Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2023

Foreword

I am pleased to present the 14th annual report of the National Review Panel. The NRP was established in 2010 following a recommendation of the Ryan Implementation Report by the Office of the Minister for Children in 2009 and since that time has submitted reports on the deaths of 145 children or young people who were in care or known to child protection services. In addition, the NRP has submitted reports on serious incidents affecting the lives of 25 children. Tusla has published summaries of NRP reports and these are available on the NRP website www.nationalreviewpanel.ie.

This report is presented in five parts. The first section provides an introduction and describes the role and function of the NRP as well as current issues affecting its performance. The second part provides statistical information and a brief analysis of the notifications made to the panel in 2023. The third section provides an overview of the reports published in 2023 including the findings, learning points and recommendations. The fourth part then presents a statistical overview and analysis of the notifications to the NRP over the past eleven years. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2023.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2023 and gave us valuable insight into their situations as service users. We acknowledge that the experience was sad and painful for them. We also express appreciation for the willingness of professionals to speak with us and acknowledge that it was a stressful experience for many of them. Particular appreciation is expressed to the Tusla staff members who made practical arrangements and provided support to families participating in online interviews. The combined perceptions 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 Naomi Boland, for her excellent support of the panel's work and for providing the statistical tabulations included in this report. Inspector Seamus Houlihan provided valuable liaison on behalf of An Garda Síochána. I would also like to acknowledge the input of the Quality and Regulation Directorate of Tusla and the valuable input of our legal advisor, Stephanie McCarthy of O'Malley, Cunneen and McCarthy solicitors.

Dr Helen Buckley,

Chairperson, National Review Panel

April 2024

1. Introduction

The National Review Panel (NRP) is an independent entity comprising of consultants from a variety of child protection and welfare backgrounds. It is commissioned by, but independent of, the Child and Family Agency. In 2023 the panel consisted of between 14 and 17 members who were assigned to cases according to their particular expertise and experience. Generally, review teams consist of two or three members, and all have oversight by the chair. None of the members have ever been involved professionally in any of the cases under review. The chair of the panel is Dr Helen Buckley, child protection consultant and Fellow Emeritus of the School of Social Work and Social Policy, Trinity College Dublin. The deputy chair is Dr Ann McWilliams, child care consultant and former lecturer in child protection and welfare at the Technological University of Dublin. Other panel members have backgrounds in social policy, social work, police work, psychotherapy, psychology, regulation, human rights and the law. The Chair and Deputy Chair are responsible for identifying cases for review, deciding on the level of review, assigning reviews to individual teams, and advising on terms of reference. The Chair quality assures and signs off on each report prior to submission.

The panel is supported by a fulltime service manager who has responsibility for the comprehensive administration of the work of the NRP including the management of notifications and case records, collection of activity data, liaison with the Quality and Risk Directorate of Tusla on the progress of reviews and other related matters, organisation of interviews, resources, HR and financial matters and the submission of reports. During 2023 additional administrative support was provided to assist the service manager. The panel also uses the services of an independent legal team. A list of panel members who completed work in 2023 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 Director of Quality and Regulation in the Child and Family Agency, and to the Health, Information and Quality Authority (HIQA).

1.1 Guidance on the operation of the NRP

The DCEDIY published interim guidance in October 2021 which is available on the Tusla website https://www.tusla.ie/uploads/content/2021_Interim_Guidance_NRP_Final.pdf

The interim guidance reflects recent changes in the structure of services as well as learning from the previous the work of the NRP. It will be replaced when the DCEDIY has completed its undertaking to restructure the NRP.

1.2 Functions of the National Review Panel

The NRP reviews cases where a child or young person dies or experiences a serious incident when that child or young person was in the care of the state or was known to Tusla, the Child and Family Agency's social work department or funded services. It also reviews cases which have come to light that carry a high level of public concern, where a need for further investigation is apparent. Its main function is to determine the quality of services provided to the children or young persons involved and their families. It focuses primarily on the effectiveness of frontline and management activity in line with national procedures and internationally recognised standards of practice and also examines the quality of inter-agency collaboration. One of its most important functions of a review is to note obstacles to good practice and identify areas for learning. Each report contains a section specifically for this purpose.

