National Review Panel

Annual Report

2012

Foreword

The National Review Panel was established in late 2010, and 2012 was its second full year of operation. At this point, 60 deaths of children and young people either in care or known to child protection services have been notified to the National Review Panel by the HSE. Reviews have been published on eighteen deaths and six serious incidents and a number of others are due for completion in the very near future. In some instances the finalisation of reports has been delayed because of ongoing criminal proceedings and other investigations. Nonetheless it has, at this stage, been possible to get a picture of the emerging themes and these are presented in the body of the report.

The value of the National Review Panel lies in its propensity to analyse child protection interventions from a systemic perspective. By highlighting the most frequently recurring themes, it fulfils the functions of identifying policy gaps and promoting learning in the child protection sector. For example, the overview of cases presented in this report has illustrated the consequences of failure to intervene early in cases of child neglect, partially because the Social Work Departments were challenged in their capacity to deal with the pressure of work referred to them. It has also highlighted two areas which require urgent remediation; these are sharing of information between services and the quality of child protection assessments. These two facets of work are inextricably linked because the ability of practitioners to make informed judgements is heavily dependent on the quality of information provided to them by services that are familiar with the children and families concerned. Weak interagency communication is a factor that features constantly in child abuse inquiries and reports. The findings of the National Review Panel confirm that it is a complex and difficult topic to address and will require policy and practice reforms in order to effect an improvement. One of the most challenging issues to emerge from the reviews was the resistance of some young people to services that could have been helpful to them and the need for practitioners to develop creative ways of engaging them. The significant proportion of young people known to the services who took their own lives adds to concern about what has been acknowledged as a widespread national problem and affirms the need for all staff to be competent in identifying and responding to indications of suicidal ideation.

The National Review Panel would like to express its appreciation to the professionals who came for interview during 2012 and to the family members who came to talk to the different review teams. We recognise that the review process has been difficult and painful, particularly for bereaved relatives. The combined insights 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.

Dr. Helen Buckley

Chairperson, National Review Panel

October 2013

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Introduction

The National Review Panel (NRP) is independently commissioned by the HSE and none of its members have been involved professionally in any of the cases under review. It is chaired by Dr. Helen Buckley, Associate Professor in the School of Social Work and Social Policy, Trinity College Dublin. The panel is supported by a fulltime service manager who has responsibility for the comprehensive administration of all aspects of the work of the NRP including the collection and compilation of records, organising and planning interviews, transcript management, resource and financial matters including staff contracts, liaison with staff and families and the finalisation of reports prior to submission. The panel also retains an independent legal team. A full list of panel members for 2012 is appended to the end of this report.

The annual report is presented in two parts. Part One gives an overview of cases notified in 2012 with some statistical information on age, gender, care status and causes of deaths of the children and young people who died. Part Two draws on information from the published reports and presents an analysis of the combined notifications from 2010, 2011 and 2012.

Functions of the National Review Panel

The NRP reviews cases where children who are in the care of the state, or have been known to the child protection services, die or experience serious incidents. Its main function is to determine the quality of service provision to the child or young person prior to their death or experience of a serious incident. It focuses primarily on the effectiveness of frontline and management activity as well the compliance with guidance and procedures. It also examines inter-agency collaboration and identifies obstacles to good practice. During 2012, the NRP continued to operate similar processes to those used in 2011, and differentiates between major, comprehensive, concise and desktop reviews

Procedures for review

The NRP has continued to use 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, and offers

an analysis of frontline and management practice in the case. This is followed by three final sections on conclusions, key learning points and recommendations. Staff are furnished with extracts of the draft reports and invited to check them for factual accuracy. It is the custom for review teams to meet with family members to share the contents of reports prior to finalisation.

Section One: Activities of NRP in 2012

1. Reviews conducted in 2012

During 2012, 57 professionals and 12 family members attended for interview with different review teams. Six reports were published in May 2012, and three more were submitted before the end of the year. Work continued on nine other reports which were carried into 2013. In addition, thirteen more reviews were commenced. As in previous years, a number of reports could not be finalised until post mortems, inquests or other local investigations had been completed.

1.1 Deaths of children and young people notified in 2012

Twenty three deaths were notified to the National Review Panel in 2012. Eleven of the children or young people who died were male, and twelve female. One serious incident was notified.

