NATIONAL REVIEW PANEL

ANNUAL REPORT

2010

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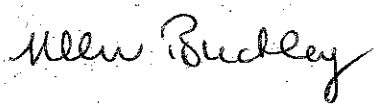
Foreword

The National Review Panel was set up one year ago to review deaths and serious incidents experienced by children who were in State care or known to HSE Children and Family Services. We now present our first annual report. The activities of the panel during the year have been largely concerned with recruiting and inducting panel members, developing protocols and strategies and meeting the sort of challenges normally associated with establishing a new programme of work.

The welfare and safety of vulnerable children is a matter of considerable public concern, and it is important that the business of child protection work is made transparent so that its complexities can be understood and confidence in the system can be maintained. As knowledge about child harm and the means of addressing it have expanded, so also have expectations about the capacity of the services to keep children safe. Yet, we know that child protection work takes place in a dynamic context that is subject to many influences, and the consequences of intervention are not always predictable. The aim of the review process is to promote learning from cases where children have died or experienced events which are likely to have serious consequence for them. We do this by recognising systemic and individual weaknesses but also by highlighting examples of good practice. The process of reviewing cases allows us to identify factors related to policy, practice and management which, if modified or further developed, may produce better outcomes for children.

At the conclusion of our first year, the flow of review reports is commencing and we look forward to seeing their recommendations bring some positive change to the sector.



Dr. Helen Buckley

Chairperson,

National Review Panel

INTRODUCTION

The *Report of the Commission to Inquire into Child Abuse* (Ryan Report) was published in May 2009. It provided a painful account of the terrible wrongs inflicted upon children who were placed in State care in the past. The report was accepted in full by the Government and, under the auspices of the Office of the Minister for Children and Youth Affairs (OMCYA), an implementation plan was published in July 2009. This implementation plan contained a recommendation that the Health Information and Quality Authority (HIQA) should develop guidance to the Health Service Executive (HSE) on the review of serious incidents, including deaths of children in care.

On January 20th 2010 HIQA published *Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care*, and this guidance was commenced in March. This guidance requires that the HSE establish a panel of appropriately skilled professionals (internal and external) to review cases under specified criteria. According to the HIQA guidance the panel should have an independent chair and deputy chair and professionals from a range of disciplines appointed for their professional expertise.

Accordingly, in June 2010, the HSE established the National Review Panel for the purpose of undertaking reviews in accordance with the HIQA guidance. Dr. Helen Buckley, Senior Lecturer and Research Fellow at the School of Social Work and Social Policy, Trinity College Dublin was appointed as Chair. Dr. Bill Lockhart, recently retired CEO, Youth Justice Agency, Northern Ireland, was appointed as deputy Chair. In addition, a senior professional manager and a senior administrative manager were assigned to support the work of the Panel. Allowing for a necessary lead in time for the induction of Panel members, the establishment of an office and the development of protocols; the core function of conducting reviews commenced effectively in August 2010.

While the National Review Panel (NRP) has been established under the auspice of the HSE, it remains functionally independent, making findings of fact and producing reports that are entirely objective and independent of the HSE. As a means of expressing this functional independence, the NRP has retained independent legal advisors and liaises directly with HIQA in relation to its work.

1. CONTEXT

1.1. Policy context

The publication of the Ryan Report and the Dublin Archdiocese Commission of Investigation Report (Murphy Report), both in 2009, created considerable public and political concern about the treatment of vulnerable children and the need for transparency and accountability. Prior to the publication of the HIQA guidance in 2010 there was no standardised or systematic way of reviewing

serious incidents, including the deaths of children in care. This posed a difficulty for the HSE in providing timely and accurate information, particularly at a time when public accountability was being demanded. The high numbers of deaths which subsequently were put into the public domain caused considerable disquiet, reinforcing demands for greater transparency.

In March 2010, Minister of State, Mr. Barry Andrews, T.D., established an Independent Review Group to examine the circumstances concerning children who died while in care, children who were known to the child protection services and young people who had been in care as children and died after their 18th birthday between 2000 and 2010. Therefore, with the Independent Review Group examining cases for the previous decade, and the National Review Panel considering cases thereafter, effective machinery has been put in place to ensure that reviews of serious incidents will not only be undertaken, but will be reported upon. This satisfies the original demands of the Ryan Report that rules and regulations are enforced, breaches reported and sanctioned; and that a culture of respecting rules and regulations be developed and maintained.

