



*Painéal Náisiúnta Athbhreithnithe*  
**NATIONAL REVIEW PANEL**

## **National Review Panel**

### **Annual Report**

**2018**

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## **Foreword**

I am pleased to submit the National Review Panel Annual Report to the Chair of the Board of Tusla.

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 2018. The third part then presents a statistical overview and analysis of the notifications over the past five years. The fourth section provides an overview of the reports published in 2018. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2018.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2018 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 the recently retired Service Manager, Ann Kennedy and her successor, Linda Nolan, in their support of the panel's work and for providing the statistical tabulations included in this report.

**Dr. Helen Buckley**

**Chairperson, National Review Panel**

**June 2019**

## **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, Fellow Emeritus, School of Social Work and Social Policy, Trinity College Dublin who 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 Deputy Chair is Dr Ann McWilliams who also contributes to the above activities. 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 notifications and case records, organising and planning interviews, transcript management, resource and financial matters including staff contracts, provision of information and updates to Tusla, 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 2018 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).

In November 2018 the government approved a proposal by the Department for Children and Youth Affairs to put the NRP on a statutory footing. This will require new legislation and is due to take place in 2019.

### **1.1 Guidance on the operation of the NRP**

During 2018, 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 the 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 2018

### 2.1 Deaths of children and young people

A total of 13 deaths of children and young people in care or known to the child protection system were notified in 2018. This figure represents a decrease of 9 on the previous year. The following table illustrates the causes of death

**Table 1**

<b>Cause of Death Summary 2018</b>			
<b>Cause of Death</b>	<b>No.</b>	<b>Male</b>	<b>Female</b>
Natural Causes	8	2	6
Suicide	3	0	3
Road Traffic Accident	0	0	0
Other Accidents	1	0	1
Drug Overdose	0	0	0
Homicide	0	0	0
Unknown	1	1	0
<b>Totals</b>	<b>13</b>	<b>3</b>	<b>10</b>

As Table 1 above shows, eight of the 13 children/young people who were notified died as a result of natural causes and three others from suicide. The three young people who took their own lives were female. One of the other deaths was from an accident and the cause of the other death has not been established.

### 2.2. Care status of children or young people whose deaths were notified in 2018

**Table 2**

<b>Care Status Summary 2018</b>				
<b>In care at time of Death</b>	<b>In aftercare at the time of death</b>	<b>In care immediately prior to 18th birthday or in receipt of aftercare services and under 21 years</b>	<b>Known to social work services</b>	<b>Total</b>
<b>1</b>	<b>1</b>	<b>0</b>	<b>11</b>	<b>13</b>

As Table 2 above shows, one young person under 18 years whose death was notified was in care at the time of their death. One other young person was in aftercare. The remaining 11 children or young people were living with their families in the community and known to child protection services.

### 2.3 Summary of deaths and serious incidents reported in respect of children in care 2018

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**

<b>Care Summary Deaths &amp; Serious Incidents 2018</b>			
<b>Deaths and Serious Incidents</b>			
	<b>Deaths</b>	<b>Serious Incidents</b>	<b>Total</b>
<b>In care</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>In aftercare/ in care immediately prior to 18th birthday</b>	<b>1</b>	<b>0</b>	<b>1</b>
<b>Known to social work services</b>	<b>11</b>	<b>0</b>	<b>11</b>
<b>Total</b>	<b>13</b>	<b>2</b>	<b>15</b>

### 2.4 Ages and gender of children and young people whose deaths were notified in 2018

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

**Table 4**

<b>Age Profiles 2018</b>			
<b>Age Band</b>	<b>No.</b>	<b>Male</b>	<b>Female</b>
<b>Infants &lt; 12 months</b>	<b>6</b>	<b>1</b>	<b>5</b>
<b>1 - 5 years old</b>	<b>1</b>	<b>0</b>	<b>1</b>
<b>6 - 10 years old</b>	<b>1</b>	<b>0</b>	<b>1</b>
<b>11 - 16 years old</b>	<b>3</b>	<b>1</b>	<b>2</b>
<b>17 - 20 years old</b>	<b>2</b>	<b>1</b>	<b>1</b>
<b>&gt; 20 Years Old</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total</b>	<b>13</b>	<b>3</b>	<b>10</b>

As the above table shows, most deaths (6) occurred in respect of infants under 12 months, with the next highest proportion (3) between 11 and 16 years old. Although the figures are too low to make useful inferences it can be noted that for the first time, the majority of children/young people who died were female.

