Guidance for the Child and Family Agency on the Operation of The National Review Panel

November, 2014.

1. Background

The National Review Panel (NRP) for the investigation of serious incidents including the deaths of children in care and known to the child protection system was set up in 2010 as part of the Implementation Plan associated with the *Report of the Commission to Inquire into Child Abuse* (2009) (Ryan Report) to review deaths and serious incidents[1] of children in care.

The NRP was established by the Health Service Executive (HSE) subsequent to the publication of guidance from the Health Information and Quality Authority (HIQA). In June, 2010, the HSE established the National Review Panel for the purpose of undertaking reviews of serious incidents, including child deaths, in accordance with HIQA guidance. Dr. Helen Buckley, Associate Professor at the School of Social Work and Social Policy, Trinity College Dublin was appointed as Chair. Dr. Bill Lockhart, retired CEO, Youth Justice Agency, Northern Ireland, was appointed as Deputy Chair. In addition, a senior professional manager and a senior administrative manager were assigned to support the work of the Panel. The core function of conducting reviews commenced effectively in August, 2010.

2. Key Stakeholders Participating in the Reviews of Deaths and Serious Incidents

2.1 National Review Panel (NRP)

The NRP is independently chaired and reviews serious incidents involving children known to child welfare and protection services of the Child and Family Agency (the Agency), including the deaths of children in care. The overarching objective of the NRP is to promote learning and best practice from its review of cases with a view to assisting the child welfare and protection system in improving its services and minimising the possibility of similar deaths and/or serious incidents to children and young people using their services.

While the NRP has been established under the auspices of the HSE and now the Child and Family Agency, it remains functionally independent, making findings of fact and producing reports that are objective and independent of the Agency. As a means of expressing this functional independence, the NRP operates separately from the Agency and has its own independent legal advisors.

The Panel consists of professionals from a range of disciplines appointed for their professional expertise. It allows for timely reviews but also immediate feedback to the system on individual or systemic risks which need urgent action.

[1]Serious incidents referred to in this Guidance are specifically child protection and welfare serious incidents (see section 4). This is because the term 'serious incident' is the term used in the Ryan Report Implementation Plan (2009) and in *Children First: National Guidance for the Protection and Welfare of Children* (2011). However, the term is also used in the Child and Family Agency/HSE serious incident management procedures and has a different meaning in that context. It should be noted that defining a serious incident in child protection and welfare is extremely complex. The nature and number of serious incidents reported will inform any future revisions of this definition.

2.2 Child and Family Agency

The enactment of the Child and Family Agency Act 2013 and consequent establishment of the Agency on January 1st, 2014, represents a significant milestone and a new point of departure in terms of policy and service provision for children and families in Ireland.

The establishment of the Agency as a distinct legal entity to deliver services for children and families aims to ensure optimal levels of performance, accountability and transparent governance within all components of service. In this regard, one of the key roles played by the Agency is the promotion of the welfare of children not receiving adequate care and protection and the development and implementation of national service policies and guidelines which inform and support relevant service provision.

The establishment and subsequent development of the Child and Family Agency provides a fresh opportunity to create a strong and authoritative organisation which is appropriately structured and enabled to deliver on the commitment of Government to the reform of child and family services.

Furthermore, the Agency represents the consolidation of a range of child and family services. This provides new opportunities for integration of expertise and service responses for children and their families. It also provides the potential for devising more outcomes-focused service provision for children and their families. Working optimally, it should offer more comprehensive child and family-oriented safeguards and supports for children and families.

2.3 Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority is the independent authority which was established in May, 2007 to drive continuous improvement in Ireland's health and social care services. HIQA was established as part of the Government's overall Health Service Reform Programme. HIQA's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health, HIQA has statutory responsibility for:

- Setting Standards for Health and Social Services;
- Monitoring Healthcare Quality — including undertaking investigations into suspected serious service failure in healthcare;
- Health Technology Assessment;
- Health Information; and
- Social Care Services Regulation.

Under the Health Act 2007, HIQA is required to monitor the Agency's compliance with the National Standards for the Protection and Welfare of Children and the National Standards For Safer Better Healthcare. Under Standard 2.11, HIQA will monitor the functioning of the NRP in relation to the principles set out in section 5 of this document.

2.4 Other Stakeholders

Other services may be requested to participate in the development of reports and include, but not be limited to, those provided by the wider "health family" under the Health Service Executive and also, An Garda Síochána, Government Departments and relevant agencies.

