Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2024

Foreword

I am pleased to present the 15th annual report of the National Review Panel. The NRP was established in 2010 following a recommendation of the Ryan Implementation Report by the Office of the Minister for Children in 2009 and since that time has submitted reports on the deaths of 149 children or young people who were in care or known to child protection services. In addition, the NRP has submitted reports on serious incidents affecting the lives of 25 children. Tusla decides on the publication or otherwise of reports. It has published summaries of 88 NRP reports to date and these are available on the NRP website www.nationalreviewpanel.ie. The NRP has operated on a non-statutory basis since its inception and relies on the cooperation of all stakeholders to facilitate its work.

This report is presented in five parts. The first section provides an introduction and describes the role and function of the NRP as well as current issues affecting its performance. The second part provides statistical information, and a brief analysis of the notifications made to the panel in 2024. The third section provides an overview of the reports published in 2024 including the findings, learning points and recommendations. The fourth part then presents a statistical overview and analysis of the notifications to the NRP over the past fourteen years. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2024.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2024 and gave us valuable insight into their situations as service users. We acknowledge that the experience was sad and painful for them. We also express appreciation for the willingness of professionals to speak with us and acknowledge that this can be a stressful experience. The combined perceptions 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 Naomi Boland, for her excellent support of the panel's work and for providing the statistical tabulations included in this report. We appreciate the assistance provided by An Garda Síochána. Ambit Compliance has provided valuable data protection advice. I would also like to acknowledge the input of the Quality and Regulation Directorate of Tusla and the valuable input of our legal advisor, Stephanie McCarthy of O'Malley, Cunneen and McCarthy solicitors.

Dr Helen Buckley,

Chairperson, National Review Panel

April 2025

1. Introduction

The National Review Panel (NRP) is an independent entity comprising of consultants from a variety of child protection and welfare backgrounds. It is commissioned by, but independent of, the Child and Family Agency. In 2024 the panel consisted of 15 members who were assigned to cases according to their particular expertise and experience. Generally, review teams consist of two or three members, and all have oversight by the chair. None of the members have ever been involved professionally in any of the cases under review. The chair of the panel is Dr Helen Buckley, child protection consultant and Fellow Emeritus of the School of Social Work and Social Policy, Trinity College Dublin. The deputy chair is Dr Ann McWilliams, child care consultant and former lecturer in child protection and welfare at the Technological University of Dublin. Other panel members have backgrounds in social policy, social work, police work, psychology, regulation, human rights and the law. The Chair and Deputy Chair are responsible for identifying cases for review, deciding on the level of review, assigning reviews to individual teams, and advising on terms of reference. The Chair quality assures and signs off on each report prior to submission.

The panel is supported by a fulltime service manager who has responsibility for the comprehensive administration of the work of the NRP including the management of notifications and case records, collection of activity data, liaison with the Quality and Risk Directorate of Tusla on the progress of reviews and other related matters, organisation of interviews, resources, HR and financial matters and the submission of reports. During 2024 additional administrative support was provided to assist the service manager. The panel also uses the services of an independent legal team and avails of the services of data protection specialists. A list of panel members who completed work in 2024 is appended to the end of this report.

While administered by the Child and Family Agency, the NRP is functionally independent. It conducts its investigations objectively and submits finalised reports to the Director of Quality and Regulation in the Child and Family Agency, and to the Health, Information and Quality Authority (HIQA).

1.1 Guidance on the operation of the NRP

The DCEDIY published interim guidance in October 2021 which is available on the Tusla website https://www.tusla.ie/uploads/content/2021_Interim_Guidance_NRP_Final.pdf

The interim guidance reflects recent changes in the structure of services as well as learning from the previous the work of the NRP. Revision of the guidance is currently being led by the DCEDIY.