During 2023, the NRP continued to differentiate between desktop, concise, comprehensive, and major reviews. Where possible preference is given to holding concise and comprehensive reviews as fuller participation of stakeholders provides greater transparency. This creates a challenge to the ability of the panel to complete its work within appropriate timelines due to occasional delays in accessing the relevant staff and family members.

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. When interviews are held in person, they are recorded and later transcribed by a transcription service. When the interview is held by teleconference, a transcriber is connected to the call. 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 with national relevance is noted, relevant recommendations are made. A toolkit for the conduct of reviews is regularly reviewed by the Chair and Deputy Chair in consultation with panel members and amended as necessary. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by the NRP. Fair procedures are followed at all times. 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. Under the 2021 guidance, the NRP provides a pre-submission draft consisting of conclusions, learning points and recommendations to the Director of Quality and Regulation in Tusla and receives feedback relevant to factual accuracy.

2. Deaths of children and young people notified in 2023

2.1 Number and causes of deaths.

A total of 29 deaths of children and young people in care, aftercare or known to the child and family services were notified in 2023. This figure represents an increase of 6 compared with 2022.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2023			
Cause	**No**	**Male**	**Female**
Natural Causes	**18**	**10**	**8**
Suicide	**4**	**1**	**3**
Homicide	**0**	**0**	**0**
Accidents	**5**	**1**	**4**
Overdose	**0**	**0**	**0**
Unknown	**2**	**2**	**0**
Totals	**29**	**14**	**15**

As Table 1 above shows, 18 of the 29 children/young people whose deaths were notified died as a result of natural causes, including Sudden Infant Death Syndrome. Four young people died from suicide and five died in accidents. Where a coroner or post-mortem has not reached a conclusion as to the cause of death, it is listed here as unknown.

2.2. Care status of children or young people whose deaths were notified in 2023.

Table 2

Care Status Summary 2023			
In care at time of Death	**In aftercare at time of death**	**Known to social work services**	**Total**
2	**1**	**26**	**29**

As Table 2 above shows, two children /young people under 18 years whose deaths were notified were in care at the time of their death, a decrease of three from 2022. One died due to an accident and one

from suicide. The remaining children or young people were living in their communities and there was a decrease of one in the number of deaths of young people using aftercare services.

2.3 Summary of serious incidents reported in respect of children in care 2023.

Table 3 below provides a summary of serious incidents that were notified to the NRP in respect of children in care or known to social work services. A serious incident is defined as an event or series of events that may have caused potentially life-threatening injury or serious and permanent impairment of health, wellbeing, or development.

Table 3

Serious Incidents Care Summary 2023	
In care	**9**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**14**
Total	**23**

Examples of serious incidents that were notified include children still living who were known to Tusla and were found to have been neglected or abused, sexually exploited, exposed to potentially harmful situations or involved in non-fatal accidents.

2.4 Ages and gender of children and young people whose deaths were notified in 2023

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

Table 4

Age Profiles 2023			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	13	8	5
1 - 5 years old	3	2	1
6 - 10 years old	1	0	1
11 - 16 years old	7	2	5
17 - 20 years old	5	2	3
> 20 Years Old	0	0	0
Total	**29**	**14**	**15**

Similar to 2022, the majority of deaths occurred in two age cohorts, infants under 12 months and young people in their teenage years.

2.5 Summary of deaths by region

Table 5

Summary by Region 2023							
Dublin Mid Leinster	Dublin North East	South East	South West	Mid West	West North West	CRS	Total
10	13	2	3	0	0	1	29

Of the 29 deaths notified in 2023, a decision was made to review ten. It was decided not to review 12 of the cases notified, and decisions on a further seven are still pending while further information is awaited.

3. Overview of reports published in 2023

The NRP will, from time to time, advise Tusla regarding publication of reviews, particularly where publication could be prejudicial to a trial or where the details are likely to identify a family. However, on whether to publish and the timing of publication are ultimately made by Tusla. When reports are due to be published, contact is made between local Tusla social work departments and the families of the children and young people who are the subjects of reviews and they are fully briefed prior to publication.

