Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2019

Foreword

I am pleased to present the 10th annual report of the National Review Panel to the Chair and Board of Tusla. The NRP was established ten years ago 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 89 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 12 children, four of whom were in foster care when they were victims of abuse. Tusla has published summaries of the majority of the 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 on the role and function of the NRP and current issues affecting its performance. The second part provides statistical information and a brief analysis of the notifications made to the panel in 2019. The third section provides an overview of the reports published in 2019 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 ten years. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2019.

The National Review Panel would like to express its appreciation to the family members who came for interview during 2019, which 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 from Tusla, family support and mental health services to meet with us and acknowledge that it was a stressful experience for many of them. 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 Linda Nolan, Interim Service Manager for most of 2019, and Naomi Boland, who was appointed Service Manager in late 2019, for their excellent support of the panel's work and for providing the statistical tabulations included in this report. Inspector Michael Lynch provided valuable liaison on behalf of An Garda Síochána. I would also like to acknowledge the support and cooperation of the Quality Assurance 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

June 2020

1. Introduction

The National Review Panel (NRP) is an individual entity comprising of child care consultants from a variety of child protection and welfare backgrounds. It is commissioned by, but independent of, the Child and Family Agency. In 2019he panel consisted of ten 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 care 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 Dublin Institute of Technology (now the Technological University of Dublin). Other panel members have backgrounds in psychotherapy, psychiatry, psychology, social work and law. The chair and deputy care 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 Assurance 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. The panel also uses the services of an independent legal team. A list of panel members who completed work in 2019 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).

The Government has approved a plan for the establishment of the National Review Panel on a statutory footing and the DCYA has given an undertaking to prepare legislation to allow for this. This action will be vital for the further development of the NRP and will enable it to take a holistic approach to reviews in acknowledgement of the multi-faceted nature of child protection.

1.1 Guidance on the operation of the NRP

During 2019, the NRP continued to operate 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 current arrangements in the administration of child protection and identifies the key stakeholders participating in reviews as the NRP, the Child and Family Agency and HIQA.

Meetings were held in 2019 between the Chair of the National Review Panel and the DYCA with regard to the revision of the guidance, which requires amendment pending the establishment of the NRP on a statutory footing. Completion of the revised guidance is expected in 2020.

1.2 Functions of the National Review Panel

The NRP reviews cases where a child or young person dies or experiences a serious incident and 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 service provision to the child or young person and their family. 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 identify obstacles to good practice and identify areas for learning. Each report contains a section specifically for this purpose.

During 2019, the NRP continued to operate similar processes to those adopted at the outset, and differentiates between desktop, concise, comprehensive and major reviews. A decision was made in 2019 to opt where possible for concise and comprehensive reviews in the future as it was considered that fuller participation of stakeholders provided more robust reviews. This creates a challenge to the capacity of the panel to complete its work within appropriate timelines.

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 is regularly revised. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by the NRP.

Over the past two years, the ability of the panel to access records and invite participation from children's services which are neither managed nor funded by the Child and Family Agency has become more complex due to data protection regulations. Currently, issues are addressed on a case by case basis but this matter will only be fully resolved when the NRP is established as a statutory body.

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 2019

2.1 Number and causes of deaths

A total of 21 deaths of children and young people in care or known to the child and family services were notified in 2019. This figure represents an increase of 8 from the previous year. The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2019			
Cause	**No**	**Male**	**Female**
Natural Causes	**8**	**3**	**5**
Suicide	**4**	**2**	**2**
Homicide	**2**	**1**	**1**
Road Traffic Accident	**1**	**1**	**0**
Other Accidental	**3**	**3**	**0**
Unknown	**3**	**2**	**1**
Totals	**21**	**12**	**9**

As Table 1 above shows, eight of the 21 children/young people who were notified died as a result of natural causes and four others from suicide (one more than in 2018). The next most common cause

of death was a combination of road traffic and other accidents experienced by four young people (an increase of three on 2018). 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 2019

Table 2

Care Status Summary 2019				
In care at time of Death	**In aftercare at 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**	**0**	**20**	**21**

As Table 2 above shows, one young person under 18 years whose death was notified was in care at the time of their death, similar to 2018. The remaining children or young people were living in their communities. There were no notifications of the deaths of young people in aftercare up to 21 years old, compared with one the previous year.

2.3 Summary of serious incidents reported in respect of children in care 2019

Table 3 below provides a summary of serious incidents that were notified to the NRP in respect of children in care. 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

Care Summary 2019 Serious Incidents	
In care	**3**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**2**
Total	**5**

2.4 Ages and gender of children and young people whose deaths were notified in 2019

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

Table 4

Age Profiles 2019			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**6**	**2**	**4**
1 - 5 years old	**5**	**4**	**1**
6 - 10 years old	**1**	**0**	**1**
11 - 16 years old	**5**	**4**	**1**
17 - 20 years old	**4**	**2**	**2**
> 20 Years Old	**0**	**0**	**0**
Total	**21**	**12**	**9**

As the above table shows, most deaths (6) occurred in respect of infants under 12 months, similar to the figure in 2018.