1.2 Functions of the National Review Panel

The NRP reviews cases where a child or young person dies or experiences a serious incident when that child or young person was in the care of the state or was known to Tusla, the Child and Family Agency's social work department or funded services. It also reviews cases which have come to light that carry a high level of public concern and where a need for further investigation is apparent. Its main function is to determine the quality of services provided to the children or young persons involved and their families. It focuses primarily on the effectiveness of frontline and management activity in line with national procedures and internationally recognised standards of practice and also examines the quality of inter-agency collaboration. One of its most important functions of a review is to note obstacles to good practice and identify areas for learning. Each report contains a section specifically for this purpose.

During 2024, the NRP continued to differentiate between desktop, concise, comprehensive, and major reviews. Where possible preference is given to holding concise and comprehensive reviews as fuller participation of stakeholders provides greater transparency. This creates a challenge to the ability of the panel to complete its work within appropriate timelines due to occasional delays in accessing the relevant staff and family members.

1.3 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. When interviews are held in person, they are recorded and later transcribed by a transcription service. When the interview is held by teleconference, a transcriber is connected to the call. Each report provides a chronological account of service provision in respect of the child who died, followed by an analysis of frontline and management practice in the case. It forms conclusions and identifies key points for learning from each review. Where a policy deficit with national relevance is noted, relevant recommendations are made. A toolkit for the conduct of reviews is regularly reviewed by the Chair and Deputy Chair in consultation with panel members and amended as necessary. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by the NRP. Fair procedures are followed at all times. Extracts from reports are provided for factual accuracy checking to professionals who have participated in the reviews and their comments are considered when finalising the reports. Under the 2021 guidance, the NRP provides a pre-submission draft consisting of conclusions, learning points and recommendations to the Director of Quality and Regulation in Tusla and receives feedback relevant to factual accuracy.

2. Deaths of children and young people notified in 2024

2.1 Number and causes of deaths.

A total of 19 deaths of children and young people in aftercare or known to the child and family services were notified in 2024. This figure represents a decrease of 10 compared with 2023.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2024			
Cause	**No**	**Male**	**Female**
Natural Causes	**8**	**4**	**4**
Suicide	**4**	**1**	**3**
Homicide	**0**	**0**	**0**
Accidents	**2**	**1**	**1**
Overdose	**0**	**0**	**0**
Unknown	**5**	**4**	**1**
Totals	**19**	**10**	**9**

As Table 1 above shows 8 of the 19 children/young people whose deaths were notified died as a result of natural causes, including Sudden Infant Death Syndrome. Four young people died from suicide and two died in accidents. Where a coroner or post-mortem has not reached a conclusion as to the cause of death, it is listed here as unknown.

2.2. Care status of children or young people whose deaths were notified in 2024.

Table 2

Care Status Summary 2024			
In care at time of Death	**In aftercare at time of death**	**Known to social work services**	**Total**
0	**2**	**17**	**19**

The remaining children or young people were living in their communities and there was an increase of one in the number of deaths of young people using aftercare services.

2.3 Summary of serious incidents reported in respect of children in care 2024.

Table 3 below provides a summary of serious incidents that were notified to the NRP in respect of children in care or known to social work services. A serious incident is defined as an event or series of events that may have caused potentially life-threatening injury or serious and permanent impairment of health, wellbeing, or development of a child or young person.

Table 3

Serious Incidents Care Summary 2024	
In care	**3**
In aftercare/ in care immediately prior to 18th birthday	**1**
Known to social work services	**2**
Total	**6**

Examples of serious incidents that were notified include children still living who were known to Tusla and were found to have been neglected or abused, sexually exploited, exposed to potentially harmful situations or involved in non-fatal accidents.

2.4 Ages and gender of children and young people whose deaths were notified in 2024.

The age and gender profile of the children and young people whose death was notified is as follows:

Table 4

Age Profiles 2024			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	9	6	3
1 - 5 years old	2	1	1
6 - 10 years old	1	1	0
11 - 16 years old	4	0	4
17 - 20 years old	2	2	0
> 20 Years Old	1	0	1
Total	**19**	**10**	**9**

Similar to 2023, the majority of deaths have occurred in two age cohorts, infants under 12 months and young people in their teenage years.