1.2. Criteria for review

Whereas much of the public and political attention over the past year or so has focused upon the deaths of children in care, the criteria set out by HIQA is much broader than this and extends to children and young people who have never been in the care system. In fact, the death rate for children in care does not exceed the national average of 4 per 10,000[1], and the vast majority of cases that fall for review by the National Review Panel do not relate to deaths in care.

The criteria set out by HIQA for cases to be reviewed are as follows:

- All deaths of children in care, including deaths by natural causes
- All deaths of children known to HSE child protection system
- Deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under Section 45 of the Child Care Act, 1991.
- Where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- Serious Incidents involving children in care or children known to the HSE Child Protection Services

These criteria are broad by international standards. For example, in England serious case reviews are undertaken in the form of local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. In Northern Ireland, under Co-operating to

[1] Two children died in care in 2010 representing 4:10,000. According to CSO Vital Statistics (2009) the death rate for children under 18 years was 3.8:10,000.

Safeguard Children (2003), in addition to death and serious injury, cases should be considered for review where:

- a child has sustained a potentially life-threatening injury through abuse (including sexual abuse) or neglect;
- a child has sustained serious and permanent impairment of health or development through abuse or neglect;
- the case gives rise to concerns about the way in which local professionals

and services worked together to safeguard children

Under the HIQA criteria, however, reviews are required to be conducted in cases known to the child protection or care system, whether or not abuse or neglect is a factor. Hence, for example, all accidental deaths and deaths by natural causes, as well as serious incidents, must be reviewed even where there is no suggestion of parental or professional wrong-doing.

Inevitably, the broad criteria for review have resulted in a large number of cases requiring review. Original estimates in the HIQA guidance suggested that there were likely to be two deaths and up to five serious incidents for national review per annum. In reality, during the nine months in which the guidance applied in 2010, 22 deaths and 8 serious incidents were notified to the National Review Panel.

From an early stage it also became apparent that the timelines imposed in the HIQA guidance are, by and large, un-workable. It requires that reviews are commenced within one month of a death or serious incident and completed within four months. The National Review Panel has found that even in the most straightforward of circumstances, such as the death of a child by natural causes, it is necessary to wait in excess of six months for medical evidence such as post-mortem results, a coroner's report or a death certificate before a review can be finalised. By virtue of the volume of records and staff involvement, more complex cases will usually take longer than this. It is noteworthy that the experience of other jurisdictions that delays in producing final reports constitute the biggest challenge to the review process.

The NRP has also experienced difficulties in the report format required by the HIQA guidance. It requires information of such detail that it would be extremely difficult to adequately anonymise the reports and render them publishable. It stipulates that separate chronologies should be provided for both the child and the family, which seems to be an unnecessary and time-consuming exercise. It further stipulates that, in addition to providing recommendations, the report should provide an action plan assigning responsibility and timelines for the implementation of recommendations. The NRP has negotiated with HIQA on both of these issues. As a result review reports will normally contain one chronology and will not contain an action plan which the NRP considers more the business of the delivery system within the HSE.

3. REVIEW PROCESS

3.1. Panel Members

Originally a panel of 17 experts comprised the National Review Panel, five nominations from the Irish Youth Justice Service (IYJS) and two HSE nominees: the remainders were independent experts. Allowing for some resignations and additional recruits, the Panel comprised twenty-two members by the end of 2010.

3.2. HSE Procedures

The HIQA guidance requires that deaths or serious incidents, or cases meeting any of the additional criteria for national review, should be referred nationally through the serious incident management procedure and to the office of the Assistant National Director (AND) for Children and Families Social Services. A protocol governing this procedure was put in place in July 2010.

The office of the AND then reports suitable cases to HIQA within prescribed timelines. At the same time the same cases are referred to the National Review Panel for consideration.