## 2.5 Summary of deaths by region

Table 5

Deaths by Region Summary 2018				
Dublin Mid Leinster	Dublin North East	South	West	Total
1	7	3	2	13

As Table 5 shows, the highest proportion of deaths occurred in Dublin North East, which is commensurate with the population in the area.

## 3. Statistical overview of all deaths notified between 2010 and 2018

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 2010/2018

Table 6

Cause of Death Summary 2010 / 2018											
Cause of Death	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total All Years	% of Total
Natural Causes	6	8	7	7	8	11	10	8	8	73	39.67%
Suicide	4	3	9	4	8	6	5	3	3	45	24.46%
Road Traffic Accident	4	1	2	0	5	1	3	2	0	18	9.78%
Other Accident	2	1	4	1	1	1	4	3	1	18	9.78%
Drug Overdose	4	2	0	1	1	0	2	1	0	11	5.98%
Homicide	2	0	1	0	2	0	1	2	0	8	4.35%
Unknown	0	0	0	4	1	2	0	3	1	11	5.98%
Totals	22	15	23	17	26	21	25	22	13	184	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 December 2018 is 184. The average rate of notified deaths is 20 per year over an almost nine year period, and the trend has been reasonably consistent. Natural causes remain the highest cause of death at almost 40% with suicide representing 24% of the total. The next highest combined total is accidents, including road accidents which together account for almost 20% of deaths. Drug overdose accounts for 6% and the numbers have been fluctuating. Homicide accounts for just over 4% of deaths. Where a coroner or post mortem has failed to identify a cause of death, this is classified as unknown, and accounts for an average of 6% of deaths.

**Table 7**

Care Status Summary 2010 / 2018 (Deaths)												
Care Status	2010	2011	2012	2013	2014	2015	2016	2017	2018	Totals	Care Status % of overall	
In care of the HSE / Child & Family Agency	2	2	3	3	3	3	1	5	1	23	12.50%	
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	1	17	9.24%	
Living at home and known to child protection services	16	11	18	13	19	16	23	17	11	144	78.26%	
<b>Total</b>	<b>22</b>	<b>15</b>	<b>23</b>	<b>17</b>	<b>26</b>	<b>21</b>	<b>25</b>	<b>22</b>	<b>13</b>	<b>184</b>	<b>100.00%</b>	

As Table 7 above illustrates, 12% of the children or young people whose deaths were notified to the NRP between 2010 and 2018 were in care; a further 9% were either in receipt of aftercare services or had been in care up to their 18<sup>th</sup> 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 / 2018																
Year	In Care at time of	Sex		Age					Cause of Death							
		Male	Female	Infants < 12 months	1-5 years	6-10 years	11-16 years	17-20 years	Natural Causes	Homicide	Suicides	Drug overdoses	Road Traffic	Other Acciden	Unknown	Totals
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
2018	2	0	2	0	0	0	1	1	0	0	2*	0	0	0	0	2
<b>Totals</b>	<b>24</b>	<b>12</b>	<b>12</b>	<b>1</b>	<b>3</b>	<b>4</b>	<b>11</b>	<b>5</b>	<b>11</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>24</b>

\* Number refers to 1 child in care and 1 child in aftercare

The causes of death of children in care and their ages is given above in Table 8, and illustrates that the majority of children whose deaths were notified and were in care died from natural causes. The



next highest cause was suicide. Equal numbers died from accident, road accident and drug overdoses. One young person in care died as a result of homicide. 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 2018**

Tusla, the Child and Family Agency, published the executive summaries of twelve reviews during 2018. The reviews on which the summaries were based comprised four comprehensive reviews, six desktop reviews and two concise reviews.

