Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2020

Foreword

I am pleased to present the 11th annual report of the National Review Panel. The NRP was established eleven 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 105 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 20 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 2020. The third section provides an overview of the reports published in 2020 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 2020.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2020, 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 speak with us and acknowledge that it was a stressful experience for many of them. We would like to thank all review participants for their tolerance of the limitations of online meetings which became necessary due to Covid 19. 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 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.

As the report will show, Covid 19 had a significant effect on the operation of the panel, particularly for the second and third quarters of 2020. The sensitivity of the subject matter of our work means that

face to face contact is the most desirable form of communication and as this was not possible within the restrictions, everyone involved had to adjust to working in a way that was less comfortable.

The cyber-attack on the health services in May 2021, which immobilised NRP systems for several months, caused a delay to the production of this report. Unfortunately the combined effect of these unforeseen events will be reflected in the output of the panel for a considerable period.

Dr Helen Buckley, Chairperson, National Review Panel

August 2021

1. Introduction

The National Review Panel (NRP) is an independent 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 2020 the panel consisted of nine 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 Technological University of Dublin. Other panel members have backgrounds in psychotherapy, psychiatry, psychology, social work and 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 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 2020 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 DCEDIY 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 2020, the NRP continued to operate under guidance published by the Department of Children and Youth Affairs in 2014, available on the DCYA website at

http://dcya.gov.ie/documents/publications/20141204GuidOperationofationalReviewPanel.pdf

The then DCYA committed to revising the guidance every three years, and in late 2020 work commenced on the production of a new set of guidelines to be published in 2021. The new guidance is intended to reflect recent changes in the structure of services as well as learning from the first ten years of the work of the NRP. It is due for implementation in 2021.

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 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 2020, the NRP continued to operate similar processes to those adopted at the outset, and differentiates 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 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. 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.

In recent times, 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 considerably more complex due to data protection regulations. This presents limitations to the NRP's ability to produce comprehensive reviews. Currently, issues are addressed on a case by case basis but this matter will only be fully resolved when the NRP has a legal right to access information from agencies outside Tusla. In the meantime the potential for data sharing between Tusla and the HSE is under review.

2. Deaths of children and young people notified in 2020

2.1 Number and causes of deaths

A total of 30 deaths of children and young people in care or known to the child and family services were notified in 2020. This figure represents an increase of nearly one third (9) from 2019.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2020			
Cause	**No**	**Male**	**Female**
Natural Causes	**11**	**6**	**5**
Suicide	**7**	**4**	**3**
Homicide	**2**	**1**	**1**
Road Traffic Accident	**2**	**2**	**0**
Other Accidental	**6**	**5**	**1**
Unknown	**2**	**1**	**1**
Totals	**30**	**19**	**11**

As Table 1 above shows, nine of the 30 children/young people who were notified died as a result of natural causes and seven others from suicide (an increase of three on the previous year). The next most common cause of death was a combination of road traffic and other accidents experienced by eight young people (an increase of four on 2019). Where a coroner or post-mortem has not reached a conclusion as to the cause of death, it is listed here as unknown. 2020 was the second consecutive year in which notifications increased, 2019 having had eight more than the previous year.

2.2. Care status of children or young people whose deaths were notified in 2020

Table 2

Care Status Summary 2020			
In care at time of Death	**In aftercare at time of death**	**Known to social work services**	**Total**
1	**6**	**23**	**30**

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 2019. The remaining children or young people were living in their communities and there was an increase of six in the number of deaths of young people using aftercare services, highlighting the vulnerability of this group.

2.3 Summary of serious incidents reported in respect of children in care 2020

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 2020 Serious Incidents	
In care	**4**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**9**
Total	**13**

2.4 Ages and gender of children and young people whose deaths were notified in 2020

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

Table 4

Age Profiles 2020			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**9**	**4**	**5**
1 - 5 years old	**0**	**0**	**0**
6 - 10 years old	**3**	**3**	**0**
11 - 16 years old	**9**	**5**	**4**
17 - 20 years old	**8**	**6**	**2**
> 20 Years Old	**1**	**1**	**0**
Total	**30**	**19**	**11**

The majority of deaths occurred in two age cohorts, infants under 12 months and 11-16 year olds, with the next highest groups being the 17 to 20 year olds.

