Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2017

Foreword

This report is presented in five parts. The first section provides an introduction on the role and function of the NRP. The second part statistical information and a brief analysis of the notifications made to the panel in 2017. The third part then presents a statistical overview and analysis of the notifications over the past eight years. The fourth section provides an overview of the reports published in 2017. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2017.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2017 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

August 2018

1. Introduction

The National Review Panel (NRP) consists of a group of consultants, individually contracted by the Child and Family Agency. Panel members are assigned to cases according to their particular expertise and experience. None of the members have been involved professionally in any of the cases under review. The panel is chaired by Dr. Helen Buckley, who was formerly an Associate Professor in the School of Social Work and Social Policy, Trinity College Dublin and is responsible for identifying cases for review, deciding on the level of review, assigning reviews to individual teams and quality assuring the reports prior to submission. 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 2017 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 Chair of the board of the Child and Family Agency, and to the Health, Information and Quality Authority (HIQA).

1.1 Guidance on the operation of the NRP

During 2017, the NRP continued to operate under guidance published by the Department of Children and Youth Affairs in late 2014, available on the DCYA website at

http://dcya.gov.ie/documents/publications/20141204GuidOperationofationalReviewPanel.pdf

The 2014 guidance reflects current arrangements in the administration of child protection and identifies the key stakeholders participating in reviews as the NRP, the Child and Family Agency and HIQA.

1.2 Functions of the National Review Panel

The NRP reviews cases where a serious incident or death occurs of children or young people under 18 who are in the care of the state, or have been known to the Child and Family Agency's social work department or funded services. It also reviews cases which have come to light which carry a high level of public concern and the need for further investigation is apparent. 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 effectiveness of frontline and management activity as well the compliance with guidance and procedures. It also examines inter-agency collaboration and identifies obstacles to good practice. One of its most important functions is to identify areas for learning and each report contains a section specifically for this purpose.

During 2017, the NRP continued to operate similar processes to those adopted at the outset, and differentiates between major, comprehensive, concise and desktop reviews

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. Interviews are recorded and transcribed. 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 learning points from each review. Where a policy deficit is noted, relevant recommendations are made. A toolkit for the conduct of reviews was revised in February 2016. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by the NRP.

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.

2. Deaths of children and young people notified in 2017

2.1 Deaths of children and young people

A total of 22 deaths of children and young people in care or known to the child protection system were notified in 2017. This figure represents a decrease of 4 from the previous year. The following table 1 illustrates the causes of death.

Table 1

Cause of Death Summary 2017			
Cause of Death	**No.**	**Male**	**Female**
Natural Causes	**8**	**4**	**4**
Suicides	**3**	**1**	**2**
Road Traffic Accidents	**2**	**2**	**0**
Other Accidents	**3**	**1**	**2**
Drug Overdoses	**1**	**1**	**0**
Homicides	**2**	**2**	**0**
Unknown	**3**	**2**	**1**
Totals	**22**	**13**	**9**

As Table 1 above shows, eight of the 22 children/young people who were notified died as a result of natural causes and three others from suicide (two less than in 2016). Two out of the three young people who took their own lives were female. The next most common cause pf death was a combination of road traffic and other accidents experienced by five young people (a decrease of two on 2016). One young person died from a drug overdoses compared with two in 2016.

2.2. Care status of children or young people whose deaths were notified in 2017

Table 2

Care Status Summary 2017				
In care at time of Death	**In aftercare at time of death**	**In care immediately prior to 18th birthday or in receipt of aftercare services and under 21 years**	**Known to social work services**	**Total**
5	**0**	**0**	**17**	**22**

As Table 2 above shows, five young persons under 18 years whose death were notified were in care at the time of their death. This is an increase of four on the 2016 figures. No young people in aftercare died, compared with one the previous year. The remaining 17 children or young people were known to child protection services.

2.3 Summary of deaths and serious incidents reported in respect of children in care 2017

Table 3 below provides a summary of deaths and serious incidents that were notified to the NRP in respect of children in care. Reviews of serious incidents are carried out when there is reason to believe that an event or series of events may have caused potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development.

