Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2021

Foreword

I am pleased to present the 12th annual report of the National Review Panel. The NRP was established twelve 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 132 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 23 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 2021. The third section provides an overview of the reports published in 2021 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 2021.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2021 and gave us valuable insight into their situations as service users. We acknowledge that the experience was sad and painful for them and made more difficult by the fact that we were prevented from having face to face meetings. 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. 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 Seamus Houlihan 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 continued to have a significant effect on the operation of the panel during 2021. The cyber-attack in May 2021 had an even more significant impact, completely

suspending the work of the panel for most of Q.2 and part of Q.3. The combined effect of these circumstances is reflected in the level of work achieved by the NRP in 2021.

Dr Helen Buckley,

Chairperson, National Review Panel

June 2022

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 2021 the 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 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 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 2021 is appended to the end of this report.

While administered by the Child and Family Agency, the NRP is functionally independent. It conducts its investigations objectively and submits finalised reports to the Chair of the Board of the Child and Family Agency, and to the Health, Information and Quality Authority (HIQA).

1.1 Guidance on the operation of the NRP

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

The new guidance reflects recent changes in the structure of services as well as learning from the first ten years of the work of 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 identify obstacles to good practice and identify areas for learning. Each report contains a section specifically for this purpose.

During 2021, 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 and was made more difficult by Covid restrictions during 2021.

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 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. Under the 2021 guidance, the NRP provides a pre-submission draft consisting of conclusions, learning points and recommendations to the Director of Quality Assurance and receives feedback relevant to factual accuracy.

2. Deaths of children and young people notified in 2021

2.1 Number and causes of deaths

A total of 27 deaths of children and young people in care or known to the child and family services were notified in 2021. This figure represents a decrease of three compared with 2020 which had seen an increase of nearly one third from 2019.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2021			
Cause	**No**	**Male**	**Female**
Natural Causes	**14**	**9**	**5**
Suicide	**6**	**4**	**2**
Homicide	**1**	**0**	**1**
Road Traffic Accident	**0**	**0**	**0**
Other Accidental	**1**	**0**	**1**
Overdose	**1**	**1**	**0**
Unknown	**4**	**4**	**0**
Totals	**27**	**18**	**9**

As Table 1 above shows, 14 of the 27 children/young people who were notified died as a result of natural causes, including Sudden Infant Death Syndrome and six others from suicide (a decrease of one on the previous year). Two out of the six young people who took their own lives were female. 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 2021

Table 2

Care Status Summary 2021			
In care at time of Death	**In aftercare at time of death**	**Known to social work services**	**Total**
4	**3**	**20**	**27**

As Table 2 above shows, four young people under 18 years whose deaths were notified were in care at the time of their death, an increase of one on 2020. The remaining children or young people were living in their communities and there was a decrease of three in the number of deaths of young people using aftercare services.

2.3 Summary of serious incidents reported in respect of children in care 2021.

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 2021 Serious Incidents	
In care	**2**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**1**
Total	**3**

2.4 Ages and gender of children and young people whose deaths were notified in 2021

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

Table 4

Age Profiles 2021			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	**14**	**9**	**5**
1 - 5 years old	**4**	**3**	**1**
6 - 10 years old	**0**	**0**	**0**
11 - 16 years old	**4**	**2**	**2**
17 - 20 years old	**5**	**4**	**1**
> 20 Years Old	**0**	**0**	**0**
Total	**27**	**18**	**9**

The majority of deaths occurred in two age cohorts, infants under 12 months and 17–20 year olds, with the next highest groups being the 11-16 year olds. Significantly more of the children and young people who died were male.

2.5 Summary of deaths by region

Table 5

Summary by Region 2021				
Dublin Mid Leinster	**Dublin North East**	**South**	**West**	**Total**
6	**3**	**8**	**10**	**27**

Of the 27 deaths notified in 2021, a decision was made to review seven. It was decided not to review 15 of the cases notified, and decisions on a further five are still pending at the time of writing.

3. Overview of reports published in 2021

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,

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 four NRP executive summary reports in 2021 (see www.nationalreviewpanel.ie).

3.1 The children/young people who were the subjects of reports published in 2021

The reports published in 2021 concerned four young people, two male and two female, who died in their teenage years. Two of the young people died from suicide, the third died following an assault and the fourth person was found dead as a result of a drug overdose. Two of the young people were in the care of Tusla at the time of their deaths and both had experienced multiple changes of placement.

3.2 Findings from the published reviews

The four published reports reached a number of conclusions, most of which have general relevance for policy makers, managers and frontline staff of Tusla. Where it becomes evident to reviewers that high rates of referral and shortages or frequent turnover of staff have impacted on services, this is acknowledged in reports. Pressure on services is a recurring theme and its effects are inevitable particularly in respect of delays in response and assessment.

