National Review Panel

Annual Report
2013

Foreword

The National Review Panel was established in late 2010, and 2013 was its third full year of operation. By the end of 2013, 77 deaths had been notified. The 2012 report provided an overview and analysis of the themes arising from the first three years of the panel's operation. A similar overview will be produced next year the 2014 annual report which will contain information on five years of notification and reviews.

This report presents analysis of the notifications made in 2013, and provides an overview of the completed reports that were published during 2013. It also details other activities of the panel during the year, including training and dissemination activities. The NRP is cognisant of the reforms currently underway in the Child and Family Agency and has taken them into account when reaching conclusions and making recommendations. Where gaps or weaknesses have been identified, these have been noted in the review reports.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2013 with the different review teams. We recognise that the review process has been difficult and painful, particularly for bereaved relatives and for staff who knew and worked with the children and young people concerned. The combined insights of staff and family members have helped to inform the conclusions reached in the reports and have contributed to the learning points identified within them. As chair of the panel, I would like to commend the work completed by Ms. Ann Kennedy, Service Manager in her excellent support of the panel's work and for providing the statistical tabulations included in this report.

Dr. Helen Buckley
Chairperson, National Review Panel
October 2014

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1. Introduction

The NRP is independently commissioned by the Child and Family Agency (formerly the HSE) and none of its members have been involved professionally in any of the cases under review. It is chaired by Dr. Helen Buckley, Associate Professor in the School of Social Work and Social Policy, Trinity College Dublin. The panel is supported by a fulltime service manager who has responsibility for the comprehensive administration of all aspects of the work of the NRP including the collection and compilation of records, organising and planning interviews, transcript management, resource and financial matters including staff contracts, liaison with staff and families and the finalisation of reports prior to submission. The panel also retains an independent legal team. A full list of panel members for 2013 is appended to the end of this report.

This annual report presents an overview of cases notified in 2013 with some statistical information on age, gender, care status and causes of deaths of the children and young people who died. It outlines some of the activities of the NRP during 2013 and other relevant matters.

2. Functions of the National Review Panel

The NRP reviews cases where children who are in the care of the state, or have been known to the child protection services, die or experience serious incidents. Its main function is to determine the quality of service provision to the child or young person prior to their death or experience of a serious incident. It focuses primarily on the quality and effectiveness of frontline and management activity as well as the compliance with guidance and procedures. It also examines inter-agency collaboration and identifies obstacles to good practice. During 2013, the NRP continued to operate similar processes to those adopted at the outset, and differentiates between major, comprehensive, concise and desktop reviews

3. Procedures for review

The NRP has continued to revise the tools that were developed at the outset for conducting reviews and finalising reports. The reviews are conducted by studying case records and, in the case of major, comprehensive and concise reviews, on interviews with family members and staff that have been involved with the case. Interviews are recorded and transcribed. Each report provides a chronological account of service provision in respect of the child who died, and offers an analysis of frontline and management practice in the case. A toolkit for the conduct of reviews had been developed at the by the chair in consultation with panel members. This was revised in 2013, reflecting both the experiences of panel members and recent policy initiatives that had been implemented by the HSE Children and Family Services. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by panel members.

Extracts from reports are provided for factual accuracy checking to persons who have given evidence in the course of reviews and their comments are considered when finalising the reports.

During 2013, seven reports were published making a total of twenty published reviews to that point. An overview of the reviews published in 2013 is presented here.

Section One

1.1. Reviews conducted in 2013

During 2013, 51 professionals and 12 family members attended for interview with the National Review Panel in respect of 10 cases. Eight review reports were submitted to the National Director for Children and Family Services and seven of these were published in November 2013. In addition 11 reviews were commenced. As in previous years it was not possible to commence some reviews until Inquests and Post Mortem reports were available.

1.2. Deaths of children and young people notified in 2013

A total of 17 deaths and 3 serious incidents were reported during 2013. The following table (Table 1) shows the care status of the children whose deaths/serious incidents were notified:

Table 1: Care Status of children and young people whose deaths / serious incidents were notified in 2013

Care Status 2013			
	Deaths	**Serious Incidents**	**Total**
In care at the time of the incident	**3**	**0**	**3**
In Aftercare at the time of the incident	**1**	**0**	**1**
In care immediately prior to 18th birthday and under 21	**0**	**0**	**0**
Known to Child Protection Services	**13**	**3**	**16**
Total	**17**	**3**	**20**

Three of the 17 children and young people who died were in the care of the HSE at the time of their deaths and one young person was in aftercare. Thirteen children or young people who died were known to child protection services, and three of the children about whom serious incidents were reported were also known to child protection services.

