National Review Panel

Annual Report

2014

Foreword

The National Review Panel was established in late 2010, and 2014 was its fourth full year of operation. By the end of 2014, 103 deaths had been notified.

This report is presented in six sections. The first section outlines the role of the panel and the processes operated by it to review the cases notified to it. The second part provides statistical information and a brief analysis of the notifications made to the panel in 2014. The third section presents an overview of the findings from reports published during 2014. The fourth section provides a statistical overview of all the deaths of children and young people notified to the NRP between 2010 and 2014. The fifth section provides an overview of the learning points and recommendations from NRP reports between 2010 and 2014. Finally, Section Six presents the names of the panel members.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2014 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

November 2015

National Review Panel

Annual Report 2014

1. Introduction

The National Review Panel (NRP) was established in 2010, and 2014 was its fourth full year of operation. The NRP is independently commissioned by the Child and Family Agency 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 2014 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 Revised guidance on the operation of the NRP

When the NRP was established in 2010, its operation was based on guidance produced by HIQA. It was specified in the document that the guidance would be revised, and this process took place in 2014. A working group was set up for this purpose. It was chaired by the Department of Children and Youth Affairs (DCYA), with representation from the Child and Family Agency, the NRP and HIQA. Revised guidance was published on the DCYA website in November 2014 and has now been implemented. It can be accessed at:

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

The 2014 guidance reflects the changes in administration of the child protection services including the establishment of the Child and Family Agency.

1.2 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 effectiveness and quality of frontline and management activity as well the compliance with guidance and procedures. It also examines inter-agency collaboration and highlights obstacles to good practice. A major function of the review process is the identification of learning points which, if addressed, may positively influence the quality of practice.

During 2014, 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

Review teams are selected for different cases according to the specific experience and skills of the panel members. 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 cases. Interviews are recorded and transcribed. Each report provides a chronological account of service provision in respect of the child who died or experienced a serious incident. The quality of frontline and management practice is analysed in each case. A toolkit for the conduct of reviews had been developed at the by the chair in consultation with panel members and is revised from time to time in line with policy developments. 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.

1.4 Interviews conducted with staff and families during 2014

A total of 47 persons were interviewed by the NRP in 2014. Fifteen were family members of foster carers of the children whose cases were under review, and the remaining 32 were staff from Tusla or other services who had been in contact with the families concerned.

2. Deaths/ Serious Incidents of children and young people notified in 2014

2.1 Deaths / Serious Incidents of children and young people

A total of 26 deaths and 3 serious incidents of children and young people in care or known to the child protection system were notified in 2014. The following table illustrates the care status of the children whose deaths / serious incidents were notified:

Table 1

Care Status Summary Deaths / Serious Incidents 2014			
Care Status	**Deaths**	**Serious Incidents**	**Total**
In Care at time of Death	**3**	**1**	**4**
In After Care at time of Death/ in care immediately prior to 18th birthday or in receipt of After Care Service and under 21	**4**	**0**	**4**
Known to the Child Protection Service	**19**	**2**	**21**
Total	**26**	**3**	**29**

Three of the young people who died were in care at the time of their death, and four were in aftercare. The remaining 19 were known to child protection services. 1 of the children about whom serious incidents were reported was in care and 2 were also known to child protection services

2.2 Gender of children and young people

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

Table 2

Gender Summary 2014	
Male	Female
18	8

As shown, the majority of children/young people who died were male (18) compared with 8 females.

2.3 Ages of children and young people

The age profile was as follows:

Table 3

Age Profiles Summary 2014			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**6**	**4**	**2**
1 - 5 years old	**4**	**2**	**2**
6 - 10 years old	**1**	**1**	**0**
11 - 16 years old	**10**	**7**	**3**
17 - 20 years old	**4**	**3**	**1**
> 20 Years old	**1**	**1**	**0**
Total	**26**	**18**	**8**

As the above table shows, most deaths occurred in respect of young people between the ages of 11 and 16 years old, with a slight increase on previous years in the deaths of infants under 12 months. However, the numbers overall are too low to allow for any inferences.