2.5 Summary of deaths by region

Table 5

Summary by Region 2020				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
10	**10**	**3**	**7**	**30**

Of the 30 deaths notified in 2020, a decision was made to review 17 cases.

3. Overview of reports published in 2020

The NRP from time to time will advise Tusla regarding publication of reviews, particularly where it could be prejudicial to a trial or where the details are likely to identify a family. However, decisions 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.

Tusla published two NRP executive summary reports in 2020 (see www.nationalreviewpanel.ie). One of these was a major serious incident review concerning a number of children from one family who suffered serious abuse while in contact with services over a number of years. The other review concerned the death of an eight week old infant.

3.1 The children/young people who were the subjects of reports published in 2020

The serious incident review published in 2020 involved a number of children in one family, some of whom were born during the period of involvement by the social work services. The review concluded that the ability of the social work service to intervene was complicated by a number of factors including concealment by the family, but that the absence of formal processing at the outset had shaped the way that the case was subsequently managed. It also found that the impact of alcohol abuse and domestic violence was not given the consideration that was due. Additionally, it found that a child sexual abuse allegation was not adequately processed and that critical assessments were not undertaken. Significantly, the review found that the reports by family members were not adequately followed up.

The second review published, which concerned an infant who died from natural causes, found that the family received a consistent social work service and that no health or developmental concerns were evident to any professional in the days prior to the baby's sudden death. It noted that there were slight gaps in the information used to make an assessment of the family's safety but that overall communication between services was good.

3.2 Key Learning identified in reviews

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 11 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 2020 include the following:

3.2.1 Responding to reports from families

- Research has noted an association between the source of a report and the likelihood of a response, showing that reports from professionals, mandated or otherwise, are more likely to be substantiated or considered critical than reports from families or members of the public[1]. Reports from families can sometimes be complicated by their relationship with the alleged perpetrator which may cause them some worry and conflict, as well as concern that by making a report they may jeopardise their contact with the children. As a learning point, it is suggested that professionals should routinely challenge their own perceptions about the reports made by extended family members and that work to address family conflict should, if possible, be part of an intervention. In view of more recent policy and practice changes regarding the manner in which referrals are currently made, including via portals and other electronic means, it is worth noting another point made in the above quoted Irish research that newer streamlined arrangements for reporting tend to privilege professionals and are less user friendly for lay referrers

3.2.2 Disclosure of child sexual abuse to professionals

- It is known from research[2] that children are less likely to disclose abuse to a professional than to family or friends, and that the manner in which professionals communicate with young people is key to the experience of disclosure being viewed as positive or negative. It is suggested that service development should focus on innovative ways of ensuring that services address children's concerns, and that services should be well publicised in places where children and young people spend time.

3.2.3 Families who are 'uncooperative' or 'hard to engage'

The two review reports published demonstrated examples of parental non engagement and disguised compliance which gave a false picture of what was really occurring in the family. An NSPCC Factsheet (2010) explains disguised compliance as involving a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. HSE Child Protection Handbook notes that a family's lack of engagement can obstruct intervention and assessment and offers practical guidance on working with families who are uncooperative.

[1] Whelan, S. (2017) At the front door: child protection reporting in a changing policy and legislative context. Phd Thesis, Trinity College Dublin

[2] Allnock, D. And Miller, P. (2013) No one noticed, no one heard: a study of disclosures of childhood abuse. London: NSPCC. Allnock, D. And Miller, P. (2013)

3.2.4 Alcohol and Domestic Violence

- Research[3] notes that when disharmony and violence co-exist with alcohol abuse, children are more likely to suffer long term adverse effects. It is further noted that parental drug misuse produces mood swings and inconsistent behaviour that can be frightening for children.

3.3. Recommendations from reviews published in 2020

In light of the recent reforms undertaken by the Child and Family Agency, the reports published in 2020 focused particularly on learning points rather than policy reform. The following recommendation concerning the transfer of cases between administrative areas reflects an issue highlighted in the serious incident report:

> The National Case Transfer Policy (2016) should be refined so that it can offer a clear direction in complex cases such as this, where a family of children with child protection needs is split geographically between two different administrative areas. Absolute clarity will be required in relation to governance issues, accountability and reporting. It will be necessary for one area to take the lead for planning but with other key stakeholders (second SWD and partner agencies) fully engaged. 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] Cleaver, H., Unell, I. and Aldgate J. (2011) Children's Needs Parenting Capacity.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2020

