Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care

20 January 2010

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority'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 and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services — Developing person centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Monitoring Healthcare Quality — Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare

Health Technology Assessment — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services

Social Services Inspectorate — Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.

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Executive Summary

The *Report of the Commission to Inquire into Child Abuse*, commonly referred to as the Ryan Report (the Ryan Report, hereafter), was published on the 20 May 2009 and the Government accepted the recommendations in full. Subsequently, an implementation plan was published by the Office of the Minister for Children and Youth Affairs (OMCYA) in July 2009 to respond to each recommendation made in the Ryan Report. The recommendations outlined that the Health Information and Quality Authority (the Authority) should develop guidance for the Health Service Executive (HSE) for the review of serious incidents including deaths in relation to children in the care of the State. This guidance will be included in the Authority's *National Quality Standards for Residential and Foster Care Services for Children and Young People* that are currently in development and due to be published in summer 2010 and the *National Quality Standards for Child Protection Services*, due to be published in 2011.

Currently in Ireland, there is no national standard or unified or systematic way of completing reviews of serious incidents including deaths of children in the care of the State. The findings of published reports, and the lack of transparency concerning internal review reports, have shaken public confidence in the review process.

The guidelines in *Children First: National Guidelines for the Protection and Welfare of Children* and the HSE's existing internal incident management policy need to be employed systematically and consistently throughout the HSE. These should also be employed systematically and consistently in all other organisations that provide care for children. A national review process should be put in place.

Part 1 of this document is the guidance. It describes a standard, unified, independent and transparent system for the review of serious incidents including deaths of children in care in Ireland. The guidance outlines the purpose of national review, the national review panel and team and the review process. The guidance also addresses the timing of review, benchmarks for individual reviews, publication and external reporting and monitoring of the review process.

Part 2 of this document reviews the literature, international practice and national structures relevant to the review of deaths and serious incidents in relation to children in care. This is also relevant and applicable to justice settings as a significant number of children accessing the justice system have previous involvement with the child welfare system. The literature review highlights that New Zealand, Australia, Canada, the United States and the United Kingdom have systematic review processes in place.

PART 1
Guidance for Reviewing Serious Incidents including Deaths of Children in Care

The purpose of this part (Part 1) is to provide guidance for the HSE on how it reviews serious incidents[1] including deaths of children in care. These reviews are completed by the HSE because it has certain statutory obligations for the protection and welfare of children. In following the guidance set out in this document, the HSE will of course need to remain 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 the literature, international practice, current structures and national practices in Ireland, as outlined in Part 2. Internal HSE procedures and protocols are also required to manage operational issues relating to the implementation of this guidance.

This guidance will be included in the Authority's *National Quality Standards for Residential and Foster Care Services for Children and Young People* that are currently in development and due to be published in summer 2010 and the *National Quality Standards for Child Protection Services*, due to be published in 2011.

1 Deaths of Children and Young Adults and Reporting to the Authority

The following deaths should be reported to the Health Information and Quality Authority's Social Services Inspectorate (SSI) within 48 hours of the death occurring:

- all deaths of children in care
- all deaths of children known to the HSE child protection system[2]
- all deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act, 1991[3]
- when a case of suspected or confirmed abuse involves the death of a child known to the HSE or a HSE funded service.

2 Defining Serious Incidents and Reporting to the Authority

A serious incident is defined as:

> A death or a potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development[4]

SSI should be informed[5] within 48 hours of any serious incidents relating to the following children:

- children in care

1 Serious incidents referred to in this guidance are specifically child protection and welfare serious incidents. This is because the term 'serious incident' is the term used in the Ryan Report Implementation Plan and in Children First (2009). However, the term is also used in the HSE serious incident management procedure and has a different definition in that context.

2 Open cases or cases which have been closed in the past two years are categorised as known to the child protection system.

3 These deaths will be notified to SSI if and when the HSE becomes aware of them and recognising that some young adults aged under 21 years may no longer be in contact with the HSE care system.

4 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.