2.5 Summary of deaths by region

Table 5

Summary by Region 2024						
Dublin Mid Leinster	**Dublin Northeast**	**South East**	**South West**	**Mid-West**	**West Northwest**	**Total**
4	**6**	**3**	**1**	**3**	**2**	**19**

Of the 19 deaths notified in 2024, a decision was made to review nine. It was decided not to review 8 of the cases notified, and decisions on a further two are still pending while further information is awaited.

3. Overview of reports published in 2024.

The NRP will, from time to time, advise Tusla regarding publication of reviews, particularly where publication could be prejudicial to a trial or where the details are likely to identify a family. However, decisions on whether to publish and the timing of publication are ultimately made by Tusla. When reports are to be published, contact is made between local Tusla social work departments and the families of the children and young people who are the subjects of reviews and they are fully briefed prior to publication. There is often a time lag between submission of reports to Tusla and their publication.

In 2024, Tusla published four executive summary reports completed by the NRP (see www.nationalreviewpanel.ie)

3.1 The children/young people who were the subjects of reports published in 2024.

The reports published in 2024 concerned an infant who died as a result of a tragic accident, a teenaged boy with special needs who died accidentally, a young girl of 14 years who died from suicide and a young girl of 17 who died from suicide. One of the young people was in care at the time of their deaths.

3.2 Findings from the published reviews

In the two cases where children tragically died as a result of accidents, the reviews found that the circumstances of their deaths could not have been predicted or prevented by services. In one case, Tusla services had very little contact with the family and had put in place a safety plan. In the other case a safety plan was also in place, and an allocated social worker was actively involved trying to complete information for an assessment and the review found weaknesses with regard to the transfer

of information between administrative areas and inconsistent application of the Child Abuse Substantiation Procedure. The 14-year-old girl who died from suicide had been in care for a number of years and had numerous placement breakdowns due to her challenging behaviour. She had settled after a period in special care but sadly took her own life following an incident where she had seriously assaulted a staff member when she was in a step-down placement. The review found that she had disjointed mental health care, which prevented her from making a trusting relationship with a clinician. It also noted that social work shortages as well as lack of suitable placements had a negative impact on the way the case was managed.

The case of the 17-year-old who took her own life had been allocated to a Tusla social worker and had been the subject of many discussions between the HSE and Tusla regarding ownership of professional responsibility for keeping the young person safe. The young girl had been known to mental health services for some time prior to her death and had several admissions to psychiatric hospitals before she was referred to Tusla. The review found that the case lacked a single integrated approach between the HSE and Tusla with no agreement as to which case should lead the coordination of professional input.

3.3. Key learning identified in the published reviews.

The learning points highlighted in the published reports generally pertain to frontline practice and local policies. In line with the objective of the National Review Panel to drive improvement in the child protection and welfare sector, each of the published reports contains a section on key learning, where specific topics are highlighted, and relevant research is cited which may improve practice in particular ways. The outstanding learning points in the reports published in 2024 include the following:

3.3.1 The need for greater clarity about the timely exchange of information between areas in order for services to be provided.

3.3.2 The need to be alert to disguised compliance where parents and carers exhibit a superficial cooperation in order to hinder professional involvement.

3.3.3 The need to pay attention to the process of moving young people from one placement to another particularly when they have attachment difficulties.

3.2.4 The importance of an early and proactive approach to engage fathers in child welfare services.

3.2.5. The need for greater clarity in procedural guidance about lead responsibility for the management and coordination of cases where children are at risk of significant harm associated with disability or mental health need.

3.2.6 The need for policy and guidance for the conduct of cases which may be designated as child welfare - high priority.

3.2.7 When initial assessments are conducted, there is a need to consult with partner agencies not only to develop the assessments, but to share conclusions which offer guidance in care planning.

3.2.8 In cases with multi agency involvement, there is an onus on all agencies to respect the complexity of decision making, to be familiar with Tusla's legal and policy mandate and to respect processes and operating procedures. The Joint Protocol for Interagency Working requires revision to incorporate more robust guidance which includes clear accountability arrangements and timelines.