The gender breakdown in respect of the children and young people who died was as follows:

Table 1A: Care Status and gender breakdown of young people whose deaths were notified in 2013

Care Status Deaths 2013			
	Deaths	**Male**	**Female**
In care at the time of the incident	**3**	**2**	**1**
In Aftercare at the time of the incident	**1**	**0**	**1**
Known to Child Protection Services	**13**	**4**	**9**
Total	**17**	**6**	**11**

As Table 1A indicates, six of the children and young people who died were male, and eleven were female.

The age profile of the children and young people who died was as follows:

Table 2: Ages of children whose deaths were notified in 2013

Age Profiles 2013			
Age Band	**Total**	**Male**	**Female**
Infants < 12 months	**7**	**2**	**5**
1 - 5 years old	**1**	**0**	**1**
6 - 10 years old	**0**	**0**	**0**
11 - 16 years old	**5**	**3**	**2**
17 - 20 years old	**2**	**1**	**1**
> 20 Years Old	**2**	**0**	**2**
Total	**17**	**6**	**11**

It is of note that more than half (8) of the children who died were under five years of age and of that number, seven were under one year. The second most represented age cohort was between 11 and 16 years old. Three young people in this age bracket died.

The causes of notified deaths were as follows:

Table 3: Causes of deaths notified in 2013

Cause of Death 2013	**Total**	***Male***	***Female***
Natural Causes	**7**	***1***	***6***
Drug Overdose	**1**	***0***	***1***
Suicide	**4**	***2***	***2***
RTA	**0**	***0***	***0***
Homicide	**0**	***0***	***0***
Other Accidental	**1**	***1***	***0***
Unknown	**4**	***2***	***2***
Overall Total	**17**	**6**	**11**

In common with previous years, natural causes were responsible for the majority of deaths, followed by suicide. However, it should be noted that due to delays in the availability of post mortems and coroners' reports, the causes of a further five deaths have not yet been verified.

The region of origin of children and young people whose deaths were notified in 2013 was as follows:

Table 4: Region of origin of children and young people whose deaths sere notified in 2013

Region	**Total**	**Male**	**Female**
Dublin North East	**6**	**1**	**5**
Dublin Mid Leinster	**7**	**2**	**5**
West	**2**	**1**	**1**
South	**2**	**2**	**0**
Totals	**17**	**6**	**11**

As in previous years, the highest number of deaths occurred in the most densely populated areas.

1.3. Comparisons with previous years

Age and gender of children and young people whose deaths were notified between 2010 and 2013

Table 5: Age and gender of children whose deaths were notified between 2010 and 2013

Age Band	No of young persons 2010	Male 2010	Female 2010	No of young persons 2011	Male 2011	Female 2011	No of Young persons 2012	Male 2012	Female 2012	No of Young persons 2013	Male 2013	Female 2013
Infants < 12 months	2	1	1	**4**	**3**	**1**	**4**	**1**	**3**	**7**	**2**	**5**
1 – 5years old	2	1	1	**2**	**1**	**1**	**4**	**1**	**3**	**1**	**0**	**1**
6 – 10 years old	0	0		**1**	**1**	**0**	**2**	**1**	**1**	**0**	**0**	**0**
11 – 16 years old	6	3	3	**3**	**1**	**2**	**5**	**2**	**3**	**5**	**3**	**2**
17 – 20 years old	12	10	2	**5**	**5**	**0**	**8**	**6**	**2**	**2**	**1**	**1**
> 20 Years Old	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**
Total	**22**	**15**	**7**	**15**	**11**	**4**	**23**	**11**	**12**	**17**	**6**	**11**

While there is a notable change in the numbers of children under one year who died in 2013, the numbers are too small to be of any statistical significance. It remains the case that teenagers are the more vulnerable group.

1.4. Notified deaths by region

Table 6: Notified Deaths by Region 2010 - 2013

Deaths By Region	2010	2011	2012	2013	Total
Dublin North East	**8**	**2**	**5**	**6**	**21**
Dublin Mid Leinster	**3**	**4**	**6**	**7**	**20**
South	**7**	**7**	**6**	**2**	**22**
West	**4**	**2**	**6**	**2**	**14**
Total	**22**	**15**	**23**	**17**	**77**

While the number of deaths of children and young people in the South and West regions has reduced, the numbers are too low to be of any statistical significance.