2.5 Summary of deaths by region

Table 5

Age Profiles 2019				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
5	**4**	**4**	**8**	**21**

Of the 21 deaths notified in 2019, a decision was made to review five. One review was prioritised at the request of Tusla and has been completed and submitted and a further four are in process. At the time of writing, information from the relevant social work departments was outstanding for two other cases which are pending a decision regarding review. The remaining 14 notifications concerned children or young people who had died from natural causes or accidents and decisions were made not to conduct reviews.

3. Overview of reports published in 2019

The Child and Family Agency published NRP executive summary reports in 2019, on seven children who had died in previous years (see www.nationalreviewpanel.ie) . These comprised one major review, one concise review and five desktop reviews. In addition, one NRP executive summary report on a serious incident involving four children was also published. This had been conducted as a major review.

The NRP regards anonymity and the privacy of families as priorities and, where relevant, advises Tusla in relation to publication where the details of a case are likely to identify a family and community because of previous media exposure or where publication could potentially prejudice a criminal trial. Where family members agree to participate in reviews, the reviewers meet with them once during the course of the review and again later to discuss the draft reports and receive feedback. When reports are due to be published, contact 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. Unfortunately the content of one 2019 review became known to the media in advance of publication and was reported on a television programme before family members could be fully prepared. This was distressing for all involved.

3.1 The children/young people who were the subjects of reports published in 2019

Two of the young people who were the subjects of reviews published in 2019 had spent time in care, one for most of his life and another for a short period during the two years prior to her death. The remaining children whose deaths were notified had been living with their families.

Two of the children died as infants from Sudden Infant Death Syndrome; one of them had been living in emergency accommodation with their mother and the other child was living in a campervan which was considered to be cramped and unsuitable. A nine year old child known to services died in hospital from a serious long term illness. A three year old child and two young people aged 19 and 16 died in accidents and a teenager aged 15 died from suicide, having been on a waiting list for CAMHS for three months.

The four children/young people who were notified together in respect of a serious incident had spent time in one particular foster placement for different periods of their lives, three of them at the same time. Three of the children were raped by the son of their foster carers when they were between the ages of 4 and 10 years of age. The perpetrator has since been convicted and imprisoned. The NRP

review focused on the decision making process and interventions that followed the disclosure of child sexual abuse made by one of the children when she was ten years old.

3.2 Findings from reports

In general, the desktop and concise reports published in 2019 affirmed the positive practices of social work departments, particularly where responses to referrals were prompt, consistent contact with families was maintained and positive relationships developed. Three of the reviews highlighted that assessment was incomplete and two reviews commented that direct contact by the SWD with the child concerned was limited. The fact that one teenager died from suicide having been on a waiting list for a mental health service for the previous three months was noted, highlighting the pressure on that service. The high turnover of social workers was a notable factor in two cases, underlining the need for smooth transitions when this inevitability occurs.

The two major reviews published in 2019 identified significant practice and management issues. One of them also highlighted the way child protection and welfare interventions can be limited by a legal framework that prioritises family reunification and limits the ability of authorities to keep a child protected from negative parental influence. While noting some excellent social work practice, the same review demonstrated limited care planning, insufficient focus on education and lack of adequate placements. The second major review identified deficits in decision making that had serious implications. It raised questions about the appropriate response to disclosures of child sexual abuse and the need for practitioners and managers to understand all the risks involved, particularly in complex cases involving multiple and possibly unknown children. It also raised issues about the assessment, training, support and review of foster carers. Importantly, it highlighted the significance of management oversight and the use of multi professional expertise in decision making where child sexual abuse is alleged in a care setting.

3.3 Key Learning identified in reviews

3.3.1. Overview of learning points

In line with the aim of the National Review Panel to drive learning in the child protection and welfare sector, each of the published reports contains a section on key learning, where areas are highlighted and relevant research is cited which may improve practice in particular ways. Over the past 10 years, the learning points most often identified have been in relation to care planning, assessment, responding to the needs of children where parental omission is not a factor, inclusion of fathers,

working with families that are reluctant to cooperate and coordination of services. The outstanding learning points in the reports published in 2019 include the following:

3.3.2 Responding to allegations of child sexual abuse of children in foster care

- Substantiated abuse of children in foster care is rare but its occurrence must be acknowledged. Where certain situations exist, such as numerous children placed in a household or female children are placed with older boys, foster carers need additional high quality supervision and support. Difficult balancing decisions need to be made if abuse is alleged and should be taken, following risk assessment, in a context of careful multi professional deliberation and agreement.

