Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2015

Foreword

The National Review Panel was established in late 2010, and 2015 was its fifth full year of operation. By the end of 2015, 124 deaths had been notified.

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 2014. The third part then presents a statistical overview and analysis of the notifications over the six year period since the NRP began its work. The fourth section provides an overview of the reports published in 2015. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2015.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2015 with the different review teams. We recognise that the review process has been difficult and painful, particularly for bereaved relatives and for staff who knew and worked with the children and young people concerned. The combined insights of staff and family members have helped to inform the conclusions reached in the reports and have contributed to the learning points identified within them. As chair of the panel, I would like to commend the work completed by Ms. Ann Kennedy, Service Manager in her excellent support of the panel's work and for providing the statistical tabulations included in this report.

Dr. Helen Buckley

Chairperson, National Review Panel

October 2015

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, Associate Professor in the School of Social Work and Social Policy, Trinity College Dublin, who is responsible for assigning reviews to individual teams and quality assures 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 2015 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

During 2015, the NRP operated under newly revised 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 the changes in administration of the child protection and identifies the key stakeholders participating in reviews as the NRP, the Child and Family Agency and HIQA. HIQA has a monitoring role on the functioning of the NRP in respect of its compliance with the principles underpinning its work.

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 2015, 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, and offers an analysis of frontline and management practice in the case. A toolkit for the conduct of reviews had been developed at the by the chair in consultation with panel members 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.

2. Deaths of children and young people notified in 2015

2.1 Deaths of children and young people

A total of 21 deaths of children and young people in care or known to the child protection system were notified in 2015. Table 1 below illustrates the causes of death.

Table 1

Cause of Death Summary 2015			
Cause of Death	**No.**	**Male**	**Female**
Natural Causes	**11**	**6**	**5**
Suicide	**6**	**6**	**0**
Road Traffic Accident	**1**	**1**	**0**
Other Accident	**1**	**0**	**1**
Drug Overdose	**0**	**0**	**0**
Homicide	**0**	**0**	**0**
Unknown	**2**	**2**	**0**
Totals	**21**	**15**	**6**

Eleven of the 21 children/young people died as a result of natural causes and six others from suicide (two less than in 2014). It is notable that all the deaths from suicide were males, following the pattern of recent years where more males than females were victims of suicide. The next most common cause was accidents experienced by two young people, including one RTA. In two cases, the cause of death had not been established at the time of writing.

2.2. Care status of children or young people whose deaths were notified in 2015

Table 2

Care Status Summary 2015			
In care at time of death	**In after care at time of death/ in care immediately prior to 18th birthday**	**Known to social work services**	**Total**
3	**2**	**16**	**21**

Three of the young people who died were in care at the time of their deaths, and two were in aftercare. The remaining 16 were known to child protection services.

2.3 Ages and gender of children and young people

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

Table 3

Age Profiles 2015			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**7**	**4**	**3**
1 - 5 years old	**2**	**2**	**0**
6 - 10 years old	**3**	**1**	**2**
11 - 16 years old	**4**	**3**	**1**
17 - 20 years old	**4**	**4**	**0**
> 20 Years old	**1**	**1**	**0**
Total	**21**	**15**	**6**

As the above table shows, most deaths occurred in respect of infants under 12 months, with the next highest proportion between 11 and 20 years old. However, the figures are too low to make useful inferences. Almost three quarters of children/young people who died were male with the largest gender difference in the older age group.

2.4 Summary of deaths by region

Table 4

Deaths by region Summary 2015				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
6	**6**	**4**	**5**	**21**

As Table 4 demonstrates there was no remarkable difference between the numbers of deaths per region.

3. Statistical overview of all deaths notified between 2010 and 2015

This section provides a comparative overview of the deaths of children and young people in care or known to child protection services over the six year period since the NRP started its work.