1.5. Causes of death 2010 – 2013

Table 7: Overview of causes of death 2010 – 2013

Cause of death	2010	Male	Female	2011	Male	Female	2012	Male	Female	2013	Male	Female	Total
Natural Causes	**6**	**4**	**2**	**8**	**5**	**3**	7	1	6	7	1	6	28
Suicide	**4**	**2**	**2**	**3**	**2**	**1**	9	5	4	4	2	2	20
Road Traffic Accident	**4**	**3**	**1**	**1**	**1**	**0**	2	2	0	0	0	0	7
Other Accidental	**2**	**2**	**0**	**1**	**1**	**0**	4	2	2	1	1	0	8
Drug Overdose	**4**	**3**	**1**	**2**	**2**	**0**	0	0	0	1	0	1	7
Homicide	**2**	**1**	**1**	**0**	**0**	**0**	1	1	0	0	0	0	3
Cause of death to be verified	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	4	2	2	4
Total	**22**	**15**	**7**	**15**	**11**	**4**	**23**	**11**	**12**	**17**	6	11	77

As Table 7 indicates, children or young people died from natural causes in one third of cases, replicating previous years. Suicide is the next highest category at over one quarter of the cases. As noted in previous reports, closer examination of the accidents and drug overdoses which together account for almost one third

of cases, reflects a certain level of risk taking behaviour. The causes of death as a percentage of the total number is reflected in Table 8 below

Table 8: Causes of death as a percentage of the totals deaths per annum

Cause of death	2010 Deaths	Deaths by Category % of Total	2011 Deaths	Deaths by Category % of Total	2012 Deaths	Deaths by Category % of Total	2013 Deaths	Deaths by Category % of Total
Drug Overdose	4	18.18%	2	13.33%	0	0.00%	1	5.88%
Suicide	4	18.18%	3	20.00%	9	39.13%	4	23.53%
Road Traffic Accident	4	18.18%	1	6.67%	2	8.70%	0	0.00%
Other Accident	2	9.09%	1	6.67%	4	17.39%	1	5.88%
Natural Causes	6	27.27%	8	53.33%	7	30.43%	7	41.18%
Homicide	2	9.09%	0	0.00%	1	4.35%	0	0.00%
Unknown	0	0.00%	0	0.00%	0	0.00%	4	23.53%
Total	22	100.00%	15	100.00%	23	100.00%	17	100.00%

1.6. Care status of children and young people whose deaths were notified between 2010 and 2013

Table 9: Care status of children whose deaths were notified between 2010 and 2013

Care Status	2010	Male	Female	2011	Male	Female	2012	Male	Female	2013	Male	Female	Total
In Care of the HSE	2	2	0	2	1	1	3	0	3	3	2	1	10
In receipt of aftercare services	4	3	1	2	2	0	2	1	1	1	0	1	9
Living at home and known to child protection services	16	10	6	11	8	3	18	10	8	13	4	9	58
Total	22	15	7	15	11	4	23	11	12	17	6	11	77

As Table 9 illustrates, children in care represent fewer than 10% of the total number, and as in 2012, the majority of deaths of children in care were from natural causes. The number of deaths of young people in aftercare, while a small percentage of the total, is significant as it refers to a narrow age cohort and further illustrates that the period after leaving care is one where a young person can be at their most vulnerable.

1.7 Overall comment

The figure of 17 deaths for 2013 follows a trend whereby the number of deaths notified to the National Review Panel has been between 15 and 23. This replicates the trend identified in the Independent Review of Child Deaths, whereby 199 deaths over 10 years were reported.

Section Two
Overview of review reports published in 2013

2.1 Findings

The seven reports published in 2013 were concerned with the deaths of six young people in their teens and one young child. Two deaths were recorded as suicide and one as natural causes. The remainder were related to risk taking behaviour including drug use. The young child was in care and three of the young people were in aftercare. The published reports on six young people who had died demonstrated certain key themes. In three cases, the young people had been placed in relative foster care at an early age and had spent a considerable period in these placements which had ultimately broken down. While each of these cases had different characteristics, the NRP found deficits in the way the different social work departments had failed to:

- match the young people's needs in respect of their placements,
- assess the capacity of the carers to deal with the challenging behaviour presented by two of these young people,
- adequately support the placements.

