Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2022

Foreword

I am pleased to present the 13th annual report of the National Review Panel. The NRP was established in 2010 following a recommendation of the Ryan Implementation Report by the Office of the Minister for Children in 2009 and since that time has submitted reports on the deaths of 142 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 24 children, four of whom were in foster care when they were victims of abuse. Tusla has published summaries of NRP reports and these are available on the NRP website www.nationalreviewpanel.ie.

This report is presented in four parts. The first section provides an introduction and describes the role and function of the NRP as well as current issues affecting its performance. The second part provides statistical information and a brief analysis of the notifications made to the panel in 2022. The third part then presents a statistical overview and analysis of the notifications to the NRP over the past eleven years. Finally, the fourth section presents an overview of the main activities of the National Review Panel during 2022. The Annual Report normally contains a section on the main points, recommendations and learning points from published reports, but as no reports were published by Tusla in 2022 that section has been omitted for this year.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2022 and gave us valuable insight into their situations as service users. We acknowledge that the experience was sad and painful for them. We also express appreciation for the willingness of professionals to speak with us and acknowledge that it was a stressful experience for many of them. Particular appreciation is expressed to the Tusla staff members who made practical arrangements and provided support to families participating in online interviews. The combined perceptions of staff and family members have helped to inform the conclusions reached in the reports and have contributed to the learning points identified within them. As chair of the panel, I would like to commend Naomi Boland, for her excellent support of the panel's work and for providing the statistical tabulations included in this report. Inspector Seamus Houlihan provided valuable liaison on behalf of An Garda Síochána. I would also like to acknowledge the support and cooperation of the Quality and Regulation Directorate of Tusla and the valuable input of our legal advisor, Stephanie McCarthy of O'Malley, Cunneen and McCarthy solicitors.

Dr Helen Buckley,
Chairperson, National Review Panel
April 2023

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 2022 the panel consisted of seventeen members who were assigned to cases according to their particular expertise and experience. Generally, review teams consist of two or three members, and all have oversight by the chair. None of the members have ever been involved professionally in any of the cases under review. The chair of the panel is Dr Helen Buckley, child protection consultant and Fellow Emeritus of the School of Social Work and Social Policy, Trinity College Dublin. The deputy chair is Dr Ann McWilliams, child care consultant and former lecturer in child protection and welfare at the Technological University of Dublin. Other panel members have backgrounds in social policy, social work, police work, psychotherapy, psychology, regulation, human rights and the law. The Chair and Deputy Chair are responsible for identifying cases for review, deciding on the level of review, assigning reviews to individual teams, and advising on terms of reference. The Chair quality assures and signs off on each report prior to submission.

The panel is supported by a fulltime service manager who has responsibility for the comprehensive administration of the work of the NRP including the management of notifications and case records, collection of activity data, liaison with the Quality and Risk Directorate of Tusla on the progress of reviews and other related matters, organisation of interviews, resources, HR and financial matters and the submission of reports. The panel also uses the services of an independent legal team. A list of panel members who completed work in 2022 is appended to the end of this report.

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

1.1 Guidance on the operation of the NRP

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

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

1.2 Functions of the National Review Panel

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

During 2022, the NRP continued to differentiate between desktop, concise, comprehensive and major reviews. Where possible preference is given to holding concise and comprehensive reviews as fuller participation of stakeholders provides greater transparency. This creates a challenge to the ability of the panel to complete its work within appropriate timelines due to occasional delays in accessing the relevant staff and family members.

1.3 Procedures for review

The NRP has continued to revise the tools that were developed at the outset for conducting reviews and finalising reports. The reviews are conducted by studying case records and, in the case of major, comprehensive and concise reviews, on interviews with family members and staff that have been involved with the case. When interviews are held in person, they are recorded and later transcribed by a transcription service. When the interview is held by teleconference, a transcriber is connected to the call. Each report provides a chronological account of service provision in respect of the child who died, followed by an analysis of frontline and management practice in the case. It forms conclusions and identifies key learning points from each review. Where a policy deficit with national relevance is noted, relevant recommendations are made. A toolkit for the conduct of reviews is regularly reviewed by the Chair and Deputy Chair in consultation with panel members and amended as necessary. The analysis of review findings is developed in line with benchmarks for good practice and management which were also developed by the NRP. Fair procedures are followed at all times. Extracts from reports are provided for factual accuracy checking to persons who have given evidence in the course of reviews and their comments are considered when finalising the reports. Under the 2021 guidance, the

NRP provides a pre-submission draft consisting of conclusions, learning points and recommendations to the Director of Quality and Regulation in Tusla and receives feedback relevant to factual accuracy.