3.1. Cause of death summary 2010/2015

Table 5

Cause of death Summary 2010 / 2015								
Cause of death	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Overall Total**	**% of Total**
Natural Causes	6	8	7	7	8	11	47	37.90%
Suicide	4	3	9	4	8	6	34	27.42%
Road Traffic Accident	4	1	2	0	5	1	13	10.48%
Other Accident	2	1	4	1	1	1	10	8.06%
Drug Overdose	4	2	0	1	1	0	8	6.45%
Homicide	2	0	1	0	2	0	5	4.03%
Unknown	0	0	0	4	1	2	7	5.65%
Totals	22	15	23	17	26	21	124	100.00%

As Table 5 above illustrates, the average rate of notified deaths is 20 per year, which has been a consistent trend. Natural causes remain the highest cause of death (40%), with suicide representing 27% of the total. The next highest combined total is accidents, including road accidents, which together account for 19% of deaths. Drug overdose accounts for 5 % and the numbers have been falling but are really too low to make any useful inference. Homicide accounts for 4% of deaths. Where a coroner or post mortem has failed to identify a cause of death, this is classified as unknown, which accounts for 6% of deaths.

3.2. Care status summary 2010/2015

Table 6

Care Status Summary 2010 / 2015								
Care Status	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Totals**	**Care Status % of overall**
In care of the HSE / Child & Family Agency	**2**	**2**	**3**	**3**	**3**	**3**	**16**	**12.90%**
In after care at time of death/ in care immediately prior to 18th birthday or in receipt of after care service and under 21 years	**4**	**2**	**2**	**1**	**4**	**2**	**15**	**12.10%**
Living at home and known to child protection services	**16**	**11**	**18**	**13**	**19**	**16**	**93**	**75.00%**
Total	**22**	**15**	**23**	**17**	**26**	**21**	**124**	**100.00%**

As Table 6 above illustrates, 13% of the children or young people whose deaths were notified to the NRP between 2010 and 2015 were in the care of the Child and Family Agency; 12% 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 75% were living at home and were known to child protection services for differing periods of time. The causes of death of children in care and their ages is given below in Table 7, and illustrates that natural causes is the cause of death of children in care twice as often as suicide and nine times more often than any of the other causes. Review reports show that most of the children and young people in care who died from natural causes were ill or disabled before their entry into care and that their entry into care was primarily for child protection. The age span during which most deaths occurred was between 11 and 16 years.

Table 7

Summary cause of deaths of children/young people in care 2010 / 2015														
Year	In care at the time of death	Male	Female	Age					Cause of death					
				Infants < 12 months	1-5 years old	6 -10 years old	11-16 years old	17-20 years old	*Natural Causes*	*Homicide*	*Suicide*	*Drug Overdose*	*Road Traffic Accident*	*Totals*
2010	2	2	0	0	1	0	0	1	1	1	0	0	0	2
2011	2	1	1	0	0	1	1	0	2	0	0	0	0	2
2012	3	0	3	0	1	1	1	0	2	0	1	0	0	3
2013	3	2	1	1	0	0	1	1	2	0	0	1	0	3
2014	3	1	2	0	0	0	3	0	0	0	3	0	0	3
2015	3	3	0	0	0	0	2	1	2	0	0	0	1	3
Totals	16	9	7	1	2	2	8	3	9	1	4	1	1	16

4. Overview of reports published in 2015

Tusla, the Child and Family Agency, published NRP reports on 20 children in 2015. These comprised an overview of internal reviews into the deaths of six children who were known to the Agency and had serious illnesses or disabilities; an overview of four comprehensive reports on the deaths of four children which were not published individually; one full individual comprehensive report, six full concise reports and three full desktop reviews. In addition, executive summaries on all reports were published.

4.1 The children/young people who were the subjects of reports published in 2015

There were two overview reports amongst the total that were published. One covered six children who had been ill or disabled and all died from natural causes. Of the four other children whose deaths were covered by an overview report, one died from homicide and one had a serious congenital disease and died just after birth. The cause of death in the other two cases, both involving young children, was not fully established by post mortem investigations. The young person who was the subject of a comprehensive review died accidentally. Two of the young people who were subject of concise reviews died accidentally, and the four other young people who were subject to concise reviews died from suicide. Two of the young people whose deaths were subject to desktop reviews died from accidents and the other child, an infant, died from Sudden Unexpected Death in Infancy.