2.4 Causes of death

Table 4

Cause of Death Summary 2014			
Cause of Death	**No.**	**Male**	**Female**
Natural Causes	**8**	**4**	**4**
Suicide	**8**	**6**	**2**
Road Traffic Accident	**5**	**3**	**2**
Other Accident	**1**	**1**	**0**
Drug Overdose	**1**	**1**	**0**
Homicide	**2**	**2**	**0**
Unknown	**1**	**1**	**0**
Totals	**26**	**18**	**8**

Eight of the 26 children/young people died as a result of natural causes, some of which were congenital, and eight others died from suicide. The next most common cause of death was RTA (road traffic accidents) which caused the deaths of 5 children/young people. One young person died as a result of different type of accident. Two children died as a result of homicide, one young person died from a drug overdose, and in one case, the cause of death was not finally established. It is notable that the three young people who died whilst in care all died from suicide. More males than females died from suicide by a factor of 3 to 1.

2.5 Area of origin

Table 5

Deaths by Region Summary 2014				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
9	**8**	**6**	**3**	**26**

As in previous years, most deaths occurred in the more densely populated areas.

3. Overview of reports published in 2014

The Child and Family Agency published four reports in July 2014. A number of other reports were submitted that year and published in early 2015. The reports published in 2014 comprised one major, one comprehensive, one concise and one desktop review. The major review was conducted in the case of a 19 year old young man who had been in care since he was eight years old and died from a drug overdose. The comprehensive review was carried out on the case of a young person aged fifteen who lived with a parent, had spent a short time in a high support unit and also died

from a drug overdose. The concise review was carried out in the case of an 18 month old child who died in a domestic accident and the desktop review was held in the case of a four year old child who had a disability and died of a terminal illness.

The major review, which spanned an eleven year period prior to 2010, found that the young person had a range of needs which were not met through contact with the HSE child care services. It also found that too much responsibility was left with his family and that frontline practice was weak, operating in an unregulated and unsupported environment with weaknesses in management and accountability.

The comprehensive review found that the young person who died had been allowed to remain too long in an environment where drug misuse was the norm, with a parent who did not have the capacity to keep him safe or meet his needs. It was pointed out that an earlier admission to care would have better protected him.

The concise review was conducted in the case of a toddler who died in a domestic accident. The review found a number of examples of positive practice but also noted the absence of planning at an important point. It was also critical of the fact that the case remained on a waiting list without much prospect of allocation.

The desktop review, which included some consultation with professionals involved in the care of the child concerned, was conducted in the case of a young child who had a disability and died from a terminal illness. The involvement of the HSE Children and Family Services was mainly in respect of efforts to gain the parents' consent to treatment and ultimately High Court Proceedings to dispense with parental consent. The review found that the HSE social work services had demonstrated very strong commitment to fulfilling the child's rights and had, despite the difficult circumstances, worked at all times to secure the cooperation of his parents.

The recommendations and learning points arising from these reviews will be covered in Section 5, which provides an overview of these matters in all the reports completed to date.

4. Statistical overview of all deaths notified between 2010 and 2014

4.1 Overview of deaths

Table 6 provides an overview of the deaths notified to the NRP between 2010 and 2014 inclusive

Table 6

Summary of Deaths Notified 2010 / 2014			
Year	**Male**	**Female**	**No of deaths**
2010	**15**	**7**	**22**
2011	**11**	**4**	**15**
2012	**11**	**12**	**23**
2013	**6**	**11**	**17**
2014	**18**	**8**	**26**

As the above table shows, the number of deaths in 2014 was the highest to date, the previous highest number having been in 2012, when there were 23 deaths. The number averages at 20 per year, which is in keeping with the figure estimated by the Independent Child Death Review Group in their 2011 report. It is difficult to make any inferences regarding these statistics as annual fluctuations cannot be linked with any particular factor. The most common reason for death was natural causes. Most of the children or young people who died were not in care, their ages varied and they were involved with a range of different (health, education, disability, psychology, mental health and youth justice) services as well as child protection and welfare. Added to this the length and type of contact with child protection and welfare services varied considerably, thus making comparison or identification of associated factors very difficult.

4.2 Causes of deaths between 2010 and 2014

Table 7 illustrates the causes of deaths notified to the NRP between 2010 and 2014, including children/young people who were in care at the time of their deaths.