3.2.9 As the reviewers notice that files are often poorly presented and hard to access, consideration needs to be given as to how best to present day to day records in a more accessible format.

3.2.10 Good professional practice would suggest that when participating in a review, professionals should prepare by reviewing their involvement in the case prior to being interviewed.

3.4. Recommendations from reviews published in 2024.

NRP recommendations are made only when there is a clear case for change and the matter identified for improvement has national relevance requiring an adjustment to a policy or guidance document. It is acknowledged that the retrospective nature of this annual report means that some of the recommendations listed below may have already been addressed, particularly as some reports were submitted up to two years prior to publication. Six recommendations were made in reports that were published in 2024, as follows:

3.4.1 It is recommended that when the operation of the CASP is reviewed, the level of adherence to correct procedure when the alleged victim and perpetrator live in different areas should be examined.

3.4.2 Tusla should develop a national policy and strategy to address the mental health needs of children in care.

3.4.3 It is recommended that Tusla and the Department of Children, Equality, Disability, Integration and Youth review Children First guidance on the key functions of Tusla to mandate Tusla as the lead agency in managing and co-ordinating inter-agency care planning in cases where the assessment of harm to a child or young person arising from their own actions is high (i.e. life threatening), combined with concerns about a parent's ability to cope with and manage this risk.

3.4.4. It is recommended that Tusla, with partner agencies and in particular CAMHS, develop guidance for the management of cases categorised as Child Welfare - High Priority.

3.4.5. It is recommended that Tusla takes steps to audit cases currently managed as child welfare – medium priority where children or young people are at risk to establish that this is an appropriate classification.

3.4.6. The Joint Protocol for Interagency Working needs further revision to assist in the management of contested cases.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2024

This section provides a comparative overview of the deaths of children and young people in care or known to child protection services since the NRP began operation in 2010.

4.1. Cause of death summary 2010 to 2024

Cause of Death Summary 2010 to 2024							
Cause of Death	**Natural Causes**	**Suicide**	**Accidents**	**Drug Overdose**	**Homicide**	**Unknown**	**Totals**
2010	6	4	6	4	2	0	**22**
2011	8	3	2	2	0	0	**15**
2012	7	9	6	0	1	0	**23**
2013	7	4	1	1	0	4	**17**
2014	8	8	6	1	2	1	**26**
2015	11	6	2	0	0	2	**21**
2016	10	5	7	2	1	0	**25**
2017	8	3	5	1	2	3	**22**
2018	8	3	1	0	0	1	**13**
2019	8	4	4	1	2	3	**22**
2020	11	7	4	4	2	2	**30**
2021	14	6	1	1	1	4	**27**
2022	15	4	1	0	0	3	**23**
2023	18	4	5	0	0	2	**29**
2024	8	4	2	0	0	5	**19**
Total All Years	**147**	**74**	**53**	**17**	**13**	**30**	**334**
% of Total	**44.01%**	**22.16%**	**15.87%**	**5.09%**	**3.89%**	**8.98%**	**100.00%**

As Table 6 above illustrates, the total number of deaths notified to the National Review Panel between February 2010 and the end of 2024 is 334. The average annual rate of notified deaths is now 24 per year while the number fluctuates somewhat. This is in a context where the number of referrals to the statutory social work services has risen from 29,277 in 2010 to 96,364 in 2024. As each of the foregoing annual reports has highlighted, the children and young people whose deaths were notified during that 14-year period were also involved with a range of different systems including health, mental health, and youth justice, with Tusla social work services playing a major role in certain cases and a minor role in others.

When the overall figures are examined, it is notable that death from natural causes occurred in the majority of cases (44%). This figure covers a wide range of conditions, including congenital and chronic

diseases, childhood illnesses such as cancer and viral infections and Sudden Unexplained Death in Infancy.

4.2 Deaths from suicide

A total of 74 young people whose deaths were notified to the NRP over the past fourteen years died from suicide. This represents nearly a quarter of all notified deaths. Twenty-seven of the young people who died from suicide were in care or aftercare. The age range was 12 years to 23, the most prevalent between 15 and 16 years with another high proportion between 17 and 18 years.