It also found non compliance with the statutory Child in Care Regulations. The reports on two of these cases noted that interventions made to protect the young people inadvertently put them at higher risk.
Other recurring themes throughout these six cases were failure to:

- intervene early with child neglect,
- acknowledge or understand the impact of early trauma,
- acknowledge the significance of repeated referrals

and lack of individual focus on the young people concerned. The reports found evidence in some instances of uncoordinated inter-agency interventions, strained inter-agency relationships and inadequate information sharing. The practice in different cases was constrained by lack of specific services, such as specialist assessment, addiction and other therapeutic inputs, and severe pressure on social work services created by the high rate of referrals. In the seventh case, that of a young child in care who was terminally ill, the review found evidence of excellent practice throughout the involvement of HSE Children and Family Services.

2.2 Learning points

One of the primary objectives of the review process is to highlight learning for practitioners and managers. The review reports each included a section entitled Key Learning Points which referenced research where relevant. The issues highlighted included the need for child centeredness, early intervention with child neglect and thorough and consistent assessment. Other points included understanding of the impact of trauma such as family violence on young children and the need to address the consequences. The importance of engaging with reluctant young people and repairing relationships with families was also raised and discussed. Qualitative aspects of child protection practice such as preventing the development of negative cultures, and opting for relative placements without fully considering their implications were highlighted.

2.3 Recommendations

The review reports that were published in 2013 made a total of **18** recommendations, some of which overlap between the reports. These principally concerned the implementation of one standard framework for comprehensive assessment, the need for protocols to promote inter agency cooperation, the addition of specialist therapeutic services and appropriate placement options, compliance with Child in Care regulations, attention to recurring referrals of child protection concerns in respect of individual children, attention to the fact that children in care may be unsafe at times and implementation of suicide prevention programmes and training.

Section 3

Other activities of the NRP during 2013

3.1 Training.

The NRP held a training day for panel members on 27th March 2013. The agenda consisted of three sessions followed by discussion. These were: *Review of legal matters and documentation* presented by Stephanie McCarthy of O'Neill, Cuneen and McCarthy Solicitors who provides legal services to the NRP; *Relative Fostering: challenges and response'* presented by Mary Meyler of the HSE Children and Family Services, and '*Youth Mental Health'* presented by Gillian O'Brien of Headstrong.

3.2 All Island Child Protection Conference

Helen Buckley, chair of the National Review Panel, was invited to present a keynote paper on the work of the National Review Panel at the All Island Child Protection Conference '*Making the Most of Opportunities and Overcoming Challenges'* held on 1st May 2013 in Dundalk. The presentation covered the review process, an overview of the 60 notifications of child deaths that had been made to the NRP since 2010 and the key learning points from the reviews. Dr. John Devaney from Queen's University Belfast gave a presentation on the Case Management Review process operating in Northern Ireland. Videos of the presentation and slides are available on http://www.dcya.gov.ie/viewdoc.asp?fn=%2Fdocuments%2FChild_Welfare_Protection%2FAll_Island_Conference_2013%2FAll_Island_Conference_2013.htm

3.3 Dissemination of review findings

A series of eight full day workshops with HSE social work, social care and family support staff and managers was held in the final quarter of 2013 to disseminate findings from the reports completed by the NRP and the findings of an audit on social work practice in child neglect cases which had been commissioned by the HSE following the Roscommon Child Care Case. Two workshops were held in each of the four regions, in Dublin, Cavan, Sligo, Limerick, Cork and Kilkenny. A total of 392 staff attended and all levels of staff were represented. The workshops consisted of presentations by Helen Buckley, chair of the NRP, and Lynne Peyton who had conducted the neglect audit. They were followed by group discussions on specific aspects of the findings from the review and audit reports. Participants were required to outline the actions required to address the points raised.

National Review Panel Members 2013

Ms. Margaret Beaumont
Mr. John Brosnan
Professor Helen Buckley (Chairperson)
Dr. Nicola Carr
Dr. Bill Lockhart
Ms. Leonie Lunny
Mr. Eamon Mc Ternan
Dr. Ann Mc Williams
Mr. Phil Mortell
Mr. Paul Murray
Mr. Liam O Dalaigh
Ms. Suzanne Phelan
Ms. Melanie Pine
Dr. Eoin O Sullivan
Ms. Deirdre Mc Teigue
Professor Ian O Donnell
Ms. Ceili O Callaghan
Ms. Jean Forbes
Ms. Michele Clear
Mr. Frank Martin
Dr. Declan Bedford