3.3. National Review Panel Procedures

The Chair of the National Review Panel considers each notification referred by the office of the AND against the HIQA criteria. If the criteria are met the case is then listed for review. Due to the exceedingly high and unanticipated numbers of notifications the NRP was faced with capacity issues from its inception. Therefore, at an early stage a priority system was agreed with HIQA and put in place:

High:

- Ongoing serious risk (e.g. child/ young person absconding regularly, child missing from care for prolonged period)
- High level of public interest
- High level of concern expressed by child/young person's family
- Special circumstances

Medium:

- As per HIQA criteria for review with none of the above

Low:

- Awaiting results of post-mortem
- Awaiting results of child sexual abuse assessment
- Awaiting results of assessment of impact of identified incident or trauma

In addition it was further agreed with HIQA that, on a pilot basis, different levels of review would be undertaken ranging from, depending on the circumstances of each case, record reviews only to full scale inquiries.

Levels of review:

1. **Major review:**

- **Criteria**: where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex (e.g. multiple placements); and where a child protection issue is likely to be of public concern
- **Process**: will involve file review and discussions with relevant staff and family members.
- **Panel**: at least three members including the chair
- **Timeline**: 12 months from start of review
- **Output**: Report as per HIQA guidance containing conclusions, recommendations and action plan

2. **Comprehensive review:**

- **Criteria**: Where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period.
- **Process:** will involve file review, meetings and discussions with relevant staff and family members
- **Panel** at least two members with oversight by the chair
- **Timeline**: 6 months from start of review
- **Output**: report as per HIQA guidance containing conclusions, recommendations and action plan

3. **Concise review:**

- **Criteria:** Where the involvement of HSE services is either of a short duration or of low intensity over a longer period.
- **Process:** file review, meetings with a small number of staff and family members
- **Panel:** two members including the chair
- **Timeline**: 4 months from start of review
- **Output**: Report as per HIQA guidance containing conclusions, recommendations and action plan

4. **Desktop review**

- **Criteria**: Where involvement of HSE services has been brief, the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no evidence that the outcome was affected by the availability or quality of a service. This would include cases of death by natural causes where no suspicions of child abuse are apparent.
- **Process**: Review of files, and may involve telephone contact with staff for the purpose of clarification.
- **Panel**: chair
- **Timeline**: 1 month from start of review
- **Output**: Brief summary report which will not contain recommendations or action plan

5. **Internal review:**

- **Criteria**: Where the notification refers to a serious incident that has more local than national implications, e.g. where a child is regularly absconding from a placement.
- **Panel:** The review should be conducted by a HSE senior staff member not involved with the case, using HIQA methodology.
- **Timeline**: one month
- **Output**: Report to be referred back to the chair of the NRP for information and quality assurance. If questions arise concerning either the quality or independence of the review, the NRP will then conduct the most appropriate type of review.

Training was provided for panel members on issues such as data analysis, report writing, fair procedures and the law. A 'toolkit' has also been devised covering information gathering, interviewing, analysing findings and the making of recommendations. Guidance on benchmarking for good practice is also provided, with world-wide links to best practice exemplars. An analysis framework has also been produced which focuses on cases in terms of the different systems involved, the child, the family, other (non HSE) services, management and practitioners. It also focuses on the relationships between the different systems, and invites consideration of a number of key issues that potentially impact on practice.

4. STATISTICAL ANALYSIS

4.1. Child Death Register

In October 2010 the HSE completed an analysis of deaths of children and young people known to the child protection system over the previous ten years. While this exercise was entirely outside of, and separate to, the of the NRP it nevertheless provides a useful backdrop to the work of the NRP as it provides a trend analysis for the previous decade.

An analysis was undertaken of deaths by natural and unnatural causes of children and young people who were either known to the child protection service or in care; or young adults in post care situations. During the period in question in excess of 200,000 referrals were made to the child care service. Over 20,000 of these referrals related directly to child protection and exclude children in care and young adults who had previously been in care. In total 199 children and young people were identified in the above categories. Their status and the causes of death are summarized in the following table:

Table 1: Cause of death

CAUSE	**In care**	**Child known**	**Young adults**	**TOTAL**
Natural causes	17	66	7	90
Accident (other than RTA)	3	25	6	34
Suicide	5	16	8	29
Drugs	5	6	6	17
Road traffic accident	3	11	3	17
Homicide	2	9	1	12
TOTAL	**35**	**133**	**31**	**199**

As the table indicates, the largest category was death by natural causes (90) and the majority of these (73) were not in care at the time. By a large majority most of the deaths (133) occurred among children and young people who were known to child care services but who were not, or ever had been, in care.