3.3.3 Review of child protection plans

- When a child is the subject of a child protection plan, review child protection conferences are normally held to consider the progress or otherwise that has been made in ensuring a child's safety and to consider if amendments to the child protection plan are necessary. As a first step, the decisions of the previous child protection conference should be reviewed from the perspective of their implementation and success in meeting a child's needs. Minutes of the child protection conference including the child protection plan should be circulated without delay to ensure that family members, professionals and others involved know and understand the actions necessary to ensure the ongoing safety of a child.

3.3.4 Managing acute parental conflict

- SWDs have responsibility for the population of children who are subject to care orders. In this context, the management of conflict with parents is a recurrent theme of practice. It was suggested that Tusla develop guidance to assist SWD practitioners and their supervisors to manage parental contact and access based on the best interests of the child, where the possibility of parental change is minimal, and where parents are not compliant with care planning for the child, and to escalate such cases internally, where necessary.

3.3.5 Linking Care Planning to the changing needs of the child:

- Whilst the basic statutory requirement under the 1995 Child in Care Regulations is for an annual statutory Child in Care Review, care planning must be seen by practitioners and managers as an active and responsive process, and its frequency should be determined not just by minimum statutory compliance but also by the assessed and changing needs of the

child. Care plans are built around core factors which include the child's placement, health, psychological development, education, contact, identity, self-development, all of which require multi-agency co-ordination. Significant changes in any of these factors may require the plan to be changed or adjusted, and good practice requires that this is mandated at multi-agency Child in Care Reviews convened according to the needs of the case.

3.4. Recommendations from reviews published in 2019

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 reports and were as follows:

3.4.1 Recommendations pertaining to children in care

Two recommendations were made in respect of parental contact. One was the development of an interdepartmental protocol on the implementation of court orders restricting parental contact. The other was the development of Tusla guidance on the management of contact in the best interests of a child where parental change has been minimal and parents are not compliant with care planning. It was also recommended that the Department of Children and Youth Affairs and the Department of Justice consider how to promote greater consistency of Court determinations in implementation of the Child Care Act. Further recommendations were made in respect of care planning, to address the participation of educational professionals in Child in Care Reviews and the timely transfer of case management where children move between Tusla administrative areas.

A recommendation was also made in respect of national procedures on foster care, with particular focus on the role of fostering link workers and the numbers of children placed with a family at any one time.

3.4.2 Recommendations pertaining to child sexual abuse services

A recommendation was made to Tusla in respect of the development of a new model for the investigation, assessment and management of child sexual abuse allegations. It emphasised the need for equal inclusion of principal stakeholders in the process and the adoption of a consensus approach that is sensitive to the needs of abused children and respectful of the uniqueness of each child and family. The formalisation of these matters in the terms of reference of the new service was recommended.

3.4.3 Recommendations pertaining to complex cases.

A recommendation was made to Tusla advising the development of an overarching multi agency policy response to the investigation and ongoing management of complex cases, e.g. those in which allegations involve multiple children in alternative care or in the community including unidentified children who may have been abused.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2019

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 2019

Table 6

Cause of Death Summary 2010 to 2019								
Cause of Death	**Natural Causes**	**Suicide**	**Road Traffic Accident**	**Other Accident**	**Drug Overdose**	**Homicide**	**Unknown**	**Totals**
2010	6	4	4	2	4	2	0	**22**
2011	8	3	1	1	2	0	0	**15**
2012	7	9	2	4	0	1	0	**23**
2013	7	4	0	1	1	0	4	**17**
2014	8	8	5	1	1	2	1	**26**
2015	11	6	1	1	0	0	2	**21**
2016	10	5	3	4	2	1	0	**25**
2017	8	3	2	3	1	2	3	**22**
2018	8	3	0	1	0	0	1	**13**
2019	8	4	1	3	1	2	3	**22**
Total All Years	**81**	**49**	**19**	**21**	**12**	**10**	**14**	**206**
% of Total	**39.32%**	**23.79%**	**9.22%**	**10.19%**	**5.83%**	**4.85%**	**6.80%**	**100.00%**

As Table 6 above illustrates, the total number of deaths notified to the National Review Panel since February 2010 is 206. The average rate of notified deaths is 21 per year over a ten-year period, and while the number fluctuates slightly from year to year, the trend has been reasonably consistent. This is in a context where the number of referrals to the child protection system has increased by 93%, from 29,277 in 2010 to 56,561 in 2019. As each of the foregoing annual reports has highlighted, the

children and young people whose deaths were notified during that ten 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 minor role in certain cases.

When the overall figures are examined, it is notable that death from natural causes occurred in the majority of cases (39%). This figure covers a wide range of conditions, including congenital and chronic conditions, childhood illnesses such as cancer and viral infections and Sudden Unexplained Death in Infancy. The latter category included the deaths of some infants where maternal drug use in pregnancy was a factor and some though not all had traces of non-prescribed medication in their systems at birth.