In 2023, Tusla published four executive summary reports completed by the NRP (see www.nationalreviewpanel.ie)

3.1 The children/young people who were the subjects of reports published in 2023.

The reports published in 2023 concerned a young person of 16 who died from suicide, an infant that died from SIDS, two young children who died as a result of homicide and an infant who suffered a life-threatening injury that will have long term effects. None of the children was in care at the time of their deaths or serious incident.

3.2 Findings from the published reviews

In relation to the four children who sadly died, the reports found that cases were allocated to social workers, with adequate management oversight, and that social work staff had formed positive

relationships with the families concerned. In one case, the unavailability of records limited the scope of review, and it was noted assessments were limited. The social workers were commended in one of the cases for their tenacity and capacity to meet very complex challenges and the same case demonstrated evidence of exemplary cooperation between services as well as good management oversight. In the case where a child was seriously injured, the review found that the initial responses and assessments made when referrals were submitted were inadequate. The review noted that the relevant Tusla administrative area had suffered serious disruption and was under severe pressure at the time this case was referred.

3.3. Key learning identified in the published reviews.

The learning points highlighted in the published reports generally pertain to frontline practice and local policies. In line with the objective of the National Review Panel to drive improvement in the child protection and welfare sector, each of the published reports contains a section on key learning, where specific topics are highlighted, and relevant research is cited which may improve practice in particular ways. The outstanding learning points in the reports published in 2023 include the following:

3.3.1 The need for workers to consider age-appropriate responses and be sensitive to the changing needs of children and young people, taking account of particular situations such as teenage pregnancy, teenage fatherhood, and the different risks to which young people may be exposed during their formative years.

3.3.2 The importance of stability in the lives of young people in care, including educational attendance and consistency of direct work and relationships with key staff.

3.3.3 The need for workers to be attentive to disguised compliance and avoid an over optimistic view of parental competencies.

3.2.4 the importance of compiling comprehensive information, including all relevant family members and taking account of the impact of factors such as frequent moves.

3.2.5. The importance of evidence-based practice and good record keeping underpinning decision making.

3.2.6 The importance of considering cultural norms when assigning support persons under the Signs of Safety Framework, particularly in cases of domestic violence.

3.2.7 The need to consider special circumstances of victims of domestic violence in ethnic minority groups.

3.4. Recommendations from reviews published in 2023.

NRP recommendations are made only when there is a clear case for change and the matter identified for improvement has national relevance requiring an adjustment to a policy or guidance document. Only one recommendation was made in in 2023, as follows:

- The Tusla alternative care guidance (Alternative Care: A Practice Handbook, Tusla, 2014) highlights that children in care may have less access to good quality sex education and advice than many other children. This matter requires to be addressed. Likewise, the practice handbook contains guidance on the type of support that should be offered to teenage mothers who are in care. Support should also be made available to young fathers in care and aftercare, acknowledging that the onset of parenthood brings a whole new set of responsibilities. The reviewers recommend that these matters are addressed in policy.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2023

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.

4.1. Cause of death summary 2010 to 2023

Cause of Death Summary 2010 to 2023							
Cause of Death	**Natural Causes**	**Suicide**	**Accidents**	**Drug Overdose**	**Homicide**	**Unknown**	**Totals**
2010	6	4	6	4	2	0	**22**
2011	8	3	2	2	0	0	**15**
2012	7	9	6	0	1	0	**23**
2013	7	4	1	1	0	4	**17**
2014	8	8	6	1	2	1	**26**
2015	11	6	2	0	0	2	**21**
2016	10	5	7	2	1	0	**25**
2017	8	3	5	1	2	3	**22**
2018	8	3	1	0	0	1	**13**
2019	8	4	4	1	2	3	**22**
2020	11	7	4	4	2	2	**30**
2021	14	6	1	1	1	4	**27**
2022	15	4	1	0	0	3	**23**
2023	18	4	5	0	0	2	**29**
Total All Years	**139**	**70**	**51**	**17**	**13**	**25**	**315**
% of Total	**44.13%**	**22.22%**	**16.19%**	**5.40%**	**4.13%**	**7.94%**	**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 2023 is 315. The average rate of notified deaths is now 24 per year while the number fluctuates somewhat from year to year. This is in a context where the number of referrals to the statutory social work services has risen from 29,277 in 2010 to 91,924 in 2023. As each of the foregoing annual reports has highlighted, the children and young people whose deaths were notified during that 13-year period were also involved with a range of different systems including health, mental health, and youth justice, with Tusla social work services playing a major role in certain cases and a minor role in others.