4.2. Notifications

From March 10th, when the HIQA guidance went live, and December 30th 2010, thirty cases were referred to the National Review Panel from the office of the AND, Children and Families Social Services. The disposal of these referrals is summarized in the following table:

Table 2: Notifications to NRP, March – December 2010

Cases under review	12
Awaiting further information	7
Awaiting review	6
Did not meet HIQA criteria	5
TOTAL	**30**

Of the twelve cases under review nine related to deaths and three related to serious incidents. Two of the cases were categorized as major reviews, four as comprehensive, five as concise and one was referred back for local review.

Decisions in relation to seven reviews were deferred pending further information becoming available. In the majority of cases this concerned medical or clinical information. For example, in cases where a coroner is involved it may take several months before the cause of death is formally established, or for a death to be registered.

Given the unexpectedly high number of cases referred for review it was inevitable that there would be a backlog of cases for review. The procedures agreed with HIQA for prioritization and levels of review provided an efficient means of managing this capacity issue, ensuring that cases waiting were kept to a minimum. However, given that the Chairperson must oversee and sign off on all reviews, in addition to direct involvement in several reviews, there is a limit to the number of reviews that can be effectively processed and managed at any one time.

The five cases that did not meet the criteria involved two where the incident predated the HIQA guidance, two where the young person was not in care or after care at the time of the incident and one where there was no care history and the case was not open to the child protection service at the time of the incident.

4.2.1. Category of cases notified

Under the HIQA guidance cases fall into four broad categories for review:

1. current cases open to the child protection service
2. in care at the time of the incident
3. in care immediately prior to 18th birthday and still under 21 years of age
4. in aftercare that the time of the incident

The following table shows the distribution of these cases across these categories:

Table 3: Category of cases notified

Category	Deaths	Serious incidents	Total
current cases open to the child protection service	11	2	**13**
in care at the time of the incident	2	5	**7**
in care immediately prior to 18th birthday and still under 21 years of age	7	0	**7**
in aftercare that the time of the incident	2	1	**3**
TOTAL	**22**	**8**	**30**

As was the trend over the previous decade, evidenced by the Child Death Register; cases known to the child protection service, but not involving care, accounted for the majority of notifications. Likewise, only a small number were in care at the time of the incident.

4.2.2. Cause of death

Again the cause of death followed a similar trend to that revealed by the Child Death Register, with natural causes as the most common reason. The following table sets out the cause of death in the twenty-two cases notified, in order of frequency:

Table 4: Cause of death

Natural causes	6
Drug overdose	4
Suicide	4
Road traffic accident	4
Homicide	2
Accident (other than RTA)	2
TOTAL	**22**

None of the deaths were related to familial child abuse; while the two homicides can be categorized as fatal (extra-familial) child abuse. In contrast, in the U.K. Ofsted reported that, of fifteen homicides reported during 2009-2010, ten were classified as murder by a parent or guardian.

Research published by UNICEF (2003) found that almost 3,500 children under the age of fifteen years die in developed countries each year as a result of child abuse. It found that Ireland had exceptionally low incidences of child maltreatment; second only to Spain, Greece and Italy. Within Europe levels in

Belgium, the Czec Republic, Hungary and France were up to six times higher; while in the USA incidences of child abuse were up to fifteen times higher. Data for children under the age of fifteen years, averaged over five years, showed Ireland to have 0.3 child deaths from maltreatment per 100,000 children. In the United Kingdom the figure was 0.9, with Portugal as the highest with a ratio of 3.7 per 100,000.

