place of work and extended family members
- The number of threats made to his physical safety by persons unknown to his family or Youthreach staff
- His being out of home and his whereabouts being unknown to his parents
- His suicide attempt and the two separate occasions on which he expressed suicidal thoughts

The failure to hold a case conference or formal strategy meeting in light of these factors is of concern to the review team as it would have enabled a structured plan to be developed for N that in turn would have been fully communicated to N's parents and other professionals.

12.3 Compliance with regulations

There were sufficient concerns in this situation to warrant a structured assessment, as stipulated in Children First, but this guidance was not followed.

There are three recorded periods during which N was out of home. No further enquiries with regard to these absences appear to have been undertaken contrary to the requirements of the Children First guidance.

The involvement of N in the drug culture both as a user and dealer was never the focus of any structured interagency discussion, despite a very strong recommendation by Youthreach to the social work department. This matter was not considered in a meaningful manner by HSE social work management and as such is not consistent with good practice as outlined in Children First

12.4 Quality of practice

12.4.1 Interaction with the Child and Family

Social Worker A, who initially met with N's mother gathered a considerable amount of information and displayed understanding with regard to the concerns being expressed by his mother. She subsequently completed the initial assessment record that was appropriately signed off by her team leader. As outlined above, a full or structured inter-agency assessment was not undertaken. When she closed the case, Social Worker A assured N's mother that she could contact the SWD if she had any further concerns. However, the decision to close the case was postponed following a report from Youthreach of further concerns that had been reported to them by N's mother. Yet the case notes do not contain any further information, indicating that none was obtained. The case was finally closed by the SWD in early 2009 with the closing

sheet completed by Social Worker A and the team leader noting that while "there are still concerns re N, he has returned to Youthreach and his behaviour at home has improved". It was noted that N was about to reach eighteen years of age.

12.4.2 Child and family focus

Gaining the trust and involvement of teenagers in discussing problems or concerns is often difficult. Social Worker A deserves praise for the fact that she spoke privately with N and was able to identify the issues of concern to him. She provided him with information on Youthreach which provided him with a very important service that was valued by him. She introduced him to the drug counsellor who provided him with a useful support service. Overall Social Worker A demonstrated good practice by adopting a child centred approach which enabled her to ascertain the issues that were of concern to N.

12.4.3 Quality of recording

Documentation in the file was legible and in chronological order.

12.5 Management

12.5.1 Inter-agency meetings or conferences

While there was informal contact with the Gardai regarding the supply and sale of drugs, a more formal structured dialogue could have resulted in a defined and cogent safety plan for N. This did not occur despite the fact it had been requested by Youthreach.

The review team fully appreciates that not all child protection situations warrant the convening of a child protection conference. However, there was no evidence that any consideration or discussion took place for or against the holding of a child protection conference. If such did occur it was not clearly documented

12.5.2 Supervision

While it emerged from our discussions with social work staff that regular supervisory meetings were held, only one written record of supervision having taken place was sourced.

12.5.3 Inter-agency collaboration

Opportunities to engage with the Gardai on foot of N being missing from home on a number of occasions were not actively explored to pursue joint collaboration opportunities. The issue of N not wanting to return to school was never the subject of any recorded discussions between the social work department and N's school. Neither was there any exploration of the potential of in-school guidance/pastoral service or the National Educational Welfare Service to contribute to constructively addressing the issues and needs presented by N.

12.5.4 Policy

As this review has indicated, the issue of suicide was of considerable concern to N's parents on a number of occasions over the period of involvement of Children and Family Services in this case. There is little

evidence to show that 'Reach Out', the national policy on suicide prevention[1] was applied in this case. Additionally the review team believe that a more robust multidisciplinary agency approach to drugs issues such as those arising in this case should be explored at local management level.

13. Conclusions

The review has reached the following conclusions:

- The case review was concerned with a young person who engaged in serious risk taking behaviour. In addition there was evidence that he had made a suicide attempt, and that his mother in particular had been seriously worried about the possibility that he may take his own life. The review is not satisfied that satisfactory efforts were made to address these concerns.

- The lack of available drug treatment services for adolescents was striking. In N's case it required significant efforts on the part of the family to source a service which was a considerable distance away from the family home.

- Drug dealing is principally an issue for the Gardai. However, there is an equal responsibility on the part of the HSE Children and Family Services to ensure the safety and protection of children who place themselves at risk. This case would clearly have benefited from stronger multi disciplinary and multi agency work to achieve this aim. The failure of the SWD to act on the suggestion of Youthreach for an interagency meeting was a lost opportunity.

14. Key Learning Points

Three key areas of learning have emerged from this review:

- There were several examples of good practice by the social worker involved in this case, including the high level of communication between Youthreach and the SWD. This collaboration facilitated the provision of a support service to N and his parents.

- The review notes that social workers failed to change their initial assessment of the case despite new evidence of difficulties being experienced by N. The tendency for practitioners to discount new information and retain their initial impressions has been noted in the literature and needs to be challenged in supervision[2].

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[1] Reach Out National Strategy for Action on Suicide Prevention 2005 – 2014 HSE and Dept of Health and Children 2005

[2] Buckley, H., Horwath, J. & Whelan, S. (2006) *Framework for the Assessment of Vulnerable Children and Their Families,* Dublin: Children's Research Centre, Trinity College, http://www.tcd.ie/childrensresearchcentre/assets/pdf/Publications/Framework.pdf

- The review notes that the identified concerns about suicide were not addressed in the context of the National Suicide Strategy Action Programme and that local resources were not sought in this regard.

15. Recommendations

The review makes the following recommendations:

1. A standard assessment framework should be implemented by social work departments for children presenting to the HSE under the provisions of the Child Care Acts.
2. Discussion and decisions regarding the holding of a strategy/case conference should always be recorded.

Signed: Helen Buckley

Professor Helen Buckley

Chairperson National Review Panel

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