Table 7 below illustrates the ages and numbers of young people whose death was caused by suicide.

Table 7

Age	No.
unknown	1
12	2
13	2
14	6
15	18
16	10
17	15
18	9
19	3
20	4
21	2
22	1
23	1
Total	**74**

Many of the young people who died from suicide had been referred to CAMHS and some had received a consistent service. However, to be eligible for a CAMHS service, it was necessary for a young person to have a diagnosed treatable mental illness. Suicidal ideation alone does not meet the eligibility criteria. It appears to be the case that if a young person who self-harms is admitted to hospital, they may be referred to CAMHS but subsequently discharged from that service because they are not deemed to be mentally ill. Notwithstanding the variability of CAMHS services, some of which are more responsive than others, it is clear that referral of young people with suicidal ideation to CAMHS continues to be generally ineffective.

4.3 Deaths from other causes

The next highest (combined) cause of death concerns accidents (16%). These included incidents such as drowning, falls, house fires, domestic and road traffic accidents. Drug overdose accounts for 5%

and the numbers vary from year to year. Thirteen homicides were notified to the NRP between 2010 and 2024, accounting for almost 4% of deaths. Where murder or other criminal proceedings are ongoing, the NRP must take particular precautions to avoid interfering with legal processes which impact on the timing of such reviews. Where a coroner or post-mortem has failed to identify a cause of death, this is classified as unknown, which accounts for an average of 9% of deaths. On occasion reviews are delayed whilst awaiting a post-mortem or coroner's report.

4.4 Care Status of children whose deaths were notified between 2010 and 2024.

Table 8

Care Status Summary 2010 to 2024				
Care Status	**In care of the HSE / Child & Family Agency**	**In aftercare at time of death / in care immediately prior to 18th birthday or in receipt of aftercare service and under 21 years**	**Living at home and known to child protection services**	**Total**
2010	2	4	16	**22**
2011	2	2	11	**15**
2012	3	2	18	**23**
2013	3	1	13	**17**
2014	3	4	19	**26**
2015	3	2	16	**21**
2016	1	1	23	**25**
2017	5	0	17	**22**
2018	1	1	11	**13**
2019	2	0	20	**22**
2020	1	6	23	**30**
2021	4	3	20	**27**
2022	5	2	16	**23**
2023	2	1	26	**29**
2024	0	2	17	**19**
Total All Years	**37**	**31**	**266**	**334**
% of Total	**11.08%**	**9.28%**	**79.64%**	**100.00%**

As Table 8 above illustrates, 12% of the children or young people whose deaths were notified to the NRP between 2010 and 2024 were in care; a further 9% were either in receipt of aftercare services or had been in care up to their 18th birthday and were under 21 years of age. The remaining 79% were living at home and were known to child protection services for differing periods of time.

4.5 Causes of death of children and ages of children and young people in care

Table 9

Year	In Care at time of death	In Aftercare at time of death	Male	Female	Age					Cause of Death						
					Infants < 12 months	1-5 years	6-10 years	11-16 years	17-23 years	*Natural Causes*	*Homicides*	*Suicides*	*Drug overdoses*	*Accidents*	*Unknown*	*Totals*
2010	2	4	3	3	0	1	0	0	5	1	1	1	3	0	0	6
2011	2	2	3	1	0	0	1	1	2	2	0	0	0	2	0	4
2012	3	2	2	3	0	0	1	2	2	2	0	2	1	0	0	5
2013	3	1	2	2	1	0	0	1	2	2	0	1	1	0	0	4
2014	3	4	5	2	0	0	0	3	4	2	0	4	0	1	0	7
2015	3	2	3	2	0	0	2	2	1	3	0	1	0	1	0	5
2016	1	1	1	1	0	0	0	0	2	0	0	0	1	1	0	2
2017	5	0	2	3	0	1	2	2	0	2	0	1	0	1	1	5
2018	1	1	0	2	0	0	0	1	1	0	0	2	0	0	0	2
2019	2	0	1	1	0	1	1	0	0	2	0	0	0	0	0	2
2020	1	6	4	3	0	0	0	1	6	1	0	3	2	0	1	7
2021	4	3	5	2	1	0	0	2	4	3	0	3	0	1	0	7
2022	5	2	6	1	1	0	0	3	3	4	0	3	0	0	0	7
2023	2	1	0	3	0	0	0	2	1	0	0	2	0	1	0	3
2024	0	2	1	1	0	0	0	0	2	0	0	2	0	0	0	2
Totals	**37**	**31**	**38**	**30**	**3**	**3**	**7**	**20**	**35**	**24**	**1**	**25**	**8**	**8**	**2**	**68**