Table 1: Care Status of children and young people whose deaths were notified in 2012

Category	Deaths	Serious Incidents	Total
Living with families and known to child protection service	18	0	18
In care at the time of the incident	3	0	3
In care immediately prior to 18th birthday and still under 21 years	0	0	0
In aftercare at the time of the incident	2	1	3
Total	**23**	**1**	**24**

Table 2 Ages of children whose deaths were notified in 2012

Age Band 2012	Total	Male	Female
Infants <12 Months	4	1	3
1 - 5 years old	4	1	3
6 - 10 years old	2	1	1
11 - 16 years old	5	2	3
17 - 20 years old	8	6	2
Total	23	11	12

Table 3 Causes of deaths notified in 2012

Cause of Death 2012	Total	Male	Female
Drug Overdose	0	0	0
Suicide	9	5	4
Road Traffic Accident	2	2	0
Other Accident	4	2	2
Natural Causes	7	1	6
Homicide	1	1	0
Overall Total	**23**	**11**	**12**

Table 4: Region of origin of children and young people whose deaths were notified in 2012

HSE Region	Total	Male	Female
HSE Dublin North East	5	2	3
HSE Dublin Mid Leinster	6	3	3
HSE West	6	2	4
HSE South	6	4	2
Total	23	11	12

A fuller analysis of the 2012 data is available in Section Two of this report in a composite overview of the total number of notified child deaths between 2010 and 2012

2. Learning and Training Events during 2012

Members of the panel attended a learning event in Queen's University Belfast on the 16th January 2012 on topic of involving families in the review process. Helen Buckley, Bill Lockhart, chair and deputy chair, presented a joint paper with Paul Harrison, Head of Policy and Strategy in

Children and Family Services at the 9th BASPCAN Congress held in Queen's University Belfast entitled 'An overview of child deaths in the Republic of Ireland'. Helen Buckley subsequently attended a post-conference meeting in Belfast of professionals and clinicians from the USA, Australia and UK who were involved in the conduct of child death reviews. This group meets when the opportunity arises and exchanges information and updates on presented a paper at.

3. Dissemination of key themes from reviews in 2012

Helen Buckley was invited by Gordon Jeyes, National Director of Children and Family Services to attend a meeting of area managers to present key themes arising from the reviews. This took place on 29th August 2012. It is intened to hold a number of national seminars in 2013 to continue the dissemination process.

Section 2 Overview of child deaths between 2010 and 2012

4. Introduction to overview

Sixty child deaths were notified to the National Review Panel between 2010 and 2012 inclusive. At this stage, it is possible to identify certain trends and offer a degree of analysis in respect of some of the issues arising in reports. The following tables provide information on the ages, the region of origin the causes of death over the three year period, and includes cases on which reviews have been completed, cases where reviews are in progress and cases where reviews have not, or will not, be conducted. These are followed by an explication of the causes of deaths and the care status of children whose deaths were notified over the three year period. The final part of the overview profiles the most commonly cited management and practice issues in the review reports, as well as the most frequently offered conclusions, key learning points and recommendations.

Table 5: Age and gender of children whose deaths were notified between 2010 and 2012

Age Band	No of Young persons 2010	Male	Female	No of Young Persons	Male	Female	No of Young persons 2012	Male	Female
	2010	2010	2010	2011	2011	2011	2012	2012	2012
Infants < 12 months	2	1	1	4	3	1	4	1	3
1 – 5 years old	2	1	1	2	1	1	4	1	3
6 – 10 years old	0	0	0	1	1	0	2	1	1
11 – 16 years old	6	3	3	3	1	2	5	2	3
17 – 20 years old	12	10	2	5	5	0	8	6	2
Total	**22**	**15**	**7**	**15**	**11**	**4**	**23**	**11**	**12**

As Table 5 above indicates, the age band during which the majority of deaths occurred was between 17 and 20 years old. During 2010, considerably more male than female children and young people died, but this was reversed in 2012 when slightly more female children and young people died.

Table 6 Notified Deaths by HSE region 2010-2012

Deaths by Region	2010	2011	2012	Total
Dublin North East	8	2	5	15
Dublin Mid Leinster	3	4	6	13
South	7	7	6	20
West	4	2	6	12
Total	**22**	**15**	**23**	**60**

As Table 6 above indicates, most deaths occurred in the south during the first two years but the figures even out in 2012. No particular inference is taken from this. Table 7 below shows the causes of deaths notified between 2010 and 2012 and the following paragraph provides some further analysis of these figures.