The main findings from reports are summarised as follows:

- Frontline response: The reviews found that delayed or inadequate assessment had consequences. They also found that the current policy on investigation of child sexual abuse meant that confusion about certain actions could arise where cases spanned more than one area.
- Interagency working: Deficits in Interagency working have been highlighted many times in NRP reports and featured strongly in one published report where a high level of gatekeeping and denial of access to certain health services was visible, resulting in a diminished service. The young person involved had multiple difficulties requiring a multi-agency response which was not forthcoming. Less than adequate communication between Tusla and An Garda Síochána was identified in two reviews. The high threshold for intervention operated by Tusla, was also evident.

- Placements: There were specific findings in the published reviews related to availability of suitable placements and care planning generally. The lack of placements for children whose behaviour put them at risk, and the lack of effective long-term planning which resulted in crises were highlighted.
- Mental health services for young people: The mental health services featured in two of the published reviews. In one instance, the review identified consistent and well-coordinated service delivery on the part of CAMHS and also reflected the views of the psychiatrists involved that there is a dearth in Ireland of specialist residential mental health services for children and young people with attachment disorders and suicidal ideation. In a different case where the young person took her own life, the reviewers noted the response of CAMHS that suicidal ideation does not constitute a mental illness. These findings reflect previous observations by the NRP of inconsistencies in CAMHS service provision.
- Classification of cases as child protection or child welfare: The published reviews once again made findings that the NRP had identified previously, that the designation of referrals as either child protection or child welfare according to parental intent often belies the nature of risk to which a child may be subject. This designation was found to have an impact on the priority given to cases and the nature of service provided. The reports also noted the need to measure the effectiveness of family support when a referral is designated as welfare and diverted down that pathway.

3.3 Key Learning identified in reviews

The learning points highlighted in the published reports generally pertain to frontline practice and local policies. In line with the aim 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. 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 2021 include the following:

- Responding to reports. The reports identified areas for learning where assessment was incomplete, child centeredness was absent and the need for young people to have a direct relationship with a social worker was evident. It was noted that practitioners need to develop

and apply understanding about the nature of learning disability and means of communicating with young people who have comprehension difficulties. The need for greater knowledge and understanding about the causes and consequences of self-harm was also highlighted. The need to consider the child's own situation and their risk profile regardless of parental intent or motivation was identified, as was the need to pay attention and analyse the reason behind cumulative and repeated reports.

- Communication with families. The published reviews also highlighted the importance of communication with families to check their understanding of how the system operated and the implications for their child. In two cases, it appeared that insufficient attempts had been made to engage with the children's separated fathers and the importance of working with the whole family was reiterated.
- Care Planning. The need for future oriented and integrated rather than crisis driven care planning was highlighted, with emphasis on the need for advocacy for children in care, attention to the role of children in Child in Care Reviews and consistent application of models of care.
- Interagency work. Recognising the complexity of interagency work, the learning points included advice about utilising both formal and informal measures to enhance cooperative working within an area.

3.4 Recommendations from reviews published in 2021

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. The reports published in 2021 identified a total of thirteen recommendations, some divided into sub-sections, that required to be addressed by Tusla at a national level. They can be summarised as follows:

- Children in care. Many of the recommendations concerning children in the care system have been made in previous years. Not for the first time, a recommendation was made for the **needs profiling of children in care** and the creation of a national database to facilitate strategic planning and provide a consistent baseline for measurement of outcomes. Related to this, another issue which has been reiterated was the need for **coordination of health, mental**

health and disability and services in complex cases particularly where young people in care have multiple difficulties. The provision and management of **special care and therapeutic step-down placements** was identified as requiring reform, and it was recommended that the process of **care planning** should include policy and guidance in relation to accessing assessments from education, health and mental health services. It was also recommended where cases are particularly complex and require more than normal resourcing, that Child in Care Reviews should be chaired at a senior managerial level and that models of care for children with complex needs should be consistently provided throughout the residential sector.

- Service gaps. A review of the **threshold for service allocation** was recommended, with specific suggestions as to how it may be conducted. Two cases featured recommendations in respect of mental health services, specifically the **provision of residential services for adolescents with attachment disorders and suicidal ideation** and **clarity about community-based services for young people with suicidal ideation** who are considered ineligible for a CAMHS service.
- Interagency working. Recommendations made in respect of interagency working related to **complex cases** where young people require a range of services from concerning education, justice, health and mental health. This has been a recurrent theme in NRP reports. More structured planning and coordination were identified as needing attention.
- Children at risk of significant harm. A further recurring theme which has been the subject of recommendations was the anomaly whereby cases where children who are at risk from their own behaviour are not classified as child protection and are often diverted to family support with no follow up to check whether they have availed of the service. Recommendations were made in two reviews specifying the **further guidance which was required about how Children First principles for protective action** should be implemented where a child is at risk and parental abuse or wilful neglect are not factors. A recommendation was also made for a **reporting mechanism** whereby the outcome of family support referrals is communicated to SWDs within a defined period.
- Response to child sexual abuse. A recommendation was made in respect of the Child Abuse Substantiation Protocol to clarify the responsibilities where cases span two or more administrative areas.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2021