The causes of death of children in care and their ages is given above in Table 9 and illustrates that the majority of the deaths of children who were in care were from either natural causes or suicide. This has been a consistent pattern. Most of these children had disabilities or chronic illnesses before their entry into care which was primarily for child protection reasons.

The age span during which most deaths of children in care occurred was between 11 and 16 years, with a higher number in the aftercare group signifying the vulnerability of that cohort.

5. Activities of the NRP during 2024

- During 2024, panel members submitted reports on four children and young people, comprising three desktop reviews and one comprehensive review. A further 12 reports were brought to finalisation stage but were retained pending data protection advice. These reports will be submitted during 2025.
- At the end of 2024 forty-eight reviews were ongoing including the above mentioned 12.
- Twenty-eight interviews took place between review teams and staff members from the Child and Family Agency and other organisations during 2024. In addition, ten meetings were held with family members.
- Quarterly meetings between the Chair, Deputy Chair and the Quality and Regulation Directorate took place as scheduled.
- The Chair of the NRP attended the Service and Quality subcommittee of the Board of Tusla in May 2024.
- All NRP members attended an in-person data protection training session with Ambit Compliance in June 2024
- The Chair, Deputy Chair and Service Manager attended a meeting with the Ombudsman for Children's Office in July 2025 regarding the proposal for a national child death review process. The NRP cautioned that their remit would not fit easily within a national process that is primarily medical.
- The Chair attended a round table briefing and discussion in September 2024 hosted by the CEO of Tusla with stakeholders in the child protection and welfare network.
- Ongoing discussions took place during the first half of 2024 between the NRP and Tusla with regard to the procurement of data protection consultancy support. After a competitive 'request for quote' process which was finalised in September 2024, Ambit Compliance was contracted by Tusla on behalf of the NRP, to provide a DP consultancy service.
- The Chair, Deputy Chair and Service Manager attended a meeting with the DCEDIY in October 2024 to discuss how their commitment to restructuring the NRP was to be actioned as well as the revision of the operational guidance issued by the DCEDIY which was due in 2024.
- An in-person training session with all panel members was held in December 2024

5.1 Outstanding issues

GDPR continues to impact on the work of the NRP, particularly in respect of obtaining full or redacted records from services outside Tusla's direct remit. The legal basis of the NRP for requesting records is

not always accepted and this impacts on reviewers' ability to undertake a holistic and balanced review. Discussions are in train to develop a data sharing agreement between Tusla and the HSE which will go some way towards resolving the matter. This matter is connected with the second outstanding issue, which is the status of the NRP in terms of governance, independence and interagency cooperation. The DCEDIY have undertaken to address this matter as part of a phased process, the next stage of which will be revision of the guidance on the operation of the panel.

Appendix:

National Review Panel members who participated in reviews during 2024

Dr Helen Buckley, (Chairperson)

Dr Ann Mc Williams (Deputy Chair)

Ms Margaret Burke

Ms Ciara Mc Kenna Keane

Mr Eamon Mc Ternan

Mr Eric Plunkett

Dr Rosaleen McElvaney

Ms Christine McConville

Dr Paul Sargent

Mr Michael Lynch

Ms Rohana Reading

Mr Ruadhan Hogan

Ms Liz Chaloner

Ms Lorraine Bates

Ms Michele Clarke