3. Purpose of Guidance

The purpose of this Guidance is to provide direction to the Agency and NRP on how it reviews serious incidents, including the deaths of children in care, in accordance with its statutory obligations for the protection and welfare of children. In following the guidance set out in this document, the Agency will be fully cognisant of its own statutory responsibilities and the statutory and legal rights of children, their families and any other statutory or judicial bodies or officers. The Guidance is informed by national and international literature, international best practice, current structures and current national operating practices of the Agency.

4. Reporting of Relevant Cases involving Children and Young People to the Panel

Where a serious incident or death occurs of children or young people under the age of 18 (other than in the case of a young person eligible for aftercare support) known to the Agency, a report must be made to the NRP and HIQA within 48 hours of the Agency becoming aware of the incident/death. The following categories of children apply:

- Children in care[2];
- Children known to the Agency's social work department or an Agency-funded service[3]; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.

In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:

- A child protection issue arises that is likely to be of wider public concern;

[2]Children who have been in care during the previous two years.
[3]Open cases or cases which have been closed in the past two years are categorised as known to the social work department or Agency-funded service.

- A case gives rise to concerns about interagency working to protect children from harm; or

- The frequency of a particular type of case exceeds normal levels of occurrence.

For the purposes of this Guidance document:

A **serious incident** is defined as:

> *A potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development.*

A child known to the Agency is defined as:

> *A child who has had episodic and regular contact with Agency services over a period of years but, does not include instances where cases have been closed for a period in excess of two years.*

Child Welfare and Protection Services, for the purposes of this Guidance, includes all services and supports (and those responsible for their delivery) relevant to the child or young person at the centre of a review by the Panel.

Local, regional and national lines of responsibility for the reporting to HIQA and the NRP, of all serious incidents, including deaths of children in care, should be clearly established within the Agency.

The Agency will develop internal policies, procedures and protocols to report cases to the NRP and HIQA. The Agency will carry out reviews of all child protection and welfare incidents at local, regional and national level as appropriate.

The NRP will make the decision to carry out a review of the case. Decisions on whether the NRP will review certain cases (e.g. where deaths are clearly from natural causes and there are no other indicators of concern) will be made by the Chair of the NRP and the Agency will be informed of same.

5. Principles Underpinning Review Process

The following principles underscore the work and reports of the review process:

- **Independence:** The NRP and its work will remain independent of the Agency and the Department of Children and Youth Affairs (DCYA).

- **Fit for purpose:** The Review Panel identified for each review should consist of a range of professionals relevant to the case.

- **National approach:** Reviews of serious incidents, including deaths of children in care, will be completed at national level to promote widespread change, if required, and identify examples of good practice.

- **Procedurally robust:** The methodology employed by the NRP in carrying out reviews, making its findings, conclusions and recommendations will be comprehensive, robust, applied consistently and have regard to similar review processes from other jurisdictions. Findings from reviews will derive directly from the information provided to reviewers, orally or in written form.

- **Fair and balanced:** In compiling its findings, the NRP will have regard to due process and the principles of natural justice.

- **Timely:** Reviews will be carried out and reports will be finalised and published in a timely manner. Immediate feedback will be provided to the system on individual or systemic risks which need urgent action.

- **Driving improvement:** Recommendations arising from reviews may be of national significance and relevant to ongoing reform in the child welfare and protection system. The review process will identify gaps in systems and services as well as strengths of the system. This will inform the Agency's practice and policy and its quality improvement cycle. Key learning points will reflect best practice and research findings relevant to the case.

- **Consistent:** The application of review methodology will result in findings and judgements being made in a consistent manner, following the analysis of information gathered during the review process.

- **Protection of confidentiality:** Reports will be anonymised as far as possible to prevent identification of the child, young person or their family. Practitioners and managers whose work is the subject of the review will not be identified by name but only by position. It should be possible to discuss any of the issues outlined in a public forum. In instances where confidentiality cannot be reasonably protected owing to the particular circumstances under review, the Panel may recommend to the Agency that the report is not published but, that the relevant learnings still emerge in an anonymised form.

- **Taking account of relevant legislation and rules of natural justice:** The reviews will be carried out with due regard to relevant legislation and principles of information governance.

- **Transparent and accountable:** The decisions and findings of the review process should be clearly communicated to the general public and Agency staff so as to achieve greater transparency and accountability regarding serious incidents relating to children and young people.

- **Systemic:** The review will take a systems-based approach which will identify issues which may arise for different services within the sector.