### **4.1 The children/young people who were the subjects of reports published in 2018**

Three of the young people whose deaths were reviewed had been in care, including one in relative foster care and another who was receiving aftercare services. Two of the young people had been in care because of parental substance abuse and mental health problems. Another had been in care because his behaviour was outside his parents' control.

In total, four of the young people who were the subjects of reports published in 2018 had died by suicide, the youngest was 15 and the eldest was 19. Of the remainder, two died from drug overdoses, two in accidents two young people died from illness. In addition, two new born infants died; one was stillborn and another infant died from SIDS while co-sleeping. Both of their mothers had been misusing drugs in pregnancy. Four of the young people who were the subject of published reports had been diagnosed with ADHD or autism.

The reasons why the twelve children who were subjects of the published reports were in contact with the services included parental drug/alcohol use in seven cases; In six cases which overlapped in some instances with the former, the main concern was the young person's out of control behaviour and their parents' inability to manage it despite their best efforts. In one of these cases, the young person was in urgent need of a residential autism service, and the lack of such a service put his safety at risk and strained his parents' capacity to protect him. In another case, a young person was the subject of allegations of child sexual abuse and was under Garda investigation.

## **4.2 Recurring practice and policy themes in reports**

The reports showed evidence of good practice in a number of cases. This was particularly evident in the two cases where children died from serious illnesses, where there were examples of consistent child centred work and excellent interagency cooperation. There were a number of other cases where early responses were initially slow but improved in quality and consistency once social workers had become involved. As in previous years, the NRP found that some cases had been placed in the 'welfare' rather than the 'child protection' category where risks were evident. It appeared to the reviewers that the classification of 'welfare' was made if no parental omission was seemed to exist, regardless of the dangers which the young person was facing often through their own behaviour and the impact on them of earlier adverse events such as domestic violence or parental addiction. It was considered by the NRP that an overly optimistic view was taken of parental capacity to cope in those cases. As in earlier years, lack of adequate assessment existed in some instances. In one case, where a young person had been accused of sexual assault on another young person, the SWD had followed Tusla policy by delaying speaking to about the allegations him until the alleged victim had been assessed. However, the NRP concluded that the delay in providing a response to him went against his best interests, despite policy being followed.

Service deficits were significant in relation to mental health services and in particular for services for children with autism. In these cases, the burden of responsibility for protecting the young people fell disproportionately on Tusla, which has no control over decisions made by health, mental health or disability services. The lack of an out of hours service in rural areas, which has since been remedied, was highlighted in one review.

## **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 specific ways. These key learning points are elaborated in the individual reports and may be summarised as follows:

### Responding to child protection and welfare reports

- More active follow up is required in cases where child protection thresholds have not been reached. The fact that parents were not considered liable for the difficulties being experienced by their children should not dilute the level of concern held by Tusla for their safety.

- It is acknowledged that the implementation of the Tusla Child Protection and Welfare Strategy should raise the standard of assessment, but this area was also highlighted as requiring improvement. In particular, it was considered that guidance on engaging with hard to reach teenagers should be developed and utilised, as a number of reviews show this to be a challenging area.
- The need to promote attendance in education and training and the implications of school dropout were highlighted in learning points.
- Learning points in the individual reviews highlighted the importance of supporting foster placements, especially the impact of placements on all the individuals involved and the avoidance of overcrowding placements which puts excessive pressure the entire family.. The need for regular visiting and direct work with children was emphasised, as well as the importance of keeping children abreast of progress where certain types of placement were being sought.
- As in previous years, the learning points highlighted the importance of evidence based practice and specifically the acquisition and use of knowledge about post-natal depression and about the impact of drug use on parenting and the health of unborn children and the damage caused to young people by excessive alcohol consumption.
- Certain aspects of interagency collaboration were highlighted including the reality that when children have complex needs, the response made to them must be multi agency rather than left to Tusla, with clarity about which agency takes the lead. In this regard, the risk of overwhelming families or individual young people with numerous professionals was cited, highlighting the necessity to agree on key workers who will lead interventions and keep the other services appraised and involved as necessary.