2. Deaths of children and young people notified in 2022

2.1 Number and causes of deaths

A total of 23 deaths of children and young people in care or known to the child and family services were notified in 2022. This figure represents a decrease of four compared with 2021.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2022			
Cause	**No**	**Male**	**Female**
Natural Causes	**15**	**11**	**4**
Suicide	**4**	**3**	**1**
Homicide	**0**	**0**	**0**
Road Traffic Accident	**0**	**0**	**0**
Other Accidental	**1**	**1**	**0**
Overdose	**0**	**0**	**0**
Unknown	**3**	**3**	**0**
Totals	**23**	**18**	**5**

As Table 1 above shows, 15 of the 23 children/young people who were notified died as a result of natural causes, including Sudden Infant Death Syndrome and four others from suicide (a decrease of two on the previous year). 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 2022

Table 2

Care Status Summary 2022			
In care at time of Death	In aftercare at time of death	Known to social work services	Total
5	**2**	**16**	**23**

As Table 2 above shows, five children /young people under 18 years whose deaths were notified were in care at the time of their death, the same number as 2021. Four died from natural causes, and one from suicide. The remaining children or young people were living in their communities and there was a decrease of one in the number of deaths of young people using aftercare services.

2.3 Summary of serious incidents reported in respect of children in care 2022.

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

Table 3

Serious Incidents Care Summary 2022	
In care	**14**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**3**

2.4 Ages and gender of children and young people whose deaths were notified in 2022

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

Table 4

Age Profiles 2022			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	10	8	2
1 - 5 years old	1	1	0
6 - 10 years old	2	2	0
11 - 16 years old	7	5	2
17 - 20 years old	1	1	0
> 20 Years Old	2	1	1
Total	**23**	**18**	**5**

Similar to 2021, the majority of deaths occurred in two age cohorts, infants under 12 months and teenage years. Significantly more of the children and young people who died were male.

2.5 Summary of deaths by region

Table 5

Summary by Region 2022						
Dublin Mid Leinster	Dublin North East	South East	South West	Mid West	West North West	Total
6	12	2	1	0	2	23

Of the 23 deaths notified in 2022, a decision was made to review ten. It was decided not to review 10 of the cases notified, and decisions on a further three are still pending at the time of writing.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2022

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 2022

Cause of Death Summary 2010 to 2022								
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**
2022	15	4	0	1	0	0	3	**23**
Total All Years	**121**	**66**	**21**	**25**	**17**	**13**	**23**	**286**
% of Total	**42.31%**	**23.08%**	**7.34%**	**8.74%**	**5.94%**	**4.55%**	**8.04%**	**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 2022 is 286. The average rate of notified deaths is now 24 per year while the number fluctuates somewhat from year to year. This is in a context where the number of referrals to the statutory social work services has risen from 29,277 in 2010 to 82,855 in 2022. 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 (42%). This figure covers a wide range of conditions, including congenital and chronic diseases, childhood illnesses such as cancer and viral infections and Sudden Unexplained Death in Infancy.

4.2 Deaths from suicide

A total of 66 young people whose deaths were notified to the NRP over the past twelve years died from suicide. This represents nearly a quarter of all notified deaths. Twenty-one 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	2
13	2
14	4
15	18
16	9
17	13
18	7
19	3
20	4
21	2
22	1
Total	**66**

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 is thus evident 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. This has been a recurring pattern since the panel was established and while it is acknowledged that local mental health initiatives have been established, notable gaps remain and the services from CAMHS vary considerably between different areas.

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 and road traffic accidents. Drug overdose accounts for 7% and the numbers vary from year to year. 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 must take particular precautions to avoid interfering with legal processes which impacts on the timing of such reviews. Where a coroner or post-mortem has failed to identify a cause of death, this is classified as unknown, which accounts for an average of 8% of deaths. On occasion reviews are delayed whilst awaiting a post-mortem or coroner's report.

