Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Annual Report

2025

Foreword

I am pleased to present the 16th 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 163 children or young people who were in care or known to child protection services. One further report was completed but withheld from submission on the advice of the Gardaí due to an ongoing criminal investigation. In addition, the NRP has submitted reports on serious incidents affecting the lives of 33 children. Tusla decides on the publication or otherwise of reports. It has published summaries of 90 NRP reports to date and these are available on the NRP website www.nationalreviewpanel.ie. The NRP has operated on a non-statutory basis since its inception and relies on the cooperation of all stakeholders to facilitate its work.

This report is presented in five 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 2025. The third section address publication issues. The fourth part then presents a statistical overview and analysis of the notifications to the NRP over the past fourteen years. Finally, the fifth section presents an overview of the main activities of the National Review Panel during 2025.

The National Review Panel would like to express its appreciation to the family members who participated in interviews during 2025 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 this can be a stressful experience. 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. We appreciate the assistance provided by An Garda Síochána. Ambit Compliance has provided valuable data protection advice. I would also like to acknowledge the input 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 2026

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 2025 the panel consisted of 13 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, 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. During 2025 additional administrative support was provided to assist the service manager. The panel also uses the services of an independent legal team and avails of the services of data protection specialists. A list of panel members who completed work in 2025 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. Revision of the guidance is currently paused due to the recent decision about placing the NRP on a statutory footing.

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 and 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 2025, 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 and inevitable 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 points for learning 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 professionals who have participated in the reviews and their comments are considered when finalising the reports. Under the 2021 interim 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 2025

2.1 Number and causes of deaths.

A total of 23 deaths of children and young people in aftercare or known to the child and family services were notified in 2025. This figure represents an increase of 4 compared with 2024.

The following table illustrates the causes of death.

Table 1

Cause of Death Summary 2025			
Cause	**No**	**Male**	**Female**
Natural Causes	**5**	**3**	**2**
Suicide	**4**	**2**	**2**
Homicide	**3**	**3**	**0**
Accidents	**3**	**0**	**3**
Overdose	**0**	**0**	**0**
Unknown	**8**	**6**	**2**
Totals	**23**	**14**	**9**

As Table 1 above shows 5 of the 23 children/young people whose deaths were notified died as a result of natural causes, including Sudden Infant Death Syndrome. Four young people died from suicide and three died in accidents. Three deaths were the result of homicide. 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 2025.

Table 2

Care Status Summary 2025			
In care at time of Death	**In aftercare at time of death**	**Known to social work services**	**Total**
0	**4**	**19**	**23**

None of the children/young people whose deaths were notified in 2025 were in care. All had been living in their communities. Four of the young people were in receipt of aftercare services.

2.3 Summary of serious incidents reported in respect of children in care 2025.

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 of a child or young person.

Table 3

Serious Incidents Care Summary 2025	
In care	**2**
In aftercare/ in care immediately prior to 18th birthday	**0**
Known to social work services	**10**
Total	**12**

Examples of serious incidents that were notified include children still living who were known to Tusla and were found to have been neglected or abused, sexually exploited, injured or exposed to potentially harmful situations or involved in non-fatal accidents.

2.4 Ages and gender of children and young people whose deaths were notified in 2025.

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

Table 4

Age Profiles 2025			
Age Band	**No.**	**Male**	**Female**
Infants < 12 months	5	3	2
1 - 5 years old	4	4	0
6 - 10 years old	2	2	0
11 - 16 years old	6	2	4
17 - 20 years old	5	3	2
> 20 Years Old	1	0	1
Total	**23**	**14**	**9**

Similar to 2024, the majority of deaths have occurred in two age cohorts, infants under 12 months and young people in their teenage years.

2.5 Summary of deaths by region

Table 5

Summary by Region 2025							
Dublin Mid Leinster	**Dublin North East**	**South East**	**South West**	**Mid West**	**West North West**	**SCSIP***	**Total**
8	**9**	**1**	**0**	**0**	**4**	**1**	**23**

**Separated Children Seeking International Protection*

Of the 23 deaths notified in 2025, a decision was made to review thirteen. It was decided not to review five of the cases notified, and decisions on a further five are still pending decision while further information is awaited.