Table 7

Cause of Death Summary 2010 / 2014							
Cause of Death	**2010**	**2011**	**2012**	**2013**	**2014**	**Overall Total Cause of Death**	**% of Total**
Natural Causes	6	8	7	**7**	**8**	**36**	**34.95%**
Suicide	4	3	9	**4**	**8**	**28**	**27.18%**
Road Traffic Accident	4	1	2	**0**	**5**	**12**	**11.65%**
Other Accident	2	1	4	**1**	**1**	**9**	**8.74%**
Drug Overdose	4	2	0	**1**	**1**	**8**	**7.77%**
Homicide	2	0	1	**0**	**2**	**5**	**4.85%**
Unknown	0	0	0	**4**	**1**	**5**	**4.85%**
Totals	**22**	**15**	**23**	**17**	**26**	**103**	**100.00%**

Table 7 shows that over one third of children or young people died from natural causes. As the individual reports indicate, these included congenital conditions and disabilities, chronic diseases and other childhood illnesses. The next highest cause of death was suicide which featured in just over one quarter of cases. Road traffic and other accidents, some of which were associated with risk taking behaviour, were responsible for approximately one fifth of the deaths. Drug overdose was the identified cause in a small percentage, and five children or young people died by homicide. In a small number of cases, the cause of death was not finally established and inquests were not routinely conducted.

4.3 Care Status of children/young people whose deaths were notified between 2010 and 2014

Table 8

Care Status Summary 2010 / 2014							
Care Status	**2010**	**2011**	**2012**	**2013**	**2014**	**Totals**	**Care Status % of overall**
In Care of the HSE / Child & Family Agency	**2**	**2**	**3**	**3**	**3**	**13**	**12.62%**
In After Care 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**	**13**	**12.62%**
Living at home and known to child protection services	**16**	**11**	**18**	**13**	**19**	**77**	**74.76%**
Total	**22**	**15**	**23**	**17**	**26**	**103**	**100.00%**

Since 2010, just over 12% of the children whose death was notified to the NRP were in care at the time of death, and the same proportion was in aftercare. Three quarters were living with their families with a small percentage in hospital at the time of death. The percentages have been fairly stable over the five year period with a slightly higher number of deaths in aftercare in 2010 and 2014.

4.4 Causes of death of children/young people in care

Table 9

Summary Cause of Deaths of children/young people in care 2010 / 2014

Year	**In Care at the time of death**	**Male**	**Female**	**Cause of Death**				
				Natural Causes	***Homicide***	***Suicide***	***Drug Overdose***	***Totals***
2010	**2**	**2**	**0**	**1**	**1**	**0**	**0**	**2**
2011	**2**	**1**	**1**	**2**	**0**	**0**	**0**	**2**
2012	**3**	**0**	**3**	**2**	**0**	**1**	**0**	**3**
2013	**3**	**2**	**1**	**2**	**0**	**0**	**1**	**3**
2014	**3**	**1**	**2**	**0**	**0**	**3**	**0**	**3**
Totals	**13**	**6**	**7**	**7**	**1**	**4**	**1**	**13**

Between 2010 and 2014, 13 children or young people who died were in care. Seven died from natural causes. Of the remaining six, one young person died from homicide, one from a drug overdose and four from suicide.

5. Overview of learning points and recommendations from NRP reports on notified cases (2010 – 2014)

From the outset, the NRP has been cognisant that reviews have taken place alongside a major reform programme in Irish child protection services including the establishment of the Child and Family Agency and the implementation of national child protection standards by HIQA. Some of the circumstances and events reviewed by the panel have spanned a number of years, going back in many instances to the 1990s to a time when services were less developed than they are at present. Care has been taken, therefore, to keep recommendations current with a clear vision of the desired outcome. Where ongoing structural or policy deficits of national relevance have been noted, recommendations have been made accordingly. Many of the problems observed are in respect of local management or practice rather than policy deficits, so it has not been considered appropriate to make national recommendations in response to these. Instead, key learning points have been highlighted in the reports, with the intention of raising the awareness of managers and those in supervisory positions of potential pitfalls in practice. Where applicable, some of the points are linked with relevant national and international research findings or policy documents, and reference is also made to the guidance documents that have been produced by Tusla.

This section will first outline the practice learning points that have been observed in different cases and then outline the nature and type of recommendations that have been made in different reports. The points are outlined below in order of the frequency with which they were identified.