4.4 Care Status of children whose deaths were notified between 2010 and 2022

Table 8

Care Status Summary 2010 to 2022				
Care Status	**In care of the HSE / Child & Family Agency**	**In aftercare at time of death / in care immediately prior to 18th birthday or in receipt of aftercare service and under 21 years**	**Living at home and known to child protection services**	**Total**
2010	2	4	16	**22**
2011	2	2	11	**15**
2012	3	2	18	**23**
2013	3	1	13	**17**
2014	3	4	19	**26**
2015	3	2	16	**21**
2016	1	1	23	**25**
2017	5	0	17	**22**

2018	1	1	11	**13**
2019	2	0	20	**22**
2020	1	6	23	**30**
2021	4	3	20	**27**
2022	5	2	16	**23**
Total All Years	**35**	**28**	**223**	**286**
% of Total	**12.24%**	**9.79%**	**77.97%**	**100.00%**

As Table 8 above illustrates, 12% of the children or young people whose deaths were notified to the NRP between 2010 and 2022 were in care; a further 10% 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 2010-2022

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
2022	5	2	6	1	1	0	0	3	3	4	0	3	0	0	0	0	7
Totals	**35**	**28**	**37**	**26**	**3**	**4**	**5**	**17**	**33**	**24**	**1**	**21**	**8**	**4**	**3**	**2**	**63**

The causes of death of children in care and their ages is given above in Table 9 and illustrates that the majority of the deaths of children who were in care were from either natural causes or suicide. This

has been a consistent pattern. Most of these children had disabilities or chronic illnesses before their entry into care which was primarily for child protection reasons.

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

5. Activities of the NRP during 2022

4.1 Secure working

As a result of the 2021 cyber-attack, the NRP panel members were issued with Tusla laptops and in June 2022 the NRP was migrated to the Tusla system. This has enabled panel members to work securely and also remotely when desired. The NRP also obtained a unique email address.

4.2 Training

The NRP held three training sessions presented by the Chair and Deputy Chair during 2022, both induction and refresher, which were attended by most panel members. In addition, four training sessions on the ICT system were provided by Tusla ICT department and an information session on the Standard Business Processes to the NRP was presented in May 2022 by the Chief Social Worker and the Assistant National Director for Practice Reform and Change.

4.3 Other activities

- A number of panel members participated in the CAMHS review conducted by the Mental Health Commission.
- In an effort to secure greater cooperation between the NRP and the HSE in relation to sharing records and interviewing staff for the purpose of reviews, a meeting was held between the Quality and Regulation directorates from the HSE and Tusla as well as representatives from the NRP and the NIRP (the equivalent panel in the HSE). This process is ongoing and further meetings are planned.
- The Chair and Deputy chair had several meetings with the Tusla Data Protection Officer to clarify the status of the NRP in relation to the use of Tusla records. Legal advices were obtained, and the matter is ongoing.
- The Chair represented the NRP at a forum held by the Ombudsman for Children in December 2022 to discuss young people whose behaviour puts them at high risk.

During 2022, panel members completed and submitted reports on eleven children and young people, comprising five desktop reviews, one concise review, three comprehensive reviews and two major reviews.

Fifty-five interviews were conducted by review teams with staff members from the Child and Family Agency and other organisations during 2022. In addition, seven meetings were held with family members.

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

The DCEDIY had committed since 2017 to review the structure and legal status of the National Review Panel and in 2020 the Department produced several options for consideration and the NRP responded by identifying the most appropriate option. The NRP had no meetings with the Department during 2022 and further action on its part is still awaited to address the outstanding issues of independence, governance and interagency working.

The NRP Chair and Deputy Chair met with the Quality and Regulation Directorate in Tusla on four occasions during 2022. The Chair of the NRP attended the Risk and Quality subcommittee of the Board of Tusla in June 2022.

6. National Review Panel members who participated in reviews during 2022

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

Ms Christine McConville

Dr Paul Sargent

Mr Michael Lynch

Ms Rohana Reading

Ms Gloria Kirwan

Mr Ruadhan Hogan

Ms Liz Chaloner

Ms Lorraine Bates