The age range of the children and young people was from a few hours old to 19 years, with the majority of deaths in late teenage years. Two young persons aged 17 who died were in care at the time of death, and four of the young people who died had been in care at some point in their childhoods. One was in aftercare. Three of the children/young people featured in the overview report who died of natural causes were in care at the time of their deaths. One young person was in care at the time of his suicide, and two other young people who had been in care for periods of time were also suicide victims.

4.2 Findings from reports

The published reports demonstrated good practices in a number of cases, particularly where children were ill or had disabilities, where care planning was good and the level of support offered to families was high. Other positive practices were noted in individual cases, for example in one case where a child was placed in safe situations that reduced his vulnerability; in a number of other cases the commitment of social workers was commended and the standard of aftercare was good. In a number of cases, the skills of different workers in building relationships with families in difficult circumstances were commended.

Weakness that were noted in the cases included delayed responses and situations where cases were managed on duty because allocation was not possible, resulting in a lack of consistency, the families meeting numerous workers and inability to assess situations in depth. It was noted that in some cases, thresholds operated by social work departments were higher than those held by other professional services which were referring in concerns that they considered to fit in the child protection category. In a small number of other cases, inadequate assessment and failure to assess children's individual needs were noted as well as failure to understand where risk assessment based on parental behaviour rather than assessment of parenting skills and capacity was required.

In two cases, it was noted that child protection plans were not appropriately revised in light of new information and that progress, or lack of it, was not appropriately evaluated. In one of these it was noted that decisions were determined by the child's wishes rather than her needs, and increased rather than decreased her vulnerability. Over optimism about a parent's capacity to deal with her son's challenging behaviour was noted in one case where an alternative placements was unavailable. Missed opportunities were noted in two cases, one where early intervention could possibly have made a very positive difference and in another where a family's expressed concerns did not have the impact that was warranted.

Two persistent problems are evident when overviewing these cases, one concerning mental health services and the other concerning inter agency cooperation. In fact, both are connected and have been evident in reports published in previous years. Waiting lists and complicated pathways to psychological and mental health services were noted in the case of a young woman who ultimately took her own life. In another case, it became evident to reviewers that mental health services not only did not share important information, but did not perceive the need to do so which illustrated the need for health and family services to become more child centred.

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. The reviews published in 2015 identified a number of key learning points. These can be summarised as follows:

- Assessment, practitioners need to always consider the impact of living with issues such as parental alcohol abuse, learning disability and domestic violence on children's development and mental health and understand when an assessment must go beyond parenting capacity to evaluate the risks posed by the behaviour of parents/carers. This is particularly pertinent where families are referred to community services. The impact of cumulative neglect on children should also be considered as well as the imposition of caring duties on young people living with ill or disabled parents.

- Planning: Planning, while taking children's views into account and facilitating their expression must be done on the basis of what is in the child's best interests. Decisions regarding placement within family or extended family must be made carefully bearing in mind the history of the proposed carers.

- Case management: while it is inevitable that social work departments under pressure will have waiting lists, efforts need to be made to see that concerns are properly assessed and that families are not subjected more than necessary to multiple interactions with different workers. Multiple referrals to a SWD should be monitored and action taken accordingly.

- Working with families: some of the reports noted the gap between expectations of families and the ability of the services to provide a response. In these instances, clarity is required to inform families of the services that can be provided. Families also require clarity about the point at which a case is closed. While the reports showed some good examples of relationship building, some indicated that

workers need at times to challenge their own perceptions about families that express themselves forcefully and give appropriate weight to their views. While there were good examples in the cases reviewed of engagement with fathers, there were also a small number of cases where fathers who had evidently played a role in their children's lives were not met by social workers. One case in particular illustrated how, if parents have a learning disability, practitioners need to connect with them in a way that they can understand. The reports showed that where families are known to be hard to reach, assignment of staff with particular or specialist skills can make a positive difference. Finally, where a child or young person dies, even if the case had been closed for several months, it is important that all staff who have been involved with them are informed, and that families are offered bereavement support

- Interagency working: where organisations are providing services to adults who themselves are parents, staff need to be familiar with the role and function of statutory social work and ways in which they can constructively contribute to the management of a child protection case.