When the overall figures are examined, it is notable that death from natural causes occurred in the majority of cases (44%). This figure covers a wide range of conditions, including congenital and chronic diseases, childhood illnesses such as cancer and viral infections and Sudden Unexplained Death in Infancy.

4.2 Deaths from suicide

A total of 70 young people whose deaths were notified to the NRP over the past twelve years died from suicide. This represents nearly a quarter of all notified deaths. Twenty-three of the young people who died from suicide were in care or aftercare. The age range was 12 years to 22, the most prevalent between 15 and 16 years with another high proportion between 17 and 18 years.

Table 7 below illustrates the ages and numbers of young people whose death was caused by suicide.

Table 7

Age	unknown	12	13	14	15	16	17	18	19	20	21	22	Total
No	1	2	2	5	18	9	15	8	3	4	2	1	**70**

Many of the young people who died from suicide had been referred to CAMHS and some had received a consistent service. However, to be eligible for a CAMHS service, it was necessary for a young person to have a diagnosed treatable mental illness. Suicidal ideation alone does not meet the eligibility criteria. It appears to be the case that if a young person who self-harms is admitted to hospital, they may be referred to CAMHS but subsequently discharged from that service because they are not deemed to be mentally ill. Notwithstanding the variability of CAMHS services, some of which are more responsive than others, it is clear that referral of young people with suicidal ideation to CAMHS

continues to be generally ineffective. The recent CAMHS review by the Mental Health Commission[1] has provided strong evidence about deficits in the service, and the situation has now become critical.

4.3 Deaths from other causes

The next highest (combined) cause of death concerns accidents (16%). These included incidents such as drowning, falls, house fires, domestic and road traffic accidents. Drug overdose accounts for 7% and the numbers vary from year to year. Thirteen homicides were notified to the NRP between 2010 and 2023, accounting for almost 5% of deaths. Where murder or other criminal proceedings are ongoing, the NRP must take particular precautions to avoid interfering with legal processes which impacts on the timing of such reviews. 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 8% of deaths. On occasion reviews are delayed whilst awaiting a post-mortem or coroner's report.

4.4 Care Status of children whose deaths were notified between 2010 and 2023.

Table 8

Care Status Summary 2010 to 2023				
Care Status	**In care of the HSE / Child & Family Agency**	**In aftercare at time of death / in care immediately prior to 18th birthday or in receipt of aftercare service and under 21 years**	**Living at home and known to child protection services**	**Total**
2010	2	4	16	**22**
2011	2	2	11	**15**
2012	3	2	18	**23**
2013	3	1	13	**17**
2014	3	4	19	**26**
2015	3	2	16	**21**
2016	1	1	23	**25**
2017	5	0	17	**22**
2018	1	1	11	**13**
2019	2	0	20	**22**
2020	1	6	23	**30**
2021	4	3	20	**27**
2022	5	2	16	**23**
2023	2	1	26	**29**
Total All Years	**37**	**29**	**249**	**315**
% of Total	**11.75%**	**9.21%**	**79.05%**	**100.00%**

[1] Mental Health Commission (2023) *Independent Review of the provision of Child and Adolescent Mental health Services (CAMHS) in the State by the Inspector of Mental Health Services. https://www.mhcirl.ie/sites/default/files/2023-07/Mental%20Health%20Commission%20Independent%20Reviews%20of%20CAMHS%20services%20in%20the%20State.pdf*

As Table 8 above illustrates, 12% of the children or young people whose deaths were notified to the NRP between 2010 and 2023 were in care; a further 9% were either in receipt of aftercare services or had been in care up to their 18th birthday and were under 21 years of age. The remaining 79% were living at home and were known to child protection services for differing periods of time.

