National Review Panel

Annual Report

2011

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Foreword

As Independent Chair of the National Review Panel (NRP), I am pleased to present the second Annual Report. As the work of the NRP entered its second year of operation, its principal challenge has been to manage the volume of work that was notified to it. It has done so by differentiating reviews into levels that reflect the depth and length of engagement between the child and family concerned and the child protection services.

The National Review Panel is committed to fair treatment of all individuals and services that it examines and it acknowledges the challenging nature of child protection work. While the review reports have critically commented on aspects of practice and management, they have particularly focused on the learning to be gained from each case. The HSE have in turn committed to disseminating the key messages to staff, in an effort to improve the quality of service. Certain themes have begun to emerge in respect of the deaths of children in the care of the HSE and known to the services, and as the number of reports accumulates, it will be possible to highlight the areas that require most attention.

The child protection services are undergoing considerable reform at present, and the NRP sees itself as well placed to contribute to their overall development.

Helen Buckley

Dr. Helen Buckley
Independent Chair,
National Review Panel

The National Review Panel Annual Report 2011

1. Introduction

The National Review Panel (NRP) was established in late 2010, and has, in principle conducted its work under the criteria established by HIQA[1], in the guidance document published in January 2010. 2011 was its first full year of operation. During 2011, the panel was notified of eleven deaths and one serious incident. Four further notifications of deaths which occurred in 2011 were received in 2012. Most of the work during the year has been in continuing and completing reviews on the twenty two cases that had been accepted for review in 2010. These included a number of major reviews which were ongoing at the end of 2011.

The NRP is independently commissioned by the HSE and none of its members have been involved 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.

2. 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.

3. Process operated by the NRP in 2011

3.1 Notification

Following the system established within the Children and Family Services in 2010, deaths and serious incidents falling within the criteria set by HIQA were notified to the newly appointed National Director of Children and Family Services in 2011. A standard template was developed by the National Office which gives minimal information about the child, as well the extent of and reason for the involvement of child protection services. As part of this system, the office of the National Director simultaneously notifies the death or serious incident to HIQA, and to the National Review Panel. During 2011, the chair of the panel met regularly with a nominated person from the National Office

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[1] Some aspects of the guidance were found to be unworkable at an early stage and modifications were subsequently agreed between the chair and HIQA.

to review notifications and discuss issues such as the flow of work, panel membership, any obstacles to the completion of particular reviews and plans for publication of reports.

3.2 Criteria for review

Due to the flow of work in 2010 which was considerably higher than anticipated, criteria for review were established in 2011 whereby decisions are made in consultation with the National Director's Office as to whether a review will take place, or whether the review will be conducted at local or national level. This decision, which may be taken before or after the full records are obtained, is dependent on the following:

- Whether the case fulfils the criteria established in the HIQA guidance.
- Whether or not the child was in care at the time of the incident or of his or her death.
- Whether the death or serious incident was clearly a direct result of child abuse or neglect.
- The cause of death. Approximately half of the deaths notified to the NRP have been from natural causes; the others were deemed to be the result of overdoses, suicide or accidents. Many of the accidents have been the result of risk taking behaviour.
- If a death was clearly predictable, i.e. where a child had congenital deformities, a terminal illness, or suffered sudden acute illness, a decision may be taken not to conduct a review. However, even where the death was apparently from natural causes, typically, from Sudden Infant Death Syndrome (SIDS) there may be cause to probe more deeply into the circumstances in which the child died, and the nature and quality of service provided in the months prior to the death.
- Where the duration of the involvement of services was short or the service delivery clearly unproblematic, a local review may be requested as an alternative.

3.3 Conduct of reviews

If an NRP review is to be considered, the local area manager is requested to arrange for a handover of all the relevant files, with pages numbered. They are expected to have locked down the files once the incident has occurred, and to produce a brief summary report. It is expected that families will be informed that a review is taking place. Where a local review is completed, it is submitted to the NRP and examined by the chair. If the review appears to be inadequate in any aspect, the chair may request revisions or allocate it for review by the NRP. This process was recently introduced in an effort to deal with the flow of work, and efforts are being made to standardise the type of local review conducted by the use of a template developed by the NRP.