Table 7: Overview of causes of death 2010-2012

Cause of Death	2010	Male	Female	2011	Male	Female	2012	Male	Female	Total
Natural Causes	6	4	2	8	5	3	7	1	6	21
Suicide	4	2	2	3	2	1	9	5	4	16
Road Traffic Accident	4	3	1	1	1	0	2	2	0	7
Other Accident	2	2	0	1	1	0	4	2	2	7
Drug Overdose	4	3	1	2	2	0	0	0	0	6
Homicide	2	1	1	0	0	0	1	1	0	3
Total	**22**			**15**			**23**			**60**

Table 8: Causes of deaths as a percentage of the total deaths for each year.

Cause of death	2010 Deaths	Deaths by Category % of Total	2011 Deaths	Deaths by Category % of Total	2012 Deaths	Deaths by Category % of Total
Drug Overdose	4	**18.18%**	2	**13.33%**	0	**0.00%**
Suicide	4	**18.18%**	3	**20.00%**	9	**39.13%**
Road Traffic Accident	4	**18.18%**	1	**6.67%**	2	**8.70%**
Other Accident	2	**9.09%**	1	**6.67%**	4	**17.39%**
Natural Causes	6	**27.27%**	8	**53.33%**	7	**30.43%**
Homicide	2	**9.09%**	0	**0.00%**	1	**4.35%**
Total	22	**100.00%**	15	**100.00%**	23	**100.00%**

5. Causes of deaths: further analysis

5.1 Children who died from natural causes (including those who were in the care of the HSE)

The highest proportion of notified deaths between 2010 and 2012, concerned children or young people, who died from natural causes. The majority of these (n=9) were babies whose post mortems recorded Sudden Unexpected Death in Infancy. The next most common cause was complications due to congenital abnormalities (n=8); two children died from terminal cancer, and two died from complications associated with respiratory infections and diabetes respectively.

5.2 Suicide

The largest number of unexpected deaths was from suicide. Fourteen out of the 16 suicides were by hanging; the remaining two were by drowning. Seven of the victims were female, nine were male. Nine of these suicides occurred in 2012. Only one of the suicide victims was in the care of the HSE at the time of death, having been known to HSE services for only a very short period. Three suicide victims were in receipt of aftercare services. The youngest child who died by suicide was 13, the eldest was 19. The age groups most represented were 15 and 16.

5.3 Children and young people who died in accidents

Fourteen children and young people (eleven male and three female) died unexpectedly from accidental causes, seven of which were road traffic incidents. The remaining seven involved accidents of a different nature, including a young person and a child who died in a fire, three separate domestic accidents involving two small children and one older teenager, and two outdoor accidents involving in one case, a drowning and in another, a serious fall.

5.4 Drug overdoses

Six of the young people died from drug overdoses. In all but one of these cases, the young person was found dead and toxicology reports indicated drug misuse, in one case the young person died in hospital of multiple organ failure associated with drug misuse. Five were male and one was female.

5.5 Homicides

Two young people and a child were killed by other persons. In two of these cases, criminal proceedings are ongoing; in the third a person has been convicted and is serving a prison sentence.

5.6 Overview of causes of death

Analysis of the above figures allows for the tentative profiling of deaths of children and young people in care and known to the child protection services. It is notable that only a small proportion of the total figure represented deaths of children in care, three of whom died from natural causes. While the numbers are small, this compares proportionately to the figures provided in the Report of the Independent Child Death Review Group (2012) where approximately half of the deaths of children in care were from natural causes. The fact that over one third of all of the notified deaths were from natural causes is also notable. The high proportion of young people who died by suicide is a cause of considerable concern and reflects what has become recognised as a national issue in respect of all young people and not confined to the cohort who are involved in child protection services. The fact that seven young people died while receiving aftercare services, mostly from suicide or drug overdoses, highlights the vulnerability of this group compared with younger children in care.

6. Care Status of children and young people whose deaths were notified between 2010 and 2012

As Table 9 below shows, six of the 60 notified deaths (10%) were children or young people currently in the care of the HSE. Of these, three were young children who had suffered from complex health problems from birth and prior to their admission to care and had died of complications relating to their conditions. One young person committed suicide within a matter of days of being received into care. The fifth was an infant whose death was recorded as Sudden Unexpected Death in Infancy, and the sixth was the victim of a homicide. A further seven young people were in aftercare situations, supported by HSE services. Three of these young people died from suicide, three were found dead following drug overdoses and one died in an accident.