Table 3

Care Summary 2017 Deaths and Serious Incidents			
	Deaths	**Serious Incidents**	**Total**
In care	**5**	**2**	**7**
In aftercare/ in care immediately prior to 18th birthday	**0**	**0**	**0**
Known to social work services	**17**	**1**	**18**
Total	**22**	**3**	**25**

2.4 Ages and gender of children and young people whose deaths were notified in 2017

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

Table 4

Age Profiles 2017			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**8**	**4**	**4**
1 - 5 years old	**4**	**2**	**2**
6 - 10 years old	**3**	**2**	**1**
11 - 16 years old	**6**	**5**	**1**
17 - 20 years old	**1**	**0**	**1**
> 20 Years Old	**0**	**0**	**0**
Total	**22**	**13**	**9**

As the above table shows, most deaths (8) occurred in respect of infants under 12 months, with the next highest proportion (6) between 11 and 16 years old. Although the figures are too low to make useful inferences it can be noted that there was a slight decrease in the numbers of infants that

died. Just over three fifths of children/young people who died were male with the largest gender difference in the younger age groups**.**

2.5 Summary of deaths by region

Table 5

Deaths by Region Summary 2017				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
8	**5**	**5**	**4**	**22**

3. Statistical overview of all deaths notified between 2010 and 2017

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

3.1. Cause of death summary 2010/2017

Table 6

Cause of Death Summary 2010 / 2017										
Cause of Death	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total All Years**	**% of Total**
Natural Causes	**6**	**8**	**7**	**7**	**8**	**11**	**10**	**8**	**65**	**38.01%**
Suicides	**4**	**3**	**9**	**4**	**8**	**6**	**5**	**3**	**42**	**24.56%**
Road Traffic Accidents	**4**	**1**	**2**	**0**	**5**	**1**	**3**	**2**	**18**	**10.53%**
Other Accidents	**2**	**1**	**4**	**1**	**1**	**1**	**4**	**3**	**17**	**9.94%**
Drug Overdoses	**4**	**2**	**0**	**1**	**1**	**0**	**2**	**1**	**11**	**6.43%**
Homicides	**2**	**0**	**1**	**0**	**2**	**0**	**1**	**2**	**8**	**4.68%**
Unknown	**0**	**0**	**0**	**4**	**1**	**2**	**0**	**3**	**10**	**5.85%**
Totals	**22**	**15**	**23**	**17**	**26**	**21**	**25**	**22**	**171**	**100.00%**

As Table 6 above illustrates, the total number of deaths notified to the National Review Panel since February 2010 is 171. The average rate of notified deaths is 21 per year over an eight year period, and the trend has been reasonably consistent. Natural causes remain the highest cause of death (38.3%), with suicide representing 25% of the total. The next highest combined total is accidents,

including road accidents which together account for 20% of deaths. Drug overdose accounts for 6% and the numbers have been fluctuating. Homicide accounts for nearly 5% of deaths. 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 5% of deaths.

Table 7

Care Status Summary 2010 / 2017 (Deaths)										
Care Status	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Totals**	**Care Status % of overall**
In care of the HSE / Child & Family Agency	**2**	**2**	**3**	**3**	**3**	**3**	**1**	**5**	**22**	**12.87%**
In aftercare at time of death / in care immediately prior to 18th birthday or in receipt of aftercare service and under 21 years	**4**	**2**	**2**	**1**	**4**	**2**	**1**	**0**	**16**	**9.36%**
Living at home and known to child protection services	**16**	**11**	**18**	**13**	**19**	**16**	**23**	**17**	**133**	**77.78%**
Total	**22**	**15**	**23**	**17**	**26**	**21**	**25**	**22**	**171**	**100.00%**

As Table 7 above illustrates, 13% of the children or young people whose deaths were notified to the NRP between 2010 and 2017 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 78% were living at home and were known to child protection services for differing periods of time.

Table 8

Summary Cause of Deaths of children/young people in care 2010 / 2017																
Year	In Care at time of death	Male	Female	Age					Cause of Death							
				Infants < 1 year	1-5 years	6-10 years	11-16 years	17-20 years	*Natural Causes*	*Homicides*	*Suicides*	*Drug Overdoses*	*Road Traffic Accidents*	*Other Accidents*	*Unknown*	*Total*
2010	2	2	0	0	1	0	0	1	1	1	0	0	0	0	0	2
2011	2	1	1	0	0	1	1	0	2	0	0	0	0	0	0	2
2012	3	0	3	0	1	1	1	0	2	0	1	0	0	0	0	3
2013	3	2	1	1	0	0	1	1	2	0	0	1	0	0	0	3
2014	3	1	2	0	0	0	3	0	0	0	3	0	0	0	0	3
2015	3	3	0	0	0	0	2	1	2	0	0	0	1	0	0	3
2016	1	1	0	0	0	0	0	1	0	0	0	1	0	0	0	1
2017	5	2	3	0	1	2	2	0	2	0	1	0	0	1	1	5
Total	22	12	10	1	3	4	10	4	11	1	5	2	1	1	1	22

The causes of death of children in care and their ages is given above in Table 8, and illustrates that the children who were in care died from natural causes more than twice as often as suicide and also twice as often as combined other causes. Most of the children and young people in care who died from natural causes were ill or disabled before their entry into care and their entry into care was primarily for child protection, apart from one case where it was for welfare reasons as the child's main carer was indisposed. The age span during which most deaths occurred was between 11 and 16 years.