5 Attempted suicides should be reported to the HSE child protection and welfare services. Internal protocols should be developed within the HSE to determine whether the case should be reviewed nationally and reported to SSI.

- children known to the HSE child protection system
- when a case of suspected or confirmed abuse involves a serious incident to a child known to the HSE or a HSE funded service.

3 Governance and Accountability

The HSE should have clear local, regional and national lines of responsibility in place for reporting all serious incidents, including deaths of children in care, within the HSE, to the chairperson of the national review panel and to SSI.

The responsibilities for reporting and reviewing incidents and complying with reviews should be set out by the HSE and communicated widely to ensure accountability at all levels. Where learning is identified, it should be acted on as quickly as possible without necessarily waiting for the review to be completed.

4 Reporting and Reviewing

A safe and effective system for reviewing serious incidents, including deaths of children in care, requires that *Children First: National Guidelines for the Protection and Welfare of Children* (2009) and the HSE Incident Management Policy and Procedure are employed systematically and consistently throughout the organisation. The HSE should develop internal policies, procedures and protocols to report and review all child protection and welfare incidents at local, regional or national level as appropriate. All child protection concerns from within the HSE and from other agencies are referred to the HSE child protection services in accordance with Children First. These referrals should include child protection and welfare serious incidents from acute hospitals, designated centres for children with a disability and other HSE services, HSE funded services and other organisations and personnel working with children. All incidents should be reviewed at local health office level.

Deaths or serious incidents, or cases which meet any of the additional criteria for national review outlined in the next section, should be referred nationally through the serious incident management procedure and to the HSE assistant national director for children and families for national review. Internal HSE procedures and protocols will be required to manage this.

Local HSE management, the HSE assistant national director for children and families and the chairperson of the review panel may need to discuss individual incidents if clarity is required about whether an incident meets the above definition of a serious incident and requires national review.

The reporting and review process is outlined in detail on page 6.

5 National Review

Due to the small number of deaths and serious incidents in Ireland and the requirement for objectivity and expertise, it is proposed that reviews[6] of serious incidents, including deaths of children in care, should be completed at national level. Based on current practice, it is estimated that the national review team may need to review up to two deaths per year and between three and five serious incidents.

6 This guidance uses the term 'review' as per the Office of the Minister for Children and Youth Affairs (OMCYA) (2009) but these national reviews are referred to as investigations in other contexts.

The following deaths and serious incidents should be reviewed by a national review team and notified to the HSE and SSI. The chairperson of the national review panel will review the facts of each case and ascertain the extent and nature of the review required:

- deaths of children in care, including deaths by natural causes[7]
- deaths of children known to the HSE child protection system
- deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act, 1991
- where a case of suspected or confirmed abuse involves the death of, or a serious incident to, a child known to the HSE or a HSE funded service
- serious incidents involving a child in care or known to the HSE child protection services.

A national review team may review additional child protection and welfare issues if they are particularly serious, occur repeatedly or thematically. These may include cases:

- where a child protection issue arises that is likely to be of public concern
- where a case gives rise to concerns about interagency working to protect children from harm
- where the number of cases of an incident exceeds typical occurrences.

6 Purpose of National Review

Reviews are completed for the following reasons:

- to determine the specific circumstances leading to the death or serious incident and ascertain whether abuse, or whether an act or failure to act, was a contributing factor to the child's death or serious incident. The review may also identify whether other separate actions, such as disciplinary action or a referral to any regulatory body, need to be undertaken
- to determine whether compliance with Children First and other set down procedures and the relevant standards of governance (leadership, organisation and management, business planning, risk management and meeting the legal requirements) and accountability among the professionals and service providers were satisfactory within the context of the information available at the time
- to make recommendations and develop an action plan
- to provide reassurance to the public on the standards of care and protection provided to children, that reviews are carried out to an appropriate standard and are independently monitored and published as appropriate
- a review or a number of reviews viewed together may 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.

7 All deaths of children in care and known to the child protection system must be reviewed by a national review team. In a situation where a child dies of apparent natural causes, the chairperson of the national review panel or a review team should look at the facts of the case, confer with the appropriate medical practitioner, and decide whether the death should be reviewed by a national team or at local health office level.

