National Review Panel

October 2011

Overview of Local Reviews submitted

Five of the cases notified to the National Review Panel were subject to local review. In general, local reviews are conducted when the Chair of the NRP considers that 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 specific local services outside Child and Family Social Services, such as hospital or mental health services are implicated. The five cases consisted of:

Case number	**circumstances**	**Reason for local rather than national review**
1	Serious incident: A young person in the care of the HSE absconded on a number of occasions in close succession over a specific period	Issue relevant for local practices
2	Serious incident: Child in care witnessed incident that could have caused trauma	Unclear if met criteria for national review
3	Young person in after care attempted suicide	Intense involvement with local mental health services
4	Death of infant whose young mother was in aftercare services	Baby died of natural causes, involvement of local hospital services in case
5	Suicide of young person who had been known to HSE Children and Family Services	Case had been open but inactive for several years. Local health area had already been the focus of a number of reviews.

All the review reports were completed by managers who had no involvement in the case. They were all conducted by reviewing social work records and in some cases, records kept by residential care units and consultations with relevant staff. Pending the development of a standard format for local reviews, the reports in these cases differ considerably in size and depth. It was considered that an overview report would best demonstrate the key issues.

Terms of reference

Each of the reviews had similar terms of reference. In general, they examined the involvement of HSE Children and Family Services in the particular case, looked at compliance with procedures, regulations and standards where relevant and sought to find key learning points.

Findings

Case Number	Quality of service provided	Compliance with procedures, regulations and standards	Key learning points and recommendations
1	This case concerned a young person who absconded from care on a number of occasions. The review noted that given this young person's history of absconding, a more rigid and controlled risk management plan should have been implemented earlier. The review also noted good inter-agency communication between the social work team, the residential staff and An Garda Síochána during the period in which the young person was missing. However, it noted that the lack of a planning meeting during this time had prevented the formulation of a clear plan of action.	The review noted a breach of Children First and the Missing Children in Care protocol i.e. lack of a planning meeting during the time that the young person was missing.	1. The Missing Children in Care Protocol should be reviewed and re-distributed for the attention of HSE staff and management. 2. An inter-agency planning meeting should take place if 'high risk' children are missing for more than 24 hours, which should detail the communication strategy with the young person's family.

	The review noted that the communication of information to the young person's family about the absconsions was inconsistent. It also noted a lack of clarity within the HSE with regard to consent for use of the media to assist in the search for missing children in care.		3. The implementation of tight Individual Absence Management Plans for young people known to be at risk of absconding, including guidance on the use of restraint. 4. Improvement in the quality of record keeping 5. The development of a clear media communications protocol for implementation when children go missing from care
2	This case concerned a young person who had experienced an event which could have caused them trauma. The young person was already engaged with a number of community services and received appropriate care following the incident. A safety plan was put in place; inter agency collaboration appeared to work well. Counselling offered and declined but offer remains open. Young person's parent indicated satisfaction with service being offered to whole family.	Satisfactory	None noted. Report demonstrates examples of positive practice.
3	This case involves an unsuccessful suicide attempt by a young person who had been in care from two years of age and was currently in aftercare. The review indicated that the young person had been abused and neglected prior to entering care. They had serious mental health	The review indicates that that child care regulations were generally applied and that meetings, reviews,	1. Consideration needs to be given to the provision of specialist psychiatric inpatient facilities for young people in care who need them.

	and associated behavioural problems, and for this reason had a number of moves while in care. The review found evidence of significant commitment on the part of staff to this young person, and considered that their needs were so complex that it was extremely difficult to meet them. The review noted some weaknesses and some strengths in the service offered. It noted that detailed planning was involved in some placements, but was lacking in others. Some placements were positive, but others did not meet the young person's needs. It found that social work intervention had been consistent with a child centred approach, and that there was frequent contact between the Children and Family Service and the young person. It also noted the commitment and continued involvement of particular mental health staff. The review noted a missed opportunity for a multi-disciplinary appraisal of the young person's progress to evaluate whether interventions and plans were working. It also noted that while there was considerable multi-disciplinary intervention, the roles and responsibilities of some of the mental health practitioners in the case management were unclear.	care plans and after care plans were held as required.	2. A National Placement Advisory Service should be established to cater for children with complex needs. 3. Thought needs to be given to the range of resources required by young people leaving care who have mental health difficulties and require psychiatric support in order to achieve independent living. 4. An independent reviewing system should be in place to ensure ongoing oversight of care plans and review schedules. 5. Consideration should be given the nature of assessment to be undertaken when children enter the care system, particularly if their complex circumstances are likely to give rise to special therapeutic needs. 6. In complex cases, a senior medical officer or child psychiatrist should be appointed to the case management team to ensure clinical oversight of services provided to children in care. 7. File management and record keeping needs to be reviewed.

			8. A clear risk management policy needs to be identified in case files where children in care have behavioural problems.
4	This review concerned the death of a baby from natural causes. The baby's mother had been considered vulnerable and had been in care up to her 18th birthday, She had an aftercare worker whom she saw regularly. In addition, she and her baby had been in receipt of a comprehensive package of family support, health, mental health and social work services including respite care. The review report notes the child's needs were appropriately identified and managed and that there was evidence on file of continuous re-assessment of the mother's needs in caring for the child indicating that the child's best interests were foremost. There was almost daily contact between the mother, child and the services. Three review meetings were held in the eight months between the child's birth and death. Inter-agency collaboration was of a good standard. The baby died from respiratory failure as a result of a viral infection. The Consultant Paediatrician who treated the baby confirmed that the mother had sought appropriate advice in respect of the child's illness and had followed it.	The review states that there was full compliance with all regulations, standards and local guidelines in this case. There was also evidence of good recording and management oversight of the case.	1. Examples of good practice in the case, include the paramountcy of the child's welfare, timely response & allocation, good assessment, effecting care planning, involvement of parent, child focused, good communication, frequent contact, regular review and good management and supervision. 2. There is a need for greater clarity about what exactly constitutes an assessment and the type of assessment being conducted. It notes that the introduction of the Business Processes should provided the necessary clarification.
5	This review concerned the suicide of a young person who had been known to the child protection services. A service had been offered to family during a crisis period five years previously and the situation had been resolved with support. The young person who later committed suicide had been offered and availed of	Compliance with relevant procedures appears to have been satisfactory.	None noted.

	counselling. The children considered to be safe and the case had been closed by HSE Children and Family Services eighteen months prior to young person's suicide.		

In summary, two of these reviews involved children in care who presented particular challenges that potentially put themselves and others at risk. The concerns in one of them were of a less serious nature and the review highlighted how **adherence to existing protocols may have improved the management of the case** and it also recommends the **development of additional protocols to deal with situations where young people abscond**. In the second case involving a young person in aftercare, the requirement for **special provisions for young people in care with complex needs,** particularly health and mental health needs was highlighted. This review together with another one dealing with an infant death recommended **attention to the process of assessment**. Each of the reviews of children in the care system recommended improvements in **record keeping practices.** Examples of good practice were noted in all reviews, these included positive inter-agency collaboration, rapid response to concerns, consistent social work and mental health service, effective planning and communication.

Helen Buckley

Chairperson, National Review Panel

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