#### **4.4. Recommendations**

The reports made a number of recommendations, mainly about mental health and autism services. The lack of adequate mental health services and the mismatch between the expectations held of CAMHS and the reality of what this service is prepared to offer are themes that have recurred frequently since the NRP was established. This very significant deficit is outside the capacity of Tusla to resolve and needs attention from the government.

Four of the children who were the subject of reviews had been diagnosed with ADHD or autism, and one case in particular illustrated the significant lack of autism services in Ireland, both at community and residential levels. The review made a number of recommendations, including the need for clarity about pathways for children whose safety is at risk and who have mental health, disability or autism needs. It was recommended that the 2017 Protocol Promote the Best Interests of Children and Families should be revisited to clarify the roles and responsibilities of different agencies. The development of procedural guidance including Tusla practice guidance on responding to children with autism and disabilities with was also recommended. These matters have been brought to the attention of the DCYA by the NRP.

The fact that the NRP is confined by its remit to making its recommendations to Tusla causes difficulty at times, such as when the issues involved in a case span different sectors including health, mental health and education. The DCYA agreed in 2018 to take responsibility for communicating with other government departments when the recommendations of reviews require action to be taken on an intersectoral basis.

## **5. Activities of the NRP during 2018**

### **5.1 Routine NRP work**

During 2018, panel members completed and submitted reports on 11 children and young people, comprising five desktop reviews, two concise reviews and four comprehensive reviews. Some of these reports were published in 2018 alongside a number of other previously submitted reviews.

Fifty nine 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.

### **5.2 Change of personnel**

Ms Ann Kennedy, who had been Service Manager with the NRP, retired in October 2018. Her post was filled on an interim basis by Ms Linda Nolan, pending a permanent appointment.

### **5.3 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. The Chair of the NRP had one meeting with the Chair of Tusla to discuss a specific case in 2018.

Dr Helen Buckley, Chair, Dr Ann McWilliams, Deputy Chair and Ann Kennedy (later replaced by Linda Nolan), Service Manager had four meetings during 2018 with Brian Lee, Director of Quality and Risk and Sinead Treacy, Manager, Quality and Risk, Tusla to provide updates on the work of the NRP and discuss matters relevant to its operation.

### **5.4 Meetings with the Department of Children and Youth Affairs**

The Chair of the NRP and representatives from Tusla had two meetings with the DCYA in 2018 to discuss a strategy for actioning recommendations that were outside the remit of Tusla and to discuss proposals for putting the NRP on a statutory basis.

### **5.5 Training**

The NRP held a training session in October 2018 where the Director of Policy and Reform and a colleague presented information about Signs of Safety, the practice framework which underpins the Child Protection and Welfare Strategy.

## **6. National Review Panel members 2018**

**Dr Helen Buckley, Chairperson)**

**Dr Ann Mc Williams (Deputy Chair)**

**Ms Eimear Berry**

**Ms Margaret Burke**

**Dr Cathleen Callanan**

**Ms Michele Clear**

**Mr Barry Fitzgerald**

**Ms Ciara Mc Kenna Keane**

**Mr Pdraig Kennedy**

**Mr Shane Mc Carthy**

**Mr Eamon Mc Ternan**

**Dr Joan Michael**

**Ms Ruth More O Ferrall**

**Ms Ceili O Callaghan**

**Ms Patricia O Connell**

**Mr John O Reilly**

**Mr Eric Plunkett**

**Dr Imelda Ryan**

**Mr Andrew Thompson**