4.2.3. Serious incidents

Contrary to expectation there were fewer serious incidents reported than deaths. In addition to accidents, which were a significant factor in cause of death, other incidents were notified as outlined below:

Table 5: Nature of serious incidents

Road traffic accident	2
Accident (other than TRA)	1
Parental abuse and neglect	2
Missing from care	1
Alleged sexual abuse by staff member	1
Witness to traumatic event	1
TOTAL	**8**

4.2.4. Age

In Ireland the majority of deaths of children occur in infants less than one year Death is most commonly attributable to congenital malformations or certain other conditions in the perinatal period. In line with this national trend, two of the six children who died from natural causes were under one year and a third was just fourteen months.

The next highest age range is 15-17 years. In this group death is most commonly attributable to injury or poisoning (OMCYA, 2010).

Over half of the deaths notified to the National Review Panel (14) occurred in young people aged fifteen years or over. Seven of the deaths were attributable to young adults aged between nineteen and twenty-two years. When natural causes and homicide is extracted from the cause of death the average age at the time of death is seventeen years. This contrasts sharply with the situation in the U.K. Ofsted (2010) found that 35% of deaths reviewed related to children under one year, with 24% relating to children aged between one and five years.

There appears to be a co-relation between personal behavior and cause of death in relation to most of the teenagers known to the National Review Panel. This is borne out by knowledge of the circumstances surrounding the four suicides, the four deaths by drug overdose, four by traffic accident and at least one of the other accidents. This has significant implications on the

effective delivery of services in circumstances where young people either risk or take their own lives.

4.2.5. Gender

Over twice as many males (15) died than females (7). There is no significant variation in the cause of death between the sexes. The average age for males at the time of death was 16 years; while in females it was 14 years.

4.2.6. National distribution of cases by Region/LHO

Table 6: Dublin North East

Dublin North Central	2
Dublin North West	4
Dublin North	2
Total	**8**

Table 7: Dublin mid Leinster

Laois/Offlay	2
Dublin West	1
Total	**3**

Table 8: South

Cork West	1
Kerry	6
Total	**7**

Table 9: West

Limerick	3
North Tipperary	1
Total	**4**

Table 10: Deaths by Region

Dublin North East	8
Dublin mid Leinster	3
South	7
West	4
Total	**22**

5. Conclusions

5.1. Following a necessary lead in period to allow for the setting up of an office and the panel itself, the NRP is now firmly established and operating to standardized protocols. For this reason, and given that it was, in effect, the last quarter of the year before the first reviews commenced no review reports were finalized within 2010. In order to fully evaluate the effectiveness of the system that is currently in place it will be necessary for a number of reviews be brought from the notification phase, through data analysis and interviewing to the production of final reports to be handed over to the National Director, Children and Families Social Services. However, even at this early stage a number of observations can be made:

5.2. While it is not strictly the business of the NRP, it is concerned that the requirement in the HIQA guidance for the HSE to publish reports may, in certain cases, pose significant challenges. For example, the NRP is very concerned that the anonymity of the children and young people concerned should be protected. This cannot be guaranteed, for example, where the circumstances of particular cases have already been aired in the national media. It is also to be anticipated that some families will not want a report to be published. It such circumstances the HSE will have to balance its obligations in relation to public accountability with the rights and wishes of the families concerned.

5.3. As described in the body of the report, the NRP is concerned that the HIQA guidance places virtually impossible obligations upon it. The combination of timelines, detail required and the unanticipated volume of notifications presents difficulties for the NRP that were never intended. Therefore, the NRP considers that the current guidance requires considerable and urgent re-drafting in order to be more reflective of the time required to produce reports and the complexities surrounding their completion and publication. It would help to ensure that reviews are concluded more rapidly and the learning passed back into practice in a timelier manner.

5.4. At the end of 2010 the NRP had twelve cases under review with a further six cases awaiting review. With such a large and unanticipated volume of cases the question must be raised, at this early juncture; is it necessary, or even beneficial, for every case to be reviewed? It would, and perhaps, should, be possible for the independent Chair of the NRP to select representative cases from which maximum learning can be extracted without running the risk, as has happened in other jurisdictions, of services being drowned in a flood of similar conclusions and recommendations.

5.5. If it were decided to afford the independent Chair such discretion it would still be possible for the HSE, through existing risk management processes, to gather, collate and maintain information in relation to all serious incidents, including the deaths of children in care and to put this information into the public domain.

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