4. Overview of reports published in 2017

Tusla, the Child and Family Agency, published NRP executive summary reports in 2017, on 13 children who had died in previous years. These comprised three comprehensive reviews, three concise reviews and seven desktop reviews.

4.1 The children/young people who were the subjects of reports published in 2017

Two of the young people who died had been in care, one had been in foster care for eighteen months and the other young person had spent a short period in residential care prior to his death. In the former case, the young person was in foster care because of a breakdown in the relationship

between herself and a relative who was caring for her. She died by suicide. The other young person had been in residential care because of neglect and maternal drug misuse and died as a result of a drug overdose. Two other young people had been in care up to 18 years and had died at 21 years; one had actually been in foster care all his life and adopted just prior to his 18th birthday. He died by suicide. The other young person had been in care for four years because of challenging behaviour and a difficult relationship with her parents. She died as a result of a drug overdose.

In total, six of the young people in the published reports had died by suicide, the youngest was 13 and the eldest was 21. Of the remainder, two died accidentally, the younger one was three months and the eldest was 17. Two young people, aged 17 and 21 respectively died from drug overdoses; a baby and a two year old died from congenital illnesses and one infant died from sudden unexpected death in infancy.

The reasons why the children who were subjects of the published reports were in contact with the services included parental drug use in five cases; alcohol abuse in two cases; domestic violence in another five cases and frequently a combination of these factors. In three cases the children themselves had mental health difficulties and two of the young people had been diagnosed with autism/developmental disorders. One of the infants had been born to a mother who had used drugs during pregnancy. Two of the young people were in care mainly because of relationship difficulties with their families due to challenging behaviour. Other children were in contact with the service because of general neglect by their parents.

4.2 Findings from reports

The reports showed evidence of some very good practice, once the services had become involved. In a proportion of cases, the initial response of the Tusla services had been either slow or incident based. Two common factors prevailed in a substantial number of cases; inadequate assessment and categorisation of cases as 'child welfare' when there were, in the opinion of the reviewers, fairly evident risk factors. In some cases, it was considered that the impact of parental drug use and domestic violence and sometimes a combination of both was not fully evaluated. Information was not always collated or shared between key stakeholders. It was notable that some social work departments were under serious pressure with high referral rates and staff shortages that inevitably impacted on their ability to provide a good quality service. This was visible where aspects of casework 'drifted' and particularly impacted where transfer of responsibility for cases between areas was required.

Some practice and policy challenges for Tusla child protection services have been demonstrated in these reports, including the following:

From a practice perspective:

- Assessment practice still requires to be improved, particularly in relation to investigation of physical abuse but also in relation to the impact of domestic violence and substance abuse.

From a policy perspective

- Five years on from the separation of Tusla from the HSE, communication difficulties continue to emerge between social work departments and the HSE public health nursing service.
- The practice of categorising cases as child protection and child welfare belies the very permeable boundaries between situations of risk and situations of need and has implications for the way that a case is processed.

4.3 Key Learning in reports

An important aim of the National Review Panel is to drive learning in the child protection and welfare sector. Each of the published reports highlights areas where reflection and consideration of relevant research evidence may improve practice in particular ways. These key learning points are elaborated in the individual reports and may be summarised as follows:

Responding to child protection and welfare reports

- Assessments, including risk assessment of suspected physical abuse need to be conducted with greater understanding of the dynamics involved and more inclusive of the impact of adverse factors, particularly combinations of factors, in both early and later phases of childhood. Full family histories need to be included and the impact of parental substance abuse and domestic violence need to be fully evaluated. Child to parent violence (CPV) needs to be recognised as a phenomenon and responded to accordingly.
- Allegations of abuse made in the context of acrimonious separations warrant investigation in respect of the emotional impact on children. Excluding fathers means that an important element of family relationships may be missed.

Working with children and families

- Where the mental health of a young person is a concern, partnership between mental health and child protection services needs to be activated. The topic of working with families who are difficult to engage needs to be creatively explored.

- Designating a case as child welfare where domestic violence exists requires careful forethought. When a family support service is provided, progress needs to be carefully evaluated.

- It is important to recognise the impact on school absenteeism not only on a child's education but also on his or her confidence, social skill development and resilience.