4.5 Causes of death of children and ages of children and young people in care

Table 9

Year	In Care at time of death	In Aftercare at time of death	Male	Female	Age					Cause of Death						
					Infants < 12 months	1-5 years	6-10 years	11-16 years	17-22 years	*Natural Causes*	*Homicides*	*Suicides*	*Drug overdoses*	*Accidents*	*Unknown*	*Totals*
2010	2	4	3	3	0	1	0	0	5	1	1	1	3	0	0	6
2011	2	2	3	1	0	0	1	1	2	2	0	0	0	2	0	4
2012	3	2	2	3	0	1	1	1	3	2	0	2	1	0	0	5
2013	3	1	2	2	1	0	0	1	2	2	0	1	1	0	0	4
2014	3	4	5	2	0	0	0	3	4	2	0	4	0	1	0	7
2015	3	2	3	2	0	0	0	2	1	3	0	1	0	1	0	5
2016	1	1	1	1	0	0	0	0	2	0	0	0	1	1	0	2
2017	5	0	2	3	0	1	2	2	0	2	0	1	0	1	1	5
2018	1	1	0	2	0	0	0	1	1	0	0	2	0	0	0	2
2019	2	0	1	1	0	1	1	0	0	2	0	0	0	0	0	2
2020	1	6	4	3	0	0	0	1	6	1	0	3	2	0	1	7
2021	4	3	5	2	1	0	0	2	4	3	0	3	0	1	0	7
2022	5	2	6	1	1	0	0	3	3	4	0	3	0	0	0	7
2023	2	1	0	3	0	0	0	2	1	0	0	2	0	1	0	3
Totals	37	29	37	29	3	4	5	19	34	24	1	23	8	8	2	66

The causes of death of children in care and their ages is given above in Table 9 and illustrates that the majority of the deaths of children who were in care were from either natural causes or suicide. This has been a consistent pattern. Most of these children had disabilities or chronic illnesses before their entry into care which was primarily for child protection reasons.

The age span during which most deaths of children in care occurred was between 11 and 16 years, with a higher number in the aftercare group signifying the vulnerability of that cohort.

5. Activities of the NRP during 2023.

- During 2023, panel members submitted reports on four children and young people, comprising three concise review and one comprehensive review.
- At the end of 2023 thirty-eight reviews were ongoing.
- Fifty-eight interviews were conducted by review teams with staff members from the Child and Family Agency and other organisations during 2023. In addition, twelve meetings were held with family members.
- Quarterly meetings between the Chair, Deputy Chair and the Quality and Regulation Directorate took place as scheduled.
- The chair and deputy chair had two meetings with the Chief Social Worker, Tusla.
- The second of two meetings took place between the NRP, Tusla and the HSE with the aim of securing consistent cooperation between the NRP and the HSE regarding the sharing records and interviewing of staff for the purpose of reviews. Legal advice from the HSE is pending.
- The Chair of the NRP attended the Service and Quality subcommittee of the Board of Tusla in May 2023.
- In July 2023, the NRP participated in an audit of the processes used by Tusla relating to reporting and review of serious incidents including deaths of children known to Tusla.
- An in-person training session with all panel members was held in December 2023
- The Chair and Deputy Chair initiated a meeting with the DCEDIY in July 2023 to discuss how their commitment to restructuring the NRP was to be actioned as well as the revision of the operational guidance issued by the DCEDIY which is due in 2024.

5.1 Outstanding issues

GDPR continues to impact on the work of the NRP, particularly in respect of obtaining records from services outside Tusla's remit. The legal basis of the NRP for requesting records is not always accepted and this impacts on reviewers' ability to undertake a holistic and balanced review. This matter is connected with the second outstanding issue, which is the status of the NRP in terms of governance, independence and interagency cooperation, and both require urgent action from the DCEDIY.

6. National Review Panel members who participated in reviews during 2023

Dr Helen Buckley, (Chairperson)

Dr Ann Mc Williams (Deputy Chair)

Ms Margaret Burke

Ms Ciara Mc Kenna Keane

Mr Eamon Mc Ternan

Ms Patricia O Connell

Mr Eric Plunkett

Dr Rosaleen McElvaney

Ms Christine McConville

Dr Paul Sargent

Mr Michael Lynch

Ms Rohana Reading

Ms Gloria Kirwan

Mr Ruadhan Hogan

Ms Liz Chaloner

Ms Lorraine Bates

Ms Michele Clarke