3. Overview of reports published in 2025.

When submitting reports to Tusla, the NRP offers a view on publication. Of the twenty reports submitted during 2025, the NRP recommended against publication of one. In two other instances, the Chair cautioned that the cases were potentially identifiable, and in one further case, the Attorney General advised against publication on the basis of an ongoing criminal investigation.

However, decisions on whether to publish and the timing of publication are ultimately made by Tusla When consideration is being given to publication, 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. In general, the wishes of families concerning publication are respected. There is often a time lag between submission of reports to Tusla and their publication.

Tusla published no NRP reports in 2025.

4. Statistical overview of all deaths notified to the NRP between 2010 and 2025

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 2025

Cause of Death Summary 2010 to 2025							
Cause of Death	**Natural Causes**	**Suicide**	**Accidents**	**Drug Overdose**	**Homicide**	**Unknown**	**Totals**
2010	6	4	6	4	2	0	**22**
2011	8	3	2	2	0	0	**15**
2012	7	9	6	0	1	0	**23**
2013	7	4	1	1	0	4	**17**
2014	8	8	6	1	2	1	**26**
2015	11	6	2	0	0	2	**21**
2016	10	5	7	2	1	0	**25**
2017	8	3	5	1	2	3	**22**
2018	8	3	1	0	0	1	**13**
2019	8	4	4	1	2	3	**22**
2020	11	7	4	4	2	2	**30**
2021	14	6	1	1	1	4	**27**
2022	15	4	1	0	0	3	**23**
2023	18	4	5	0	0	2	**29**
2024	8	4	2	0	0	5	**19**
2025	5	4	3	0	3	8	**23**
Total All Years	**152**	**78**	**56**	**17**	**16**	**38**	**357**
% of Total	**42.58%**	**21.85%**	**15.69%**	**4.76%**	**4.48%**	**10.64%**	**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 2025 is 357. The average annual rate of notified deaths is now 24 per year while the number fluctuates somewhat. This is in a context where the number of referrals to the statutory social work services has risen from 29,277 in 2010 to over 105,000 in 2025. As each of the foregoing annual reports has highlighted, the children and young people whose deaths were notified during that 15-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 78 young people whose deaths were notified to the NRP over the past fifteen years died from suicide. This represents nearly a quarter of all notified deaths. Twenty-eight of the young people who died from suicide were in care or aftercare. The age range was 12 years to 23, 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
10	1
11	0
12	3
13	2
14	6
15	18
16	10
17	16
18	9
19	4
20	4
21	2
22	1
23	1
Total	**78**

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 may be referred to CAMHS but subsequently discharged from that service because they are not deemed to be mentally ill. Notwithstanding the variability of CAMHS services, some of which are more responsive than others, it is clear that referral of young people with suicidal ideation to CAMHS continues to be generally ineffective.

4.3 Deaths from other causes

The next highest (combined) cause of death concerns accidents (16%). These included incidents such as drowning, falls, house fires, domestic and road traffic accidents. Drug overdose accounts for 5% and the numbers vary from year to year. Fifteen homicides were notified to the NRP between 2010 and 2025, accounting for a little over 4% of deaths. Where murder or other criminal proceedings are ongoing, the NRP must take particular precautions to avoid interfering with legal processes which impact 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 11% 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 2025.

Table 8

Care Status Summary 2010 to 2025				
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**
2023	2	1	26	**29**
2024	0	2	17	**19**
2025	0	4	19	**23**
Total All Years	**37**	**35**	**285**	**357**
% of Total	**10.36%**	**9.80%**	**79.83%**	**100.00%**

As Table 8 above illustrates, 10% of the children or young people whose deaths were notified to the NRP between 2010 and 2025 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