4.2 Deaths from suicide

A total of forty-nine young people whose deaths were notified to the NRP over the past ten years died from suicide. This represents nearly a quarter of all notified deaths. Twelve 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 17 and 18 years with another high proportion between 15 and 16 years.

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

Table 7

Age	No.
unknown	1
12	1
13	2
14	2
15	14
16	8
17	10
18	5
19	3
20	0
21	2
22	1
Total	49

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 is considered to be a mental health problem but does not always qualify for a CAMHS service.

The next highest combined total is accidents. These included incidents such as drowning, falls, domestic accidents and road accidents. A minority of these were associated with risky behaviour and in total account for 19% of deaths. Drug overdose accounts for 6% and the numbers have been fluctuating. Homicide accounts for nearly 5% 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 7% of deaths.

4.3 Care Status of children whose deaths were notified between 2010 and 2019

Table 8

Care Status Summary 2010 to 2019				
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**
Total All Years	**25**	**17**	**164**	**206**
% of Total	**12.14%**	**8.25%**	**79.61%**	**100.00%**

As Table 8 above illustrates, 12% of the children or young people whose deaths were notified to the NRP between 2010 and 2019 were in care; a further 8.25% 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 79.61% were living at home and were known to child protection services for differing periods of time.

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

Table 9

Summary of age 2010-2019																	
Year	In Care at time of death	In Aftercare at time of death	Male	Female	Age					Cause of Death							
					< 12 months	1-5 years	6-10 years	11-16 years	17-22 years	*Natural Causes*	*Homicides*	*Suicides*	*Drug overdoses*	*Road Traffic Accidents*	*Other Accidents*	*Unknown*	*Totals*
2010	2	4	3	3	0	1	0	0	5	1	1	1	3	0	0	0	6
2011	2	2	3	1	0	0	1	1	2	2	0	0	0	1	1	0	4
2012	3	2	2	3	0	1	1	0	3	2	0	2	1	0	0	0	5
2013	3	1	2	2	1	0	0	1	2	2	0	1	1	0	0	0	4
2014	3	4	5	2	0	0	0	3	4	2	0	4	0	1	0	0	7
2015	3	2	3	2	1	0	0	3	1	3	0	1	0	1	0	0	5
2016	1	1	1	1	0	0	0	0	2	0	0	0	1	1	0	0	2
2017	5	0	2	3	0	1	2	2	0	3	0	1	0	0	1	0	5
2018	1	1	0	2	0	0	0	1	1	0	0	2	0	0	0	0	2
2019	2	0	1	1	0	1	1	0	0	2	0	0	0	0	0	0	2
Totals	25	17	22	20	2	4	5	11	20	17	1	12	6	4	2	0	42

The causes of death of children in care and their ages is given above in Table 9, and illustrates that the children who were in care died from natural causes almost one and half times 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 had disabilities or were ill before their entry into care. Their entry into care was primarily for child protection reasons. The age span during which most deaths occurred was between 11 and 16 years.

5. Activities of the NRP during 2019

5.1 Routine NRP work

During 2019, panel members completed and submitted reports on 13 children and young people, comprising 11 desktop reviews, one concise review, and one major review. Some of these reports were published in 2019 alongside a number of other previously submitted reviews.

Twenty seven interviews were conducted by review teams with staff members from the Child and Family Agency and other organisations during 2019. In addition, seven interviews were held with family members of children and young people who were the subjects of reports and one further meeting was held with a family member to discuss a draft report.

5.2 Change of Personnel

Ms Naomi Boland, was appointed as permanent Service Manager with the NRP in Q3 2019, taking over from Linda Nolan, who had been covering the post on an interim basis.

5.3 Meetings between the NRP and the Child and Family Agency

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, Chair, Ann McWilliams, Deputy Chair and the Service Manager had four meetings during 2019 with Brian Lee, Director of Quality and Risk and the National Risk and Incident Manager, Tusla to provide updates on the work of the NRP and discuss matters relevant to its operation.

5.4 Meetings with the Department of Children and Youth Affairs

The Chair of the NRP and representatives from Tusla had two meetings with the DCYA in 2019 to discuss a strategy for actioning recommendations that were outside the remit of Tusla and to discuss proposals for putting the NRP on a statutory basis.

6. National Review Panel members who participated in reviews during 2019

Dr Helen Buckley, (Chairperson)

Dr Ann Mc Williams (Deputy Chair)

Ms Margaret Burke

Ms Michele Clear

Ms Ciara Mc Kenna Keane

Mr Eamon Mc Ternan

Ms Patricia O Connell

Mr Eric Plunkett

Dr Imelda Ryan

Mr John O'Reilly