5.1 Practice issues/key learning points highlighted in reports

5.1.1 Assessment

The practice weakness which was identified in the majority of reports was the manner in which assessments were conducted. There were very few examples of good quality assessment in the records examined by the NRP, and the best ones were often conducted by external agencies. There were weaknesses in the way information was gathered but also in the analysis of the findings, where the implications of the information gathered were not always specified and the rationale for risk estimation was not always clear.

5.1.2 Engaging with families

The next most frequently mentioned practice weakness, notable in half of the cases, was difficulty in engaging with families and young people. This is clearly a challenging area, particularly where families are angry and hostile or where their expectations surpass what can be offered. There were some positive examples where workers were firm, respectful and consistent with hard to engage families and eventually managed to build trust. Some adolescents were very resistant to services yet there are a small number of examples where opportunities were successfully and/or flexibly used (for example, agreeing that a professional from one particular service took a lead role) but many others where no engagement took place. The potential for developing relationships in difficult circumstances was undermined in some cases by frequent changes of social worker, a factor which creates considerable challenge for the service.

5.1.3 Thresholds and intake

In just under half of the cases, issues arose in relation to managing intake and the application of thresholds. There were a number of instances where cases were designated as 'child welfare' even when risks were apparent or where risks had been noted but a short period of stability had ensued. In some cases the designation appeared to carry no particular implications but in a small number of welfare cases, the response was not adequate for the concerns that were apparent.

5.1.4 The need to challenge fixed views

In around one third of the reports, the need for staff to reflect on and revise assessments, plans and interventions in the light of new information was evident. In some cases, undue optimism was demonstrated along with a tendency to repeat the same interventions or recommendations regardless of their previous ineffectiveness.

5.1.5 Out of home care

Although only a minority of reports concerned children or young people who had been in care, a significant number of key learning points were visible in those cases. A minority concerned relative foster care, or informal placements with non assessed individuals or families. Reviews found that the placements were made without sufficient forethought that they did not meet the children's needs in some cases, and that carers did not always get the support they required. The NRP is aware of the efforts made first by the HSE and later by Tusla to address this issue after it was highlighted by HIQA.

Practice issues that arose in relation to mainstream (mostly foster care) placements included difficulty in finding suitable placements, matching children with carers who did not have the capacity to meet their needs, timing of Child in Care reviews, management of access and maintenance of contact between siblings. There were a small, but significant, number of instances where children or young people's challenging behaviour meant that they were still at risk even while in care.

5.1.6 Inter-agency working

One third of the reviews found that the quality of service was affected by inter-agency issues. Recurrent themes included inadequate information sharing between services, lack of clarity about responsibilities or non-sharing of responsibilities. In a small number of cases, opportunities to develop creative solutions were missed due to the lack of an inter-agency forum. There were also a number of instances of positive collaboration which were highlighted as examples of good practice.

5.1.7 Suicide and self harm

Between 2010 and 2014, over a quarter of the deaths reviewed were from suicide, and in some cases there were warning signs or previous incidents of self harm. While there was no instance where it was clear that intervention could have prevented a young person from taking their own life, it became evident that **all** child protection and welfare practitioners need to be comfortable with addressing suicidal tendencies and also vigilant about ensuring as far as possible that children or young people are able to avail of therapeutic services.

5.1.8 Bereavement

In a number of reviews, it was noted that support was offered to families by Children and Family Services after a child or young person had died, but this was not always the case. It was also noted that some staff members in different services only became aware of death when they were contacted by the NRP. The reports on these cases have suggested that even where contact between a service and the family has ceased, or even where relationships may have been difficult, that an immediate offer of sympathy and support should be made. Reviews further suggested that efforts should be made to contact staff members who worked with the child or young person to inform them about the death.

5.1.9 Gender and culture

Practice issues in respect of culture and gender were visible in a small number of cases. Two of the learning points identified were the need to provide cultural support to families who may be isolated by their minority ethnic status and the need to be aware of relativistic assessments of families from different cultures. In four cases, the reports highlighted that fathers had been left out of assessment and planning even though they were involved in the children or young person's lives.

5.1.10 Positive practice

The reviews identified a number of positive practices that could be used as exemplars, including the following: Where cases were regularly reviewed, particularly where children were in care, planning was usually appropriate and effective. Where regular contact between children and their families was maintained, even in complex and challenging circumstances, it helped to preserve their attachments and sense of identity. Where schools provided extra supports, they helped some vulnerable young people to achieve good outcomes that they may otherwise have missed. The reviews highlighted cases where trust was built with formerly hostile families through patient persistence on the part of practitioners, where good communication between services was maintained and finally, where innovative and creative solutions were tried and succeeded.