7 The National Review Panel and the Review Team

7.1 The Review Panel

The *Report of the Commission to Inquire into Child Abuse, 2009 Implementation Plan* states that the HSE and the Irish Youth Justice Service (IYJS) will develop a panel (internal and external) of appropriately skilled professionals to undertake investigations[8] by December 2009.

The review panel should consist of:

- an independent chair and a deputy chair of the panel. The independent chair and deputy chair should have the skill and expertise required to develop chronologies and undertake, write up and manage reviews within agreed timeframes. The HSE should ensure that the chairperson and deputy chairperson are available to complete reviews
- 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 expertise, specific knowledge of best practice, research and policy and their experience of review, analysis and report writing. Individual review teams will be drawn from the review panel and appointed for their expertise and availability.

It may benefit panel members to undergo specific training. The HSE should ensure that the review panel and the review team have adequate administrative support available to them.

The chairperson should ensure that the vast majority of the reviews are not undertaken by a very small subset of panel members.

7.2 The Review Team

The review team should be composed of:

- the chairperson or deputy chairperson
- an additional two to four members of the review panel invited by the chairperson. The chairperson should ensure that there is a mix of expertise, skill and disciplines on the review team.

The review team should have a formal communication link with the agreed HSE manager.

7.3 Remuneration

All panel members who are employed by the State, or employed in agencies who are in receipt of state funding, should be released from their normal duties to take part in individual review teams as required. Other panel members who are not in state employment and form part of a review team may be reimbursed for their work on a review team to such an extent as is sanctioned by the Chief Executive of the HSE.

8 The term "investigation" is taken to mean "national review" in this context.

8 Timing of the Review

The timely nature of the review process is essential. It should be commenced within one month of the death or serious incident coming to attention of the HSE and should be completed within four months, unless an alternative timescale is arranged between the review team and the HSE and agreed with SSI.

This review should not interfere with any legal processes for example a coroner's inquiry or Garda investigation but should operate concurrently provided its operation is not affected by or impinges 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. The Garda Síochána/Director of Public Prosecutions should be consulted where there is an ongoing criminal investigation. The HSE should agree protocols with the Garda Síochána/Director of Public Prosecutions and the Coroner Service around the timing of the review. Concurrent investigations or other processes including disciplinary processes should take place separately and should not impact on this review.

The review should not be delayed as a matter of course because of outstanding criminal proceedings or a decision not to prosecute. In these circumstances, the HSE should consult with the Authority to agree the timing. However, in order not to prejudice criminal proceedings, the HSE in consultation with the Garda Síochána/Director of Public Prosecutions and the Authority may agree to delay publishing a report in its entirety.

9 The Reporting and Review Process

9.1 The following deaths of children should be referred onwards from HSE local health offices through the serious incident management procedures and to the HSE assistant national director for children and families and reported to the Health Information and Quality Authority's Social Services Inspectorate within 48 hours of the death occurring:

- all deaths of children in care
- all deaths of children known to the HSE child protection system[2]
- all deaths of young adults (up to 21 years of age) who were in the care of the HSE in the period immediately prior to their 18th birthday or were in receipt of aftercare services under section 45 of the Child Care Act, 1991
- when a case of suspected or confirmed abuse involves the death of a child known to the HSE or a HSE funded service.

The information to be included in this report is highlighted in Appendix 2.

9.2 All other incidents should be reviewed locally to determine whether they meet the criteria of a serious incident as outlined in the previous section. All serious incidents, and any other cases that meet the additional criteria for national review outlined, should be referred onwards through the serious incident management procedures and to the HSE assistant national director for children and families. These serious incidents should be reported to SSI within 48 hours. The information to be included in this report to SSI is highlighted in Appendix 2.

Local HSE management, the HSE assistant national director for children and families and the chairperson of the review panel should discuss individual incidents if clarity is required and may also decide to refer the serious incident back to the local health office for review.

9.3 All incidents that are not referred to the national team should be reviewed at local health office level in line with Children First and the HSE's Incident Management Policy and Procedure.

