National Review Panel

Annual Report

2016

Foreword

The National Review Panel was established in late 2010, and 2016 was its sixth full year of operation. By the end of 2016, 149 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 2016. 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 2016. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2016.

The National Review Panel would like to express its appreciation to the family members and professionals who came for interview during 2016 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

April 2017

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 2016 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 2016, the NRP operated 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 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.

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 2016, 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 2016

2.1 Deaths of children and young people

A total of 25 deaths of children and young people in care or known to the child protection system were notified in 2016. This was an increase of four on 2015, with a rise in the numbers of young people who died in accidents. The following table illustrates the causes of death

Table 1

Cause of Death Summary 2016			
Cause of Death	**No.**	**Male**	**Female**
Natural Causes	**10**	**5**	**5**
Suicide	**5**	**2**	**3**
Road Traffic Accident	**3**	**2**	**1**
Other Accident	**4**	**3**	**1**
Drug Overdose	**2**	**2**	**0**
Homicide	**1**	**1**	**0**
Unknown	**0**	**0**	**0**
Totals	**25**	**15**	**10**

As Table 1 above shows, ten of the 25 children/young people who were notified died as a result of natural causes and five others from suicide (one less than in 2015). Three out of the five young people who took their own lives were female and two were male, one was 12 years old and the remaining four were between 15 and 17. The next most common cause pf death was a combination of road traffic and other accidents experienced by seven young people (an increase of five on 2015). Two young people died from drug overdoses compared with none in 2015.

2.2. Care status of children or young people whose deaths were notified in 2016

Table 2

Care Status Summary 2016				
In care at time of Death	**In aftercare at the 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**
1	**0**	**1**	**23**	**25**

As Table 2 above shows, one young person under 18 years whose death was notified was in care at the time of their death. This is a decrease of two on the 2015 figures. Another young person who died was over 18 and under 21 and had been in care up to their 18th birthday. The remaining 23 were known to child protection services.

2.3 Summary of deaths and serious incidents reported in respect of children in care 2016

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 2016 Deaths and Serious Incidents			
	Deaths	Serious Incidents	Total
In care	1	3	4
In aftercare/ in care immediately prior to 18th birthday	1	0	1
Known to social work services	23	2	25
Total	25	5	30

2.4 Ages and gender of children and young people whose deaths were notified in 2016

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

Table 4

Age Profiles 2016			
Age Band	No.	Male	Female
Infants < 12 months	9	4	5
1 - 5 years old	3	2	1
6 - 10 years old	0	0	0
11 - 16 years old	7	4	3
17 - 20 years old	6	5	1
> 20 Years Old	0	0	0
Total	25	15	10

As the above table shows, most deaths (9) occurred in respect of infants under 12 months, with the next highest proportion 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 increase in the numbers of infants that died.

Almost three fifths of children/young people who died were male with the largest gender difference in the 11 to 16 age **group.**

2.5 Summary of deaths by region

Table 5

Deaths by Region Summary 2016				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
9	**2**	**8**	**6**	**25**

As Table 5 above demonstrates, there were proportionately more deaths in Dublin Mid Leinster than in the other regions.

3. Statistical overview of all deaths notified between 2010 and 2016

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

3.1. Cause of death summary 2010/2016

Table 6

Cause of Death Summary 2010 / 2016									
Cause of Death	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total All Years Cause of Death**	**% of Total**
Natural Causes	**6**	**8**	**7**	**7**	**8**	**11**	**10**	**57**	**38.26%**
Suicide	**4**	**3**	**9**	**4**	**8**	**6**	**5**	**39**	**26.17%**
Road Traffic Accident	**4**	**1**	**2**	**0**	**5**	**1**	**3**	**16**	**10.74%**
Other Accident	**2**	**1**	**4**	**1**	**1**	**1**	**4**	**14**	**9.40%**
Drug Overdose	**4**	**2**	**0**	**1**	**1**	**0**	**2**	**10**	**6.71%**
Homicide	**2**	**0**	**1**	**0**	**2**	**0**	**1**	**6**	**4.03%**
Unknown	**0**	**0**	**0**	**4**	**1**	**2**	**0**	**7**	**4.70%**
Totals	**22**	**15**	**23**	**17**	**26**	**21**	**25**	**149**	**100.00%**

As Table 6 above illustrates, the total number of deaths notified to the National Review Panel since February 2010 is 149. The average rate of notified deaths is 21 per year over a seven year period, and the trend has been reasonably consistent. Natural causes remain the highest cause of death (38%), with suicide representing 26% of the total. The next highest combined total is accidents, including road accidents (30), which together account for 21% of deaths. Drug overdose accounts for 7% and the numbers have been fluctuating. 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 an average of 5% of deaths.