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 report and can be summarised as follows:

- Mental Health: it was recommended that the Child and Family Agency take steps to ensure that adequate therapeutic services are available to young people, particularly those with suicidal tendencies. It was also recommended that agreements are reached between the Agency and CAMHS about referral pathways. It was suggested that channels should be established between child protection services and adult mental health services to promote awareness of the effect of adult mental health on children and to facilitate the sharing of information.

- Assessment: It was recommended that the initial assessment form should be revised to allow for greater depth of assessment. It was further recommended that community and family support services should be introduced to the concept of risk assessment to enable them to expedite referrals for children in their services that require urgent child protection intervention.

- Case management: it was recommended that a policy of monitoring repeated referrals be introduced.

- Suicide: it was recommended that suicide prevention should become a priority for the Agency, and that counselling should be provided as a preventive measure to families that have experienced a suicide.

- Other recommendations included the need to adhere to procedures with regard to placement of children in supported lodgings, to clarify with the coroner the circumstances in which an inquest is not deemed necessary where a child has unexpectedly died, and the need for relationships to be further developed between the Agency and Traveller organisations.

5. Activities of the NRP during 2015

5.1 Training

A training day was held on 15th January 2015, chaired by Dr. Helen Buckley and attended by NRP panel members and invited speakers. In the morning session, the panel was introduced to Brian Lee, recently appointed Director of Quality in the Child and Family Agency, who gave a presentation on how the agency was planning to implement quality assurance measures. Other presentations were given by Linda Creamer, Area Manager Dublin North City, on recent child protection policies, and by Grainne Collins, Policy Manager Alternative Care, on recent policies in alternative care and on the new Alternative Care Practice Handbook.

The afternoon session was spent discussing the newly implemented guidance on the operation of the NRP, and a recently published Annual Report of the National Panel of Independent Experts on Serious Case Reviews in the UK.

5.2. Learning Event

The Child and Family Agency organised a full day national learning event for staff on 26th March 2015 to disseminate information about the review process and findings from reports. The main speakers were:

- Brian Lee, Director of Quality in the Agency, who spoke about the context for the event and the work being conducted in the Quality Unit

- Dr. Helen Buckley, Chair of the National Review Panel, who provided an overview of the work of the panel including key findings

- Paul Harrison, Director of Policy and Strategy who spoke about the influence of inquiry recommendations on policy
- Professor Andy Pithouse, University of Cardiff, who spoke about recent child protection policy developments in Wales
- Patricia Finlay, Area Manager Kildare/West Wicklow who spoke about the impact on an area of a child death
- Vicky Blomfield and Nuala Ward, Children's Services Regulations, HIQA who spoke about their role with the NRP
- Fred McBride, Chief Operations Officer of the CFA who spoke about implementation of recommendations

5.3 Meetings between the Chair of the NRP and the Board of the Child and Family Agency

Under the 2014 Guidance on the Operation of the National Review Panel, the Chair of the NRP reports directly to the Chair of the Board of the Child and Family Agency. The NRP comes under the ambit of the Quality Assurance and Risk Committee of the Agency's Board. Helen Buckley met with Norah Gibbons, Chair of the Child & Family Agency in March 2015, and gave a presentation to the Quality Assurance and Risk Committee on the work of the NRP in October 2015.

6. National Review Panel members 2015

Dr Declan Bedford

Dr Cathleen Callanan

Dr Nicola Carr

Ms Michele Clear

Dr Bill Lockhart (Deputy Chair)

Ms Deirdre Mc Teigue

Mr Eamon Mc Ternan

Dr Ann Mc Williams

Mr Frank Martin

Dr Joan Michael

Ms Ceili O Callaghan

Dr Ian O Donnell

Ms Suzanne Phelan

Dr Imelda Ryan