9.4 Once it is known that a death or other serious incident has occurred, each head of discipline or service manager is responsible for securing records and or photocopying all records relating to the child and the case to guard against loss or interference. They are also responsible for forwarding these records to the national review team. The HSE should complete an initial local review as per internal HSE protocols.

9.5 The national review should be commenced within one month and completed within a further four months of the serious incident coming to the attention of the HSE, unless an alternative timescale is arranged between the review team and the HSE and agreed with SSI.

9.6 The national review will be undertaken by a national review team, which will include members of the national review panel.

9.7 A copy of the completed report and the executive summary should be forwarded in its entirety to SSI within four months.

9.8 The HSE should publish the executive summary of the reports, at the very least, and the entire report, if possible, within 30 days of completing the report. The Chief Executive's response to the recommendations should be published within 45 days of publication of the report.

9.9 SSI will monitor all reports to ensure that the review process is in compliance with this guidance.

9.10 The Authority may decide, or be requested by the Minister[9], to conduct a review or investigation under the Health Act 2007, if the review process has not been completed satisfactorily or the findings are indicative of wider concerns. The findings of this review will be published by the Authority.

9.11 SSI will publish an analysis of these reports outlining key findings, practice issues and learning points as appropriate.

9 All references to the Minister in this guidance refer to the Minister for Children and Youth Affairs.

10 Benchmarks for Individual Reviews

10.1 Components of the Review

The chairperson in consultation with the review team should:

- determine the scope, objectives and terms of reference of the review. These may alter when new information comes to light in the course of the review. Specific internal HSE protocols, policies and procedures will need to be developed. Relevant issues include:
  - focus on the care and the services provided to the child
  - focus on obtaining evidence to support the findings within a limited timeframe
  - over what period of time should the events in the child's life be reviewed
  - timeframes for completing the review
  - objectivity and impartiality
  - how relevant information can best be obtained and analysed
  - focus on the policies and procedures, protocol and legislation that impacted specifically on the care provided to the child
  - what agencies and professionals should contribute to the review
  - arrangements for the referral of immediate issues that arise to the appropriate parties and ensuring that they are dealt with in a timely fashion. For example, criminal investigations, disciplinary matters or quality and safety issues
  - clarity around ownership, authorship and editing of the report
  - support and feedback process for the families, children, staff and media before, during and after the review.

The review team, which includes the chairperson, should:

- review all documentation and data that is relevant to the case
  - relevant local, regional and national documentation and data from within the HSE and other state funded agencies.
- interview
  - parents or carers, family and children[10]
  - relevant staff.
- undertake site visit(s)
  - analyse data obtained from the site(s).

10.2 The Review Report

The review report should be written objectively and relate to legislation and regulation, standards, good practice and internal HSE policies and procedures. All individual staff members should be referred to by position and not by name. The chairperson will finalise the review report in consultation with the review team.

10 If it is not possible or appropriate to include or complete these interviews, the reason should be outlined in the report.

The final report and the executive summary should take account of all relevant new information that becomes available through the course of the review and the facts, conclusions and recommendations should be revised accordingly. The report should include the following sections:

- executive summary
  - including information about the review process, key findings and issues arising from the case, the recommendations made and the action plan
  - as this will be made public, it should be anonomised to protect the confidentiality of children, their family members and others and it should be possible to discuss any of the issues outlined in the summary in a public forum
  - names, job titles or profession and employer of each member of the review team and the report author.
- introduction
  - summary of the circumstances that led to a review being undertaken in this case
  - scope of the review, objectives and terms of reference
  - the contributors and the nature of their contribution to the review
  - outline the methodology used, including the documents reviewed and whether information was provided in an interview or in written form
  - list any external investigations being completed
  - review committee members and author of the report.
- facts
  - social and developmental history of the child, family genogram including extended family and household, reasons for the child being in care and history of the family within the child protection system
  - profile of the child's needs, if the child was referred to the appropriate professionals, if the child's needs were assessed and if the appropriate services were provided in a timely fashion
  - multi-agency perspective. Profile of all services involved with the child to include numbers, activity, purpose and function of the service, complaints, incidents, relevant policies, protocols and or procedures
  - a chronology of involvement with the child and a separate chronology of involvement with the family which shows integrated involvement of all relevant agencies, professionals and others. Timelines may be useful when information is complex
  - clear background information and details of the circumstances surrounding the death or other serious incident and how the case was handled by all agencies and professionals involved prior to and in the aftermath of the incident.
- findings
  - the findings, fully outlined, and an overall judgment made concerning the adequacy of care provided to the child throughout his or her lifetime. This should be linked to regulations, standards, good practice and research evidence.