- Where the capacity of a SWD to respond to the volume of cases referred to it is severely stretched, prioritisation needs be carefully conducted. Decisions about case closure should reflect real improvement in family situations rather than simply an absence of recent child protection reports.

- The establishment and maintenance of reliable channels of communication is particularly required since the separation of Tusla from mainstream health services.

Working with children in care

- While family placements often work very well for children, they are subject to certain vulnerabilities and require specific supports. The importance of placing siblings together where possible needs to be recognised

- Placement of children in a foster family should comply with foster care standards and not challenge the capacity of foster carers to meet the needs of all the children in their care. Foster carers need regular and consistent contact by fostering link worker.

- Children in care need opportunities to develop relationships with their allocated social workers. The importance of providing children in care with information about their backgrounds needs to be recognised and built into practice.

- When the opportunity exists for a child in care to be adopted by his or her foster carers, the process should be expedited.

4.4. Recommendations

The reports made a number of recommendations, some of which have already been addressed by the Child and Family Agency. These reflect the principal issues highlighted in the reports and were as follows:

- The evaluation of risk should become a standard element of any national assessment framework.
- Local areas promote, as far as possible, collaborative responses to domestic violence which utilises the combined and individual skills of all relevant services.
- The establishment of a nationwide Drugs Liaison Midwife service is not within the remit of the Child & Family Agency. However, it is suggested here that any opportunity to promote its establishment is taken by the agency.
- Staff turnover should be identified as a potential obstacle to good practice in the forthcoming Child and Family Agency Child Protection and Welfare Practice Handbook, with pointers as to how disruption or delays in service could be minimised.
- Tusla should revisit the 2012 review regarding the integration of the National Educational Welfare Board (NEWB) with Tusla to ascertain whether outstanding challenges have been addressed.
- The inquest jury in one case 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.
- It is recommended that formal channels for communication between the Child and Family Agency and the public health nursing service are established and maintained.

5. Activities of the NRP during 2017

5.1 Routine NRP work

During 2017, panel members completed and submitted reports on 9 children and young people, comprising five desktop reviews, two concise reviews, two comprehensive reviews. Some of these reports were published in 2017 alongside a number of other previously submitted reviews.

Thirty five interviews were conducted with staff members from the Child and Family Agency and staff from organisations outside the Child and Family Agency as well as family members.

Meetings to discuss reports prior to finalisation and publication were held with nine family members in respect of five different reviews.

5.2 Recruitment

A programme was initiated in late 2016 and completed in early 2017 to recruit new members to the NRP. An advertisement was placed in the Irish Times and relevant websites and 59 applications were received. Following shortlisting and interviewing, 12 new panel members were offered contracts and invited to take part in a training programme in May 2017. The new members were from backgrounds of social work, education, psychotherapy, law, and an Garda Síochána. The two day programme covered introduction to the review process; doing a review; legal aspects of the review process; case management; recent Tusla reforms and case study exercises. It was delivered by Dr Helen Buckley with contributions from existing panel members, as well as Sinead Treacy and Cormac Quinlan from Tusla and Eoghan Cole, BL who is a legal advisor to the NRP.

5.3 Replacement of deputy chair

In May 2017 Dr Bill Lockhart resigned his position as deputy chair of the panel and was replaced by Dr Ann McWilliams.

5.4 Meetings between the NRP and the Child and Family Agency

The Chair of the NRP reports directly to the Chair of the Child and Family Agency. The NRP comes under the ambit of the Quality Assurance and Risk Committee of the Agency. Helen Buckley, Chair, Ann McWilliams, Deputy Chair and Ann Kennedy, Service Manager had four meetings during 2017 with Brian Lee, Director of Quality and Risk and Sinead Treacy, National Risk and Incident Manager, Tusla to provide updates on the work of the NRP and discuss matters relevant to its operation.

6. National Review Panel members 2017

Dr Declan Bedford

Ms Eimear Berry

Ms Margaret Burke

Dr Cathleen Callanan

Ms Michele Clear

Mr Barry Fitzgerald

Dr Bill Lockhart (Deputy Chair) Retired May 2017

Ms Ciara Mc Kenna Keane

Mr Padraig Kennedy

Mr Shane Mc Carthy

Ms Deirdre Mc Teigue

Mr Eamon Mc Ternan

Dr Ann Mc Williams (Deputy Chair from July 2017)

Mr Frank Martin

Dr Joan Michael

Ms Ruth More O Ferrall

Ms Ceili O Callaghan

Ms Patricia O Connell

Professor Ian O Donnell

Mr John O Reilly

Mr Eric Plunkett

Dr Imelda Ryan

Mr Andrew Thompson