3.2. Care status summary 2010/2016

Table 7

Care Status Summary 2010 / 2016 (Deaths)									
Care Status	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Totals**	**Care Status % of overall**
In care of the HSE / Child & Family Agency	**2**	**2**	**3**	**3**	**3**	**3**	**1**	**17**	**11.41%**
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**	**16**	**10.74%**
Living at home and known to child protection services	**16**	**11**	**18**	**13**	**19**	**16**	**23**	**116**	**77.85%**
Total	**22**	**15**	**23**	**17**	**26**	**21**	**25**	**149**	**100.00%**

As Table 7 above illustrates, 11% of the children or young people whose deaths were notified to the NRP between 2010 and 2016 were in care; a further 11% 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.

Summary of cause of death of children/young people in care 2010/2016

Table 8

Summary Cause of Deaths of children/young people in care 2010 / 2016															
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
2016	1	1	0	0	0	0	0	1	0	0	0	1	0	1
Totals	17	10	7	1	2	2	8	4	9	1	4	2	1	17

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 2016

Tusla, the Child and Family Agency, published NRP reports on 13 children in 2016, on children who had died in previous years. These comprised an overview of internal reviews into the deaths of four children who were known to the Agency and died from natural causes; an overview of four comprehensive reports and one desktop review of the deaths of five children which were not published individually; two comprehensive reviews and two full desktop reviews.

4.1 The children/young people who were the subjects of reports published in 2016

There were two overview reports amongst the total that were published. One of them covered two infants and a young child and a young person who had been ill or disabled. All of the subjects of this overview died from natural causes including congenital diseases, physical disabilities and terminal cancer. One of the children and the young person had spent periods in care.

The second overview report concerned the deaths of five young people between 14 and 21 years three of whom had spent periods in care. The cause of death in four cases was suicide and in the fifth case the post mortem indicated that death was caused by a drug overdose. Two of the young people had been diagnosed with serious psychiatric conditions and had been hospitalised and two others had been referred to community mental health services because of attempted self-harm. The fifth young person had special needs. Two of the young people had been subjected to bullying and two had grown up in homes where domestic violence was an ongoing occurrence. Family relationships were difficult in all the cases. The needs of the young people became increasingly complex as they matured.

The individual reports which were published covered the circumstances of three young people who died from suicide between the ages of 15 and 19 and an infant who died aged just a few months old. One of the young people had been in care from a young age, and another had spent some periods in care from the age of 14. Two of the young people had come to the attention of services because of their parent's inability to manage their challenging behaviour. A third young person came into care at a very young age because of parental substance abuse and domestic violence and the very young child came to the attention of services because parental domestic violence.

4.2 Findings from reports

The reports showed evidence of some very good practice, for example, a high standard of aftercare provision, creativity used in planning placements, continuity of social work service and flexible provision of Child and Adolescent Mental Health services. Some very different situations were described in the reports as children and young people were being cared for in varying contexts. Overall, it appeared that assessment practice still needs to be improved and placing children with complex needs in foster care continues to be a challenge. Inevitably, turnover of staff also causes difficulties.

In those cases where children and babies were terminally ill or disabled, coordination of health and social services was often problematic and in some instances it was not clear which sector had budgetary responsibility for matters like home care and equipment. The review noted that this confusion and lack of coordination is likely to recur now that health and social services are provided by separate agencies.

Mental health problems were experienced by six of the thirteen children and young people, two of whom had serious mental illness; the others had exhibited self-harm and had ongoing suicidal ideation. In general, however, once the young people were linked with services, the quality of services provided was good, in fact quite exceptionally good in two cases.

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

<u>From a practice perspective:</u>

- Assessments, including risk assessments and follow up of child sexual abuse allegations, need to be conducted at greater depth and more inclusive of the impact of adverse factors in both early and later phases of childhood.
- The issue of working with families that are resistant to social work and young people who refuse to engage with therapeutic services continues to pose challenges for Tusla staff.

<u>From a policy perspective</u>

- Foster families with specialist expertise are required from time to time, particularly where children are either mentally or physically unwell or have challenging behaviour or disabilities. This presents a considerable challenge to existing services but is an area that needs ongoing consideration.
- New challenges exist for Tusla now that child protection services have been separated from mainstream and specialist health services. A mutual understanding about shared and individual responsibilities, including budgetary matters, needs to be developed in cases where children in care are critically ill or are disabled, so that the appropriate resources are in place. It is vitally important that these services are delivered in a coordinated way to avoid overwhelming families. Given that around one third of cases notified to the NRP concern children who die as a result of illness or the effects of disability, this is a significant issue.

- Young people leaving care who have mental health problems need a specific type of service. In addition to dearth of accommodation, the reports highlighted inconsistent access to adult mental health services and lack of treatment options. This is partially outside the remit of Tusla and requires an overarching interdepartmental approach.
- Protocols need to be developed in respect of a number of matters concerning the deaths of young people who were in care or aftercare, mainly in relation to communicating information about the death to extended family and professionals who have worked with the young person.