5.2 Overview of recommendations made in NRP reports

Where the NRP noted deficits that needed to be addressed by the Child and Family Agency on a national basis, recommendations were made accordingly. The NRP is limited in its remit and can only make recommendations to the Child and Family Agency. Where it is apparent that a policy deficit is the responsibility of a service outside the Child and Family Agency, the NRP brings it the attention to the Agency and recommends that it takes the matter further.

5.2.1 Oversight and management

The majority of recommendations concerned oversight and management of intake and case planning as well as corporate responsibility for complex cases. The issues identified included monitoring/auditing of waiting lists and repeat referrals. Overviews were recommended in respect of gaps in service. In one case, the poor quality of practice highlighted the need for a complete

review of the local area. Some of the earlier recommendations concerned guidance on thresholds, prioritisation, policies on record keeping, supervision and management of child protection conferences, and policy on working with domestic violence

5.2.2 Assessment

A significant number of reports recommended the implementation one standard assessment framework. A review of the initial assessment form was also recommended.

5.2.3 Out of home care

The majority of recommendations on out of home care concerned the need for implementation of regulations on care planning, and frequency of reviews. A recommendation was made for guidance on care planning and it is noted that the Agency has already responded to this. Recommendations were made about relative foster care: assessment, support and training as well as review of the outcomes of relative placements. A review of the out of hours' service was recommended and it was proposed that each area should develop a profile of their population of children in care to inform future planning.

A number of reviews addressed the need for the HSE and later Tusla to collaborate with other sectors in order to prioritise therapeutic services for children in care and also educational needs of children in care.

A number of reviews recommended greater transparency of decision making in respect of applications for Special Care. This was relevant to only a small number of reviews but was considered to be crucially important.

Specific recommendations were made in relation to various consent and legal issues for young people in foster care and aftercare.

5.2.4 Interagency working

Recommendations were made to address some inter-agency difficulties, including protocols about agreed thresholds and mutual expectations and sharing of information, a matter that has become more significant since the child protection services have become separate from the wider health sector.

Linked to this topic, a significant number of recommendations were made about health services, (including public health, primary care, mental health, hospitals and disability). While the remit of the NRP does not cover health services, the purpose of recommendations was to draw the attention of children and family services to these issues with a view to the agency addressing them in the appropriate forum.

5.2.5 Suicide

Given the high rate of suicide amongst young people, recommendations on this topic were made in a number of reports. These included the need for prevention programmes to be made available to all staff and easier access to therapeutic services for young people who had emotional difficulties but were not considered to meet the criteria for mental health services. Reports also recommended

access to counselling for young people known to the service who had lost friends or family members to suicide, and bereavement counselling for families who had lost a young person to suicide.

5.2.6 Mental Health services

Reports made a number of recommendations in respect of CAMHS and adult mental health services. These were mainly about promoting collaboration but also continuity of service when young people changed placement. Reports also recommended a review of services nationally for young people abusing substances, and the development of channels of communication between child protection and adult mental health services in an effort to promote greater awareness of the impact of parental mental illness on children.

5.2.7 Training

A small number of recommendations were made about training on specific topics such as working with hard to engage families, child protection training for health staff and training in risk assessment for community organisations.

The NRP acknowledges that a number of the policy and practice issues that it highlighted in earlier reports were addressed by the HSE first and later Tusla over the five years since the review process was established. These include policies on supervision, thresholds, caseload management, domestic violence and child protection conferences. It also acknowledges the publication and circulation of practice guidance on child protection and children in alternative care.

6. National Review Panel Members 2014

Ms. Margaret Beaumont

Dr. Declan Bedford

Professor Helen Buckley (Chairperson)

Dr. Nicola Carr

Ms. Michele Clear

Ms. Jean Forbes

Mr Peter Kieran

Dr. Bill Lockhart

Mr. Frank Martin

Dr Joan Michael

Dr Tom Moran

Mr. Eamon Mc Ternan

Dr. Ann Mc Williams

Ms. Deirdre Mc Teigue

Mr. Paul Murray

Ms. Ceili O Callaghan

Professor Ian O Donnell

Dr. Eoin O Sullivan

Ms. Suzanne Phelan