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 2020

Table 6

Cause of Death Summary 2010 to 2020								
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**
2020	11	7	2	2	4	2	2	**30**
Total All Years	**92**	**56**	**21**	**23**	**16**	**12**	**16**	**236**
% of Total	**38.98%**	**23.73%**	**8.9%**	**9.75%**	**6.78%**	**5.08%**	**6.78%**	**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 2020 is 236. The average rate of notified deaths is 21 per year over an eleven year period while the number fluctuates somewhat from year to year. This is in a context where the number of referrals to the child protection system has more than doubled from 29,277 in 2010 to 66,649 in 2020. As each of the foregoing annual reports has highlighted, the children and young people whose deaths were notified during that eleven 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 of the infants had traces of non-prescribed medication in their systems at birth.

4.2 Deaths from suicide

A total of fifty six young people whose deaths were notified to the NRP over the past eleven years died from suicide. This represents nearly a quarter of all notified deaths. Fifteen 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	No.
unknown	1
12	1
13	2
14	3
15	17
16	8
17	11
18	6
19	3
20	1
21	2
22	1
Total	56

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.

4.3 Deaths from other causes

The next highest combined total concerns 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 almost 20% of deaths. Drug overdose accounts for 7% and the numbers have been fluctuating. Homicide accounts for nearly 6% 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.

4.4 Care Status of children whose deaths were notified between 2010 and 2020

Table 8

Care Status Summary 2010 to 2020				
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**
Total All Years	**26**	**23**	**187**	**236**
% of Total	**11.02%**	**9.32%**	**79.66%**	**100.00%**

As Table 8 above illustrates, 11% of the children or young people whose deaths were notified to the NRP between 2010 and 2020 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 80% 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 2010-2020																	
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
2020	1	6	4	3	0	0	0	1	6	1	0	3	2	0	0	1	7
Totals	26	23	26	23	2	4	5	12	26	17	1	15	8	4	2	1	49

The causes of death of children in care and their ages is given above in Table 9, and illustrates that the majority children who were in care died from natural causes or suicide. Most of the children and young people in care who died from natural causes had disabilities or chronic illnesses before their entry into care. Their entry into care 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 much higher number in the aftercare group.

5. Activities of the NRP during 2020

5.1 Routine NRP work

NRP work was significantly disrupted by Covid 19 during 2020, as the office became inaccessible when the first restrictions were implemented. As panel members are not employed by Tusla, they did not have access to the internal network and it was several months before arrangements could be put in place to allow secure remote working whereby confidential case records could be transferred to panel members. As a result, the backlog of work increased considerably. Interviews that had been planned were postponed until the panel members were equipped to use teleconferencing. As interviews with family members can be particularly sensitive, a lot of practical arrangements, preparation and support for interviewees needed to be provided by staff when these were conducted online. During 2020, panel members completed and submitted reports on 16 children and young people, comprising 2 desktop reviews, 3 concise reviews, 3 major reviews and one comprehensive review. One of these reports was published in 2020 alongside a previously submitted review.

Nine interviews were conducted by review teams with staff members from the Child and Family Agency and other organisations during 2020. In addition, three meeting were held with a family member to discuss a draft report.

Training for panel members was postponed to 2021 because of the ongoing disruption caused by Covid 19.

5.2 Meetings between the NRP, the Child and Family Agency and the Department of Children

The NRP met regularly with the Quality Assurance Directorate in Tusla during 2020, to update and discuss routine matters as well as disruptions caused by Covid 19. The Chair had a meeting with Mr Pat Rabbitte, Chair of Tusla in Q1.

In Q2 of 2020, the Chair of the NRP initiated contact with Chair of Tusla to discuss the operational framework of the NRP and to highlight difficulties in recruiting adequately experienced panel members, as well as the ongoing and increasingly problematic challenges relating to governance, interagency working and independence whilst the NRP is under the ambit of Tusla. These matters were also brought to the attention of the DCYA for further discussion. The Department approved the extension of public service pay restoration to panel members and undertook to revive a process first started in 2017 to restructure the panel. In addition, the NRP Chair requested that the 2014 Guidance

for the Operation of the National Review Panel be updated in the meantime. Work on this commenced in late 2020.

6. National Review Panel members who participated in reviews during 2020

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 Imelda Ryan

Dr Rosaleen McElvaney