The NRP has continued its 2010 strategy of differentiating between major, comprehensive, concise and desktop reviews as follows:

- **Major review:** to be held where contact with the HSE services prior to the incident has been long in duration (five years and longer) and intense in nature, where the case has been complex,

- **Comprehensive review:** to be held where involvement of HSE services has been over a medium to long period of time (up to five years) and/or where involvement of services has been reasonably intense over a shorter period.
- **Concise review:** to be held where the involvement of HSE services is either of a short duration or of low intensity over a longer period.
- **Desktop review:** to be held where involvement of HSE services has been brief or the facts of the case including the circumstances leading up to the death or serious incident are clearly recorded, and there is no immediate evidence that the outcome was affected by the availability or quality of a service. The methodology is confined to a review of written materials.
- **Local review,** as outlined above

3.4 Allocation of panel members

The panel currently has twenty members including the chair, and all members are currently occupied with reviews. The professional backgrounds of the panel members are mixed and include social work, social policy, psychology and law. Most of the panel members have expertise in specialist areas and some work as consultants in addition to panel work. The HIQA guidance recommended that each team should consist of three or four members including the chair or deputy chair of the NRP. However, due to the high volume of reports, it has not been possible to allocate this number and in fact, a two member panel, led by one member with addition oversight from the chair of the NRP, is generally sufficient. The relatively small number of major reviews usually requires more members. While the multi-disciplinary input is important, experience has shown that it is essential to include on each panel a member who has had the experience of managing a child protection social work service either in the Republic of Ireland or in Northern Ireland.

3.5 Tools, procedures and protocols

A number of tools have been developed to guide the work of the panel, and a standard template has been developed to promote consistency in the writing of reports for both national and local reviews. A system of benchmarking practice was developed and will be revised in line with the HIQA National Standards on Child Protection published in July 2012. Procedures and protocols for contacting and interviewing staff and family members have also been produced with the aim of ensuring fairness and balance. These documents are regularly reviewed.

3.6 Conducting a review and finalising the report

The panel finalised eleven reports in 2011. One was a major review, five were concise and the remainder were desktop reviews. It addition, the NRP produced and published an overview of five local reviews that had been conducted. The panel continued to work on seventeen other reviews during 2011. A total of one hundred and two staff members, and external agency staff attended for

interview. Depending on the level of review, others such as teachers were invited to interview. A number of interviews were held outside Dublin. Nineteen family members met with the panel. Under the strategy adopted by the NRP, extracts from the initial drafts of reports were provided to individual interviewees in respect of the evidence they provided, to allow for fact checking and submission of further information to the panel. Where possible, face to face meetings were held with family members in order to check facts and share initial findings.

Final revisions were subsequently made to the reports, which were signed off by the Chair and submitted to the National Director of the Children and Family Services, who forwarded them to HIQA.

3.7 Reports

The NRP is committed to providing reports that are sufficiently succinct to be readable and useful in terms of knowledge transfer. Most desktop, concise and comprehensive reports were under 35 pages. One of the main functions of the NRP is to highlight key learning points, in order to minimise the likelihood of identified errors and weaknesses in practice from recurring. Each report finalised in 2011 contained a section entitled 'Key Learning Points', where these matters were identified and discussed and references, where relevant, were made to research findings that support the learning points.

The panel is cognisant of the experience of other jurisdictions where report recommendations tend to accumulate and take on a repetitious nature. Accordingly, it has adopted a methodology whereby recommendations are restricted to matters that are of national relevance and are actionable. Most reports contain three or less recommendations.

4. Oversight of the National Review Panel by HIQA

The chair of the NRP, the NRP Service Manager and the National Director's designate met regularly with HIQA during 2011. HIQA has an oversight role in respect of the NRP and monitors the reports to ensure that they are in compliance with the guidance. Completed reports are submitted to HIQA which reserves the right to re-open a case for investigation if the NRP review is not deemed to be satisfactory. To date, HIQA has not indicated any dissatisfaction with the quality of reports submitted to them.

The HIQA guidance was due for revision in 2011, however this process was postponed in anticipation of the completion of the National Standards for Child Protection & Welfare, at which point in was envisaged that the HSE would assume responsibility for further development of the guidance.

5. Referrals 2011

5.1 Child deaths and Serious Incidents notified in 2011

Table 1: Category of cases notified

Category	Deaths	Serious Incidents	TOTAL
current cases open to the child protection service	11	0	11
in care at the time of the incident	2	1	3
in care immediately prior to 18th birthday and still under 21	0	0	0
in aftercare at the time of the incident	2	0	2
Total	15	1	16

Note: Four deaths which occurred in 2011 were not notified until 2012. These deaths are included in Table 1 above.

It is notable that of the children and young persons who died, only two were in care at the time of death, and two were in aftercare services.