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 focus on matters such as:

- Assessment

There is a need for timely assessment which takes account of, amongst other issues, the impact of trauma, multiple adversities and pre-care experience on a child's development, the long term effects of growing up while witnessing domestic violence, the impact of being bullied at school and the impact on parenting capacity of alcohol misuse,

- Education

The participation of schools in community networks should be promoted locally both to enhance child welfare and to expedite the transfer of information to child protection services without delay. The impact of being out of school on a child's welfare needs to be considered at a practice level.

- Coordination

Where children in receipt of child protection services are terminally ill, the coordination of services needs to be facilitated where possible in order to reduce stress on families and avoid the need for them to have to report their histories and circumstances to numerous different professionals.

- Placement issues

The importance of contact between siblings who are placed with different families needs to be recognised and put into practice alongside the the need for a plan to manage risk when young people in care are self-harming or absconding.

- Interaction with families

Techniques for engaging resistant families and young people need to be put into operation

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:

- Placement of children with complex health needs

  The need to recruit and train foster carers who are sufficiently skilled to care for very ill children with complex needs was recommended along with the development of a joint strategy for collaboration between case managers and budget holders in child protection and health services.

- Mental Health

  It was recommended that social work departments consider children with self-harming behaviour to be at risk until the case has been assessed by CAMHS and that they check that referrals have been followed up.

- Steps to take if a child in foster care dies

  It was recommended that the foster care training and foster carers' contracts should include a section on the appropriate steps to take if a child or young person in care or aftercare dies, including a protocol for communication with family members and staff that have recently worked with the child or young person.

- Aftercare:

  It was recommended that Tusla press for a resolution of the scarcity of accommodation for young people with a diagnosed mental illness who are in aftercare and require semi sheltered situations.

- Special Care

  It was recommended that the criteria for admission to special care are revised and that a clear rationale is provided if a request for care is unsuccessful

- Children at risk from their own behaviour:

  It was recommended that consideration be given at a national level of developing an appropriate response to young people at risk from their own behaviour, possibly through the Meitheal programme.

5. Activities of the NRP during 2016

5.1 Routine NRP work

During 2016, panel members completed and submitted reports on 11 children and young people, comprising four desktop reviews, three concise reviews, two comprehensive reviews and one composite report on five children. Some of these reports were published in 2016 alongside a number of other previously submitted reviews.

Forty four 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 Training

A training day was held on 19th January 2016, chaired by Dr. Helen Buckley and attended by NRP panel members and invited speakers. In the morning session, the panel was addressed by Mark

Yalloway from the Quality Assurance Directorate and Cormac Quinlan, recently appointed Director of Policy and Strategy who presented a summary of recent policy developments and other current issues. In the afternoon, Helen Buckley gave a presentation on the role of HIQA with the NRP, followed by a discussion.

5.3 Presentation at Tusla Conference March 2016

Tusla, the Child and Family Agency organised a two day conference on March 22nd and 23rd 2016 entitled 'Towards a Child Protection and Welfare Strategy; Building a Future by Reclaiming our Practice. Dr. Helen Buckley, Chair of the NRP was invited to give a keynote presentation at the conference, which focused on learning from research, reviews and enquiries. Her presentation focused on the 'surface' and 'depth' aspects to child protection work, i.e. law policies and procedures as well as ideologies, principles, practice challenges and critical questions. It looked at sources of learning for practitioners and policy makers and identified untapped learning resources such as statistical information on prevalence of different abuse types and welfare concerns. The presentation went on to examine the strengths of inquiries as sources of learning, and also cautioned against over reliance on them, given their limitations and short time frame. It made the point that research takes a broader perspective and provides substantial empirical evidence, so that a combination of both inquiry reports and research studies is likely to engender a deeper understanding of the challenges and complexities of child protection work.

5.4 Meetings between the NRP and 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 Child and Family Agency. The NRP comes under the ambit of the Quality Assurance and Risk Committee of the Agency. Helen Buckley met with Norah Gibbons, Chair of the Child and Family Agency in June 2016 to discuss current issues for the NRP. In addition, three meetings were held between representatives of the NRP (Helen Buckley, Chair, and Ann Kennedy, Service Manager) and representatives from the Quality Assurance Directorate (Brian Lee and Mark Yalloway) to discuss administrative matters.

5.5. Panel Membership

A campaign to recruit new panel members was started in 2016. The process was managed independently by the NRP with the assistance of the HR department of the Child and Family Agency. A notice inviting applications was posted on the Child and Family Agency website, the Irish Times and the Activelinks website in November 2016 inviting applications from suitably qualified staff from the disciplines of social work, social care, psychology, medicine, nursing, education, law and policing. Applications were received in December 2016 and interviews were due to be held early in 2017 with a view to contracting new panel members as soon as possible.

6. National Review Panel members 2016

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 Imelda Ryan