Table 9 Care Status of children whose deaths were notified between 2010 and 2012

Care Status	2010	Male	Female	2011	Male	Female	2012	Male	Female	Total
In care of the HSE	2	2	0	2	1	1	3	0	3	7
In receipt of aftercare services	4	3	1	2	2	0	2	1	1	8
Living at home and known to child protection services	16	10	6	11	8	3	18	10	8	45
Total	22			15			23			60

7. Analysis of practice and management issues highlighted in reports published to date.

To date, twenty four National Review Panel reports have been published, eighteen of which concern the deaths of children and young people and six of which concern serious incidents. One of the objectives of the NRP was to provide reports in a consistent format which would allow some comparative analysis and permit identification of recurring factors. At this point it is possible to note the frequency with which some themes emerge, and these are discussed below under the headings of management, frontline practice, overall conclusions reached in review reports, key learning points identified in reviews and recommendations made in review reports. It must be noted at this point that while a minority of individual reviews were highly critical of practice and management in a number of respects, others identified only a small number of weaknesses. Overall, the NRP found examples of positive practice at all levels in the majority of cases that it reviewed. Such findings are often obscured by the negative factors highlighted in some reports but it is important to acknowledge them here.

7.1 Management

Reviews generally examined management issues in terms of policies and protocols which provide the infrastructure for frontline practice. This includes management of intake and allocation of work, assessment, supervision, inter-agency meetings and sharing of information.

7.1.1. Management of intake and allocation of work

In a minority of reviews, the ability of social work departments to manage the rate of referral was significantly compromised, with the knock on effect that cases could not be allocated within the requisite time frame, or they were held on duty over a prolonged period which meant that in-depth work could not be undertaken. In four cases, the duty system appeared to be 'blocked' and in three instances, management of the waiting list and prioritisation of work appeared to be inconsistent. In a small number of cases, unfilled posts added to this difficulty.

In four cases, it was evident that referrals about the same child and family were repeatedly closed and re-opened without allocation, which ultimately meant that assessment was never really conducted with the required thoroughness. It was considered that more oversight and audit of repeat referrals was required.

7.1.2 Assessment

The lack of guidance on the conduct of comprehensive assessment was identified in over half of the published reports and this had an observable effect on later actions taken. A combination of these factors appeared to delay allocation to social workers in approximately 50% of the cases.

7.1.3 Supervision

The National Office for Children and Families introduced a supervision policy for staff within the last two years. The published reviews cited evidence that for the most part, supervision occurred regularly and staff felt supported. It was not clear that the policy was being followed in detail and there were some instances where supervision records were absent from files but overall, the standard and frequency of supervision appeared to be satisfactory.

7.1.4 Inter agency cooperation, collaboration and communication.

The published reviews showed very mixed evidence of inter agency cooperation and its impact on the welfare and protection of the children who had died. In most instances there was a good level of informal cooperation, but closer examination indicated that in approximately half of the cases, inter-agency work could become fragmented unless it was coordinated by the social work departments. This indicates despite aspirations in policy documents that 'child protection is everybody's business' the reality is that the SWD still has to maintain a coordinating role.

There were a number of cases where a wide range of services were involved in a disjointed fashion. The most common weakness was failure to communicate relevant information about events in the child or young person's life.

7.1.5 Inter-agency meetings and child protection conferences

Over half of the published reviews found that an inter-agency meeting would have assisted in the compiling of information but was not held. While it is recognised that child protection conferences are time consuming and expensive, the reviews found that failure to hold them

meant that opportunities to share important information and to jointly consider creative solutions to some emerging difficulties were missed.

7.1.6 Placement of children with relatives

A small, but significant, number of reviews found that young people who had died had been placed with relatives who had not at any stage been assessed as suitable carers and had not been adequately trained or supported to deal with the challenging behaviour presented by the young people. In one case there was no information on file about one of the relative foster care situations where a young person had lived for five years. In three cases, allegations of abuse against relative foster carers were not investigated properly.

7.1.7 Protocols

In certain individual cases, reviews identified the need for protocols on specific topics, such as local protocols on domestic violence, drug misuse, discharge of infants from hospital into vulnerable situations, joint work between youth justice, probation and social work services.

7.2 Frontline Practice

The NRP reports focused its reviews of frontline practice in respect of initial response and assessment, interaction with families, focus on children and record keeping.

7.2.1 Assessment and initial intervention

Inadequate assessments were identified in the majority of published reviews; in some cases no assessment was conducted and in others, important information was known but its impact was not considered. In two cases, the reviews noted that child sexual abuse allegations were not properly investigated, and in three cases, it was noted that physical abuse allegations were not satisfactorily processed. In two, it was considered that the impact of domestic violence on children was ignored. In one, the serious implications of a young person's chronic health problem were not understood by staff. In a small number of cases, indicators of serious child neglect were not followed up in a timely manner.