6. Purpose of Conducting Reviews

Reviews are completed for the following reasons:

- To review the quality of services provided to a child or young person in instances of death or serious incident and to determine if an act or failure to act (including referral or failure to refer to any other agency or regulatory body), was a contributing factor to the child's death or serious incident;

- To determine compliance with relevant standards of governance and accountability to identify weakness in policy and practice for the case under review;

- To gain an understanding of the risk factors to which children are exposed and those inherent in the child protection and welfare system, and to identify evidence based key learning in relation to child protection practice in the Agency and other relevant services;

- To drive change in the Agency to ensure, to the greatest extent possible, that any systems failures associated with the serious incident/death of a child/young person are not repeated;

- To identify and commend examples of good practice within the child welfare and protection systems; and

- To identify and promote the learning that emerges from all reviews and, in particular, to identify system wide strengths and weaknesses and use relevant findings to provide high quality and safe care to children and families using the services of the Agency.

7. The National Review Panel and the Review Team

7.1 The Review Panel

The Review Panel should consist of:

- An independent Chair and a Deputy Chair. The independent Chair and Deputy Chair should have the skill and expertise required to develop, undertake, quality assure and manage reviews within agreed timeframes.

- Professionals from a range of disciplines and agencies with expertise in areas such as public health, medicine, mental health, psychology, social work, social care, law, law enforcement and detention should also be considered. These persons should include representation from other jurisdictions. All the Panel members should be appointed for their professional knowledge and experience of best practice and management in child protection, relevant research and policy, and their competence in analysis and report writing.

In addition:

- In order to avoid conflicts of interest, former employees of the Agency should not serve on the Panel until at least two years have elapsed since their retirement or

resignation from the Agency. Furthermore, as a corollary, current employees of the Agency should not serve on the Panel.

- Individual review teams will be drawn from the Review Panel and appointed for their expertise and availability.

- The Agency should ensure that the Review Panel and the review team have adequate administrative support and accommodation available to them.

- Training should be provided by the Agency for Panel members on an annual basis as identified by the Chair and in relation to the review process or specific professional issue.

- Remuneration of Panel members will be in accordance with all relevant guidelines and requirements for the public service as determined by the Department of Public Expenditure and Reform.

- The process for appointment to the NRP will be agreed between the Chair of the NRP and the Board of the Agency.

- The Chair of the NRP will report directly to the Chair of the Board of the Agency.

8. Timing and Publication of the Review

The reviews should take place and progress in a timely manner, following the receipt of the referral.

Timelines determined by the NRP in relation to the finalisation of reports, including exceptional cases which might lead to delay, should be communicated to the Board of the Agency for each review. There is a need to conclude matters as soon as is practicable so that the learning identified is not lost or has its value lessened, from the perspective of the child welfare and protection system of the Agency.

The review should not interfere with any legal processes, such as a coroner's inquiry or Garda investigation but, should operate concurrently provided its operation is not affected by or impinging upon any such legal process. Nor should it interfere with the exercise of legal rights by any person or body in any such other legal processes. There will be consultation with An Garda Síochána/Director of Public Prosecutions where there is an ongoing criminal investigation. The Agency will agree protocols with An Garda Síochána/Director of Public Prosecutions and the Coroner Service in order to establish the timing of the publication of the report. However, in order not to prejudice criminal proceedings, the Agency, in consultation with An Garda Síochána/Director of Public Prosecutions, may decide to delay publishing a report in its entirety. This information should be communicated to HIQA.

Other processes including disciplinary processes should take place separately and should not impact on the review.

The Agency should publish the executive summary of all reports, at the very least, and should aim to publish the full report. HIQA should be informed of the reasons if a decision is made not to publish a report. All completed reports, including the executive summaries, should be forwarded by the Agency to HIQA, once received from the NRP, regardless of whether or not they will be published.

Reviews may be published in batches where the Agency and the NRP are in agreement that such action will not impact on the timeliness of the review nor compromise public accountability or learning identified. Groups of reports will be published on a quarterly basis. In addition to an annual report, the NRP may, periodically, produce an overview of all published reports to provide a summary and analysis of all matters of relevance.

9. Monitoring the Review Process

HIQA has a significant role in relation to the inspection of child protection and welfare services provided by the Agency. Under the *National Standards for the Protection and Welfare of Children* (2012), HIQA has been given the oversight role in relation to:

- Carrying out monitoring of the review process (with a view to validating the implementation of the key principles) to ensure that the review process is in compliance with this Guidance; and

- Production of an annual report on the monitoring of the National Review Panel and process.

This will provide public assurance that the NRP operates in accordance with the necessary level of independence from the Agency and is adhering to key principles.

10. Review of Guidance

This Guidance will be reviewed at regular intervals and, in any event, not less than once every three years.