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	17-23 years	*Natural Causes*	*Homicides*	*Suicides*	*Drug overdoses*	*Accidents*	*Unknown*	*Totals*
2010	2	4	3	3	0	1	0	0	5	1	1	1	3	0	0	6
2011	2	2	3	1	0	0	1	1	2	2	0	0	0	2	0	4
2012	3	2	2	3	0	0	1	2	2	2	0	2	1	0	0	5
2013	3	1	2	2	1	0	0	1	2	2	0	1	1	0	0	4
2014	3	4	5	2	0	0	0	3	4	2	0	4	0	1	0	7
2015	3	2	3	2	0	0	2	2	1	3	0	1	0	1	0	5
2016	1	1	1	1	0	0	0	0	2	0	0	0	1	1	0	2
2017	5	0	2	3	0	1	2	2	0	2	0	1	0	1	1	5
2018	1	1	0	2	0	0	0	1	1	0	0	2	0	0	0	2
2019	2	0	1	1	0	1	1	0	0	2	0	0	0	0	0	2
2020	1	6	4	3	0	0	0	1	6	1	0	3	2	0	1	7
2021	4	3	5	2	1	0	0	2	4	3	0	3	0	1	0	7
2022	5	2	6	1	1	0	0	3	3	4	0	3	0	0	0	7
2023	2	1	0	3	0	0	0	2	1	0	0	2	0	1	0	3
2024	0	2	1	1	0	0	0	0	2	0	0	2	0	0	0	2
2025	0	4	2	2	0	0	0	0	4	3	0	1	0	0	0	4
Totals	37	35	40	32	3	3	7	20	39	27	1	26	8	8	2	72

The causes of death of children in care and their ages are given above in Table 9 and illustrate that the majority of the deaths of children who were in care were from natural causes. This has been a consistent pattern. Most of the children concerned had disabilities or chronic illnesses before their entry into care which was primarily for child protection reasons. The next highest cause of death was suicide and as Table 7 above shows, the age cohorts affected were in the mid to late teens.

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 2025

- During 2025, panel members submitted reports on twenty-two children and young people, comprising six desktop reviews, seven concise reviews, one comprehensive review and six major reviews. A further report was brought to finalisation stage but was withheld from submission pending the completion of a Garda investigation.

- At the end of 2025 thirty-seven reviews were ongoing.

- Sixty-four interviews took place between review teams and staff members from the Child and Family Agency and other organisations/professions during 2025. In addition, eight meetings were held with family members.

- In early 2025 the Chair, Deputy Chair and Service Manager attended a meeting with the DCDE concern the revision of the guidance for Tusla on the operation of the NRP. Following the meeting the DCDE circulated a draft of the revised document for discussion and NRP members provided a detailed joint response. This was later paused due to the decision about placing the NRP on a statutory footing.

- Quarterly meetings between the Chair, Deputy Chair and the Quality and Regulation Directorate took place as scheduled.

- Funding was provided for the appointment of a Grade IV administrative officer to support the NRP and the post was filled in May 2025

- The Chair of the NRP attended the Service and Quality subcommittee of the Board of Tusla in May 2025.

- The Chair and Deputy Chair had monthly meetings with Ambit Compliance during 2025 and attended a meeting with the Data Protection Commissioner to discuss GDPR matters. The contract between Tusla and Ambit Compliance was renewed so that Ambit continued to provide a data protection consultancy service to the NRP during 2025.

- As previous annual reports have stated, the DCDE, formerly the DCYA, undertook in 2018 to address the legal status of the NRP. In October 2025, the Taoiseach announced that the NRP would be put on a statutory footing. The Chair attended a number of meetings with the DCDE during 2025 to discuss this matter and the NRP understands that work on drafting the legislation is ongoing at the time of writing.

- Several cases that had attracted a high level of media attention were referred to the NRP during 2025 and the Chair engaged with the media on a number of occasions.
- NRP members made a joint submission to the National Policy Framework on Alternative Care based on NRP findings, and the Chair attended a focus group and workshop on the topic.
- A number of online meetings took place during the year to update panel members on likely changes to the panel structure. All NRP members attended an in-person training session in December 2025.

Appendix:

National Review Panel members who participated in reviews during 2025

Dr Helen Buckley, (Chairperson)

Dr Ann Mc Williams (Deputy Chair)

Ms Margaret Burke

Ms Ciara Mc Kenna Keane

Mr Eamon Mc Ternan

Dr Rosaleen McElvaney

Ms Christine McConville

Dr Paul Sargent

Mr Michael Lynch

Ms Rohana Reading

Mr Ruadhan Hogan

Ms Liz Chaloner