7.2.2. Engagement with children and families

Five reviews noted the slowness of the social work department to become involved with a child and family that had been referred. In ten of the cases, the reviews noted that there was difficulty on the part of social workers engaging with families combined with frustration on the part of some of the families who believed that their concerns were not being taken seriously. In a small number of cases there appeared to be a lack of regular social work involvement. In six cases, there were evident difficulties engaging the young people concerned who were very resistant to services; however in a number of others there were examples of very successful engagement. In five cases, the reviews considered that the children's needs had not been met by services,

including their placement needs. Reviews noted in three cases that decisive action to protect children was not taken in a timely manner.

7.2.3 Focus on children

Five of the published reviews are critical of the lack of focus on the children concerned; however this has to be seen in contrast to four others where it was considered that the attention given to the children or young people was exceptionally conscientious on the part of workers.

7.2.4 Record keeping

With some exceptions, record keeping was considered to be of a good standard, with a notable improvement in recent times.

7.3 Overall conclusions reached in the published reports

All of the children and young people whose deaths were notified to the National Review Panel came from complex backgrounds. Some were already very ill before they came into contact with the services, others had mental health and behavioural problems and some young people habitually engaged in risk taking behaviour. While a number of management and practice weaknesses were identified, there was no case in which the review team concluded that action or inaction on the part of HSE services was a direct contributory factor in the child or young person's death.

In approximately one third of the published reports, it was considered that the Social Work Departments were challenged in their capacity to deal with the pressure of work being referred to them. The majority of conclusions reached in reports were concerned with poor inter agency cooperation and substandard assessment of the child or young person's needs which meant that frontline practitioners were working with limited information. In a minority of cases, the conclusions of reports focused on missed opportunities to work with the families involved. Conclusions are listed at the end of each report.

7.4 Key learning points identified in the reports

One of the main objectives of the process adopted by the NRP is to promote learning and the development of creative responses to challenging practice and policy issues. A number of points were identified in the different reports, some of which were specific to particular cases and others which were generalisable to a number of them. The consequence of failing to respond to early signs of child neglect was highlighted as a learning point in several reports, as was the importance of providing a holistic response and greater sharing between disciplines and services of responsibility for child protection and welfare. Some of the issues identified for learning were quite challenging, including the need to address the tendency for young people to resist services

that could have been very helpful for them, and the need to address the tensions that commonly exist between families and professionals which sometimes prevented the concerns of carers from being heard.

The small number of cases where children and young people were placed in care with relatives indicated a number of areas for learning, including the importance of assessing a child's needs and matching them with the capacity of the proposed foster carers and providing ongoing support including specific interventions if a child or young person has particular needs.

A number of reports highlighted the importance for staff of understanding indications of suicidal ideation in young people and having the skills to respond. Finally, the reports emphasised the importance of staff challenging their perspectives and avoiding 'fixed' notions when conducting assessments. Key learning points are outlined in the individual reports.

7.5 Recommendations made in review reports

The NRP is conscious of the number of recommendations made in review reports over the years and has focused more on key learning points emerging from individual cases and attempted to restrict recommendations to matters that are of national concern which are likely to benefit from a policy change. It is noted that some recent reforms have made earlier recommendations redundant. The recommendation that was most frequently made was for Children and Families to adopt a framework for the comprehensive assessment of children's needs for safety and welfare. The other most frequently recurring recommendation concerned the need to improve channels of communication and the standard of information sharing between services. Strategies for prioritising reports for investigation in areas that were struggling to respond to high notification rates were also recommended. In two cases reports recommended in depth reviews of practices in the local areas concerned. Recommendations are detailed in the individual reports.

National Review Panel Members 2012

Ms. Margaret Beaumont

Mr. John Brosnan

Professor Helen Buckley (Chairperson)

Dr. Nicola Carr

Dr. Bill Lockhart

Ms. Leonie Lunny

Mr. Eamon Mc Ternan

Dr. Ann Mc Williams

Mr. Phil Mortell

Mr. Paul Murray

Mr. Liam O Dalaigh

Ms. Suzanne Phelan

Ms. Melanie Pine

Dr. Eoin O Sullivan

Ms. Deirdre Mc Teigue

Professor Ian O Donnell

Ms. Ceili O Callaghan *

Ms. Jean Forbes *

Ms. Michele Clear *

Mr. Frank Martin *

* Members who joined the Panel during 2012