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 2021

Cause of Death Summary 2010 to 2021								
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**
2021	14	6	0	1	1	1	4	**27**
Total All Years	**106**	**62**	**21**	**24**	**17**	**13**	**20**	**263**
% of Total	**40.30%**	**23.57%**	**7.98%**	**9.13%**	**6.46%**	**4.94%**	**7.60%**	**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 2021 is 263. The average rate of notified deaths is now 20 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 more than doubled from 29,277 in 2010 to 63,050 in 2021. As each of the foregoing annual reports has highlighted, the children and young people whose deaths were notified during that 12-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 (40%). 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.

4.2 Deaths from suicide

A total of 62 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. Eighteen 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	**4**
15	**18**
16	**9**
17	**12**
18	**7**
19	**3**
20	2
21	2
22	**1**
Total	**62**

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 are referred to CAMHS but subsequently discharged from that service because they are not deemed to be mentally ill. It thus appears that referral of young people with suicidal ideation to CAMHS is often ineffective and that specific services for young people who self-harm need to be further developed either with the HSE or within Tusla.

4.3 Deaths from other causes

The next highest (combined) cause of death concerns traffic and other accidents (21%). These included incidents such as drowning, falls, house fires, domestic accidents and road traffic accidents. Drug overdose accounts for 7% and the numbers have been fluctuating. Thirteen homicides have been notified to the NRP since 2010, accounting for almost 5% of deaths. Where murder or other criminal proceedings are ongoing, the NRP has to take particular precautions to avoid interfering with legal processes and this often results in a delayed review. 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 2021

Table 8

Care Status Summary 2010 to 2021				
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**
Total All Years	**30**	**26**	**207**	**263**
% of Total	**11.41%**	**9.89%**	**78.71%**	**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.

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

Table 9

Summary of age 2010-2021																	
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*	*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	1	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	0	0	0	2	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	2	0	1	0	0	1	1	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
2021	4	3	5	2	1	0	0	2	4	3	0	3	0	0	1	0	7
Totals	30	26	31	25	2	4	5	14	30	20	1	18	8	4	3	2	56

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 natural causes or suicide. 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 2021

5.1 Disruption to routine NRP work

The Covid-19 restrictions continued to impact on the ability of panel members to do their work, in particular because of inability to conduct in-person interviews. Although panel members had adjusted to remote working and online meetings, the cyber-attack of May 2021 had a significant impact and effectively suspended the work of the NRP for three months thus significantly reducing the output of reports. The restoration of secure working arrangements was staggered. Four new panel members were recruited in between February and April 2021 but because of continued disruption of the IT system in Tusla, together with pressure on the IT staff available to support the panel, there was a delay in equipping three of the new members with computers. Overall, IT limitations during 2021 had a considerable impact on the work of the panel. At the time of writing, these matters were all resolved.

During 2021, panel members completed and submitted reports on nine children and young people, comprising four desktop reviews, two concise reviews, and one comprehensive review. One of these reports was published in 2021 alongside three previously submitted reviews.

Twenty-six interviews were conducted by review teams with staff members from the Child and Family Agency and other organisations during 2021. In addition, one meeting was held with a family member.

The NRP held a full day online training session in May 2021 which had the dual aim of inducting new panel members and updating existing panel members on procedures for working and recent changes in policy and guidance. Two panel members presented a review recently on a complex case for the purposes of discussion and learning. In addition, a number of online meetings were held to discuss routine matters between panel members and compensate for the inability to hold in-person office meetings.

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

Early in 2021, the Chair and Deputy Chair participated in a series of six meetings with the DCEDIY for the purposes of revising the Guidance for the Operation of the National Review Panel. The document was finalised in May and published in October 2021.

The DCEDIY had committed since 2017 to review the structure and legal status of the National Review Panel in order to address the outstanding issues of independence, governance and interagency

working. In late 2020 the Department produced several options for consideration. The NRP made a response identifying the most appropriate option and a further response from the Department is pending.

Data protection legislation has impacted in recent years on the ability of the NRP to obtain records from organisations that are not under the ambit of Tusla. Towards the end of 2021 the NRP engaged with the Data Protection Officer in Tusla to establish a formal basis for sharing of information which is currently in use on a trial basis.

The NRP Chair and Deputy Chair met with the Quality Assurance Directorate in Tusla on three occasions during 2021, one quarterly meeting having been postponed due to the cyber-attack. The Chair of the NRP attended the Risk and Quality subcommittee of the Board of Tusla in September 2021 and drew attention to the delays in setting up new panel members on the IT system.

6. National Review Panel members who participated in reviews during 2021

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 Eimear Gilchrist