- analysis
  - analysis of the individual case, the particular governance and accountability issues and the local and national implications. It should include:
    - legislation, regulations, standards, policies and procedures, protocols and guidance that were followed or lacking in relation to the particular case
    - any action or inaction by staff that may have contributed
    - evidence of good practice and reasons for commendation of particular staff
    - the service issues and challenges and the systems or root causes of these challenges
    - the local and national implications of the challenges identified.
- recommendations
  - recommendations should, where possible, be few in number, focused, specific and capable of being implemented
  - recommendations made should address the systematic or root causes
  - lessons and implications for national and local policy, legislation and practice should be highlighted.
- action plan
  - the action plan should be in place, with timeframes assigning responsibility for the implementation of the various recommendations. It should also outline the arrangements for auditing and reviewing the implementation of the action plan and identify arrangements to provide feedback and debriefing to staff.

11 Reporting and External Monitoring

The HSE should publish the executive summary of all reports, at the very least, and should aim to publish the full report. SSI 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 sent to SSI on completion, regardless of whether or not they will be published.

SSI should submit a quarterly report to the Minister for Children and Youth Affairs setting out key issues and learning of systemic importance arising from the findings and recommendations of reviews received over the period.

Records should be kept by the HSE of all incidents investigated at both local and national level and include the conclusions reached, actions identified as required, the person responsible for these actions and the timeframes for implementation and all activities related to the review. These records must be held indefinitely. The Authority may require access to these at a later date if it considers it necessary. SSI will monitor all reports to ensure that the review process is in compliance with this guidance and may publish an analysis of these reports outlining key findings, practice issues and learning points as appropriate.

The Authority may decide, or be requested by the Minister, to conduct a review or investigation under the Health Act 2007, if the review process has not been completed satisfactorily or the findings are indicative of wider concerns. These findings will be published in full unless there is a compelling reason not to do so and in that case an executive summary will be published.

The Authority has statutory powers for review and investigation under the Health Act 2007. Under Section 8 of the Health Act 2007, the Authority may evaluate information concerning the services and the health and welfare of the population and provide advice and make recommendations to the Minister and the HSE about deficiencies identified by the Authority in respect of this information.

Under Section 9 of the Health Act 2007, the Authority may decide, on receipt of a report, to conduct an independent investigation if it considers that there is a serious risk to the health or welfare of a person receiving those services, or the risk may be a result of any act, failure to act or negligence on the part of the HSE or other service provider. Alternatively, the Minister may require the Authority to undertake an investigation under Section 9 of the Health Act 2007.

12 Review of Guidance

This guidance will undergo interim review prior to the publication of the Authority's *National Quality Standards for Child Protection Services* in 2011 and will be reviewed in 2012.

PART 2
Literature, International Practice and National Structures on Child Death and Serious Incident Review

1 Introduction

The *Report of the Commission to Inquire into Child Abuse*, (the Ryan Report) was published on the 20 May 2009. The Government accepted the full list of recommendations in the Ryan Report and took the decision to draft the implementation plan which responded to the 20 recommendations in the report.

The implementation plan was published by the Office of the Minister for Children and Youth Affairs (OMCYA) in July 2009 and it states that all efforts should be made to minimise the occurrence of serious incidents to children in the care of the State. A death, or serious incident occurring to a child, is a tragic event and any subsequent review should take this into account. *The Report of the Commission to Inquire into Child Abuse, 2009, Implementation