Table 2 Comparison of cases notified in 2011 with those notified in 2010

Category	**Deaths 2010**	**Deaths 2011**	**Serious Incidents 2010**	**Serious Incidents 2011**
current cases open to the child protection service	11	11	2	0
in care at the time of the incident	2	2	5	1
in care immediately prior to 18th birthday and still under 21	7	0	0	0
in aftercare at the time of the incident	2	2	1	0
Total	22	15	8	1

Table 3: Cause of death of children and young people notified in 2011

Natural Causes	8
Drug Overdose	2
Suicide	3
Road traffic accident	1
Accident (other than RTA)	1
Total	15

Table 4: Comparison of causes of death between 2010 and 2011

Cause of death	2010	2011
Natural Causes	6	8
Drug Overdose	4	2
Suicide	4	3
Road traffic accident	4	1
Homicide	2	0
Accident (other than RTA)	2	1
Total	22	15

When 2010 and 2011 are compared, it is notable that the numbers of children who died while in care remained low. No deaths of children by homicide were notified in 2011. The numbers of children who died in road traffic accidents was lower in 2011 than 2010 and the proportions of children dying from other causes do not differ significantly.

Table 5: Age Profiles of children and young people who died in 2011

Age Band		Gender	
	No of Deaths of young persons	Male	Female
Infants < 12 months	4	3	1
1 – 5 years old	2	1	1
6 – 10 years old	1	1	0
11 – 16 years old	3	1	2
17 – 20 years old	5	5	0
Total	15	11	4

Comparison of age profiles between 2010 and 2011

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

When the age profiles of the children who died are compared, the trend is maintained whereby young people between the ages of 17 and 20 years old appear to be most at risk.

Table 6: National Distribution of cases of deaths by Region

Dublin Mid Leinster	4
Dublin North East	2
HSE West	2
HSE South	7
TOTAL	15

Table 7: National Distribution of cases of deaths by Region in 2011 compared with 2010

Region	2010	2011
Dublin Mid Leinster	3	4
Dublin North East	8	2
HSE West	4	2
HSE South	7	7
TOTAL	22	15

The tables above are presented principally for illustrative purposes, as the numbers are too small to make any meaningful inferences at this point.

5.2 Serious Incidents

Only one serious incident was notified to the NRP in 2011, compared to eight in 2010. It could be speculated that the definition of serious incident in the HIQA guidance as 'a potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development' is somewhat ambiguous and does not allow for easy identification of cases for notification.

5.3 Reports completed and published

During 2011, the NRP completed and submitted reports covering 11 cases to the National Director for Children and Family Services. All the reports were published on the HSE website. Since that time, reviews on a further six of the cases that had been referred during the 2010 and 2011 were completed, submitted and published. During 2011, eleven other reviews commenced or were in process, most of which will be completed by the end of 2012.

6. Learning & Training Events

The chair of the NRP met with HSE Children & Family Services monitors on two occasions during 2011 and delivered presentations on the review process. Members of the panel attended a seminar organised by Baspcan (British Society for the Study and Prevention of Child Abuse and Neglect) in Belfast in April 2011, where the issue of publication of reviews was debated. In September 2011, Paul Harrison, Acting Head of Policy & Strategy/Quality Assurance in Children and Family Services, and Helen Buckley, Chair of the NRP, presented a paper at a child welfare conference in Prato, Italy, on the development of the NRP process.

7. Remit of the panel

The limited remit of the panel continued to be a matter of concern to the NRP during 2011. Under the HIQA guidance, the remit of the NRP is limited to what the HIQA guidance describes as 'child protection services' provided by the HSE or HSE funded agencies. The definition of 'child protection services' has never been satisfactorily clarified. As a result, there is doubt over whether the remit of the NRP extends to public health nursing or other health or mental health services provided by the HSE to children and families. The panel currently has no power to compel cooperation from mainstream or alternative educational services. Even though the NRP was set up with a remit to review cases in the Youth Justice Service, it has no authority to compel staff members from the Probation & Welfare Service or An Garda Síochána to cooperate. The National Office has committed to contacting the relevant office within an Garda Síochána to clarify arrangements for their involvement.

The experience of the panel during 2011 was that in some cases, personnel who worked in agencies outside Children and Family Services and from outside the HSE and had been actively involved in cases, were willing to participate in reviews. However, this has not always been the case; some invitations for interview have been refused and the authority on which the panel's requests for participation or access to records held by other services has been queried. The consequence of this is that the panel are sometimes unable to properly investigate a case. It can also mean that HSE social workers may carry an unfair burden of liability while other services are not called to account even if their contribution to the case has also been of a poor standard. The NRP finds this to be a matter of considerable concern and has drawn attention to it.

It can be important for review teams to consider the contents of post mortem reports and attend coroner's inquests. As it is not standard practice for local social work teams to seek post mortem reports or attend inquests where children in care or known to them have died, the panel has experienced delays in either ascertaining the dates of inquests or obtaining reports. The National Office has committed to establishing a protocol with the Coroner's Office in order to address this.

8. Themes from the reviews

Patterns and trends in child deaths and serious incidents will become more apparent as more reports are completed. While the numbers from 2011 were relatively low, the depth at which the reviews were conducted allowed for clear themes to emerge, as follows:

- None of the child deaths notified between March 2010 and December 2011 was a direct result of child abuse or neglect. It is possible that some children in Ireland died from abuse during this time, but had not been in receipt of a social work service and therefore did not come within the scope of the National Review Panel.

- In the majority of cases, social work teams appeared to be under serious pressure, with the rate of referral exceeding the capacity of the areas to respond in a timely manner. This caused delays in the screening, assessment and investigation of cases. It also meant that reports where the problems being experienced by the child and family did not present as urgent or of a dramatic nature were put on waiting lists or received a delayed response. This understandable tendency conflicts with the stated mission of the service to provide early intervention in 'welfare' cases. It was also apparent that a gap existed in respect of provision for children with behaviour or addiction problems and a lack of clarity about what expectations existed around the response to be made when a case was classified as 'welfare'

- In some instances, waiting lists were operated but there was neither consistency nor transparency to indicate how this process was managed.

- One of the most consistent findings was that initial assessment was not routinely conducted and full assessment was not conducted according to any specific framework.

- There was a discernible pattern in respect of young people who died aged between sixteen and nineteen years. Some of these young people, in the context of their families if not as individuals, had been referred to SWDs as young children because of parental problems with drugs, domestic violence, alcohol, mental health or any combination of these factors. All of these young people had suffered neglect, and some had experienced serious trauma, school dropout, substance abuse and/or involvement with the Gardaí before they died by suicide, drug overdose or accident.

- In a number of cases, there was a lack of joined up work where its need was apparent. Examples include: lack of a multi agency domestic violence policy, lack of strategy or multi agency approach in respect of adolescent substance misuse, and lack of communication or protocols between health and community based services.

- In a small number of cases, child protection conferences could have assisted in the recognition of needs and the integration of service provision but were delayed or just did not occur. In some of those cases, records show that high levels of concern were held by

some professionals working with the families but the absence of fora for multi-disciplinary discussion prevented appreciation of the full picture.

- While records were reasonably well kept in some files, reviewers have found the case files difficult to negotiate as there appeared to be no standard method of record keeping in operation.

- The problem of youth suicide has been nationally recognised and a number of reviews indicated that young people in contact with the child protection system were vulnerable to it. There was little evidence that thought had been put into suicide prevention as a broad strategy.

- While supervision appears to have been generally available to frontline workers both formally and informally, there was not sufficient evidence to indicate that it is provided consistently and in line with expected standards.

- A number of reviews showed evidence that workers need skills in working with adolescents who are often 'hard to reach'.

- Some reviews demonstrated patchy compliance with regulations.

The reviews also found many examples of positive practice. It was not unusual to find that the quality of work varied throughout a child and family's contact with services, with some individual frontline practitioners or managers demonstrating particular competence and diligence. It was also clear the majority of the children and young people who died or whose very complex needs could not be met by statutory child protection services alone and required input from a range of services and agencies.

9. Actions to be taken in response to the reports

A stated purpose of the NRP process is to 'identify system wide strengths and weaknesses and the findings used to provide high quality and safe care to people using health and social care services'. (HIQA guidance page 4, section 6)

The HIQA guidance specified that reports should contain an action plan in response to recommendations. However, at an early stage it was agreed that this task should be the responsibility of the HSE.

9.1 Dissemination of learning

The National Director of Children and Family Services has signalled a commitment to disseminate learning from the reports through a process of knowledge transfer. There is potential for formal liaison between the NRP and the training department of the HSE C & F Services/New Agency in order to promote the process of learning from the reviews.

9.2 Contribution to public policy and reform

Notwithstanding the requirement for action plans by the HSE, the NRP is of the view that the findings and recommendations of the reports that have been published to date should be taken into account by the Department of Children and Youth Affairs in the development of child protection policy, particularly in the context of current and forthcoming reforms. The NRP reports cover each case in considerable depth, and have focused in detail on practice and policy issues that require to be addressed.

Dr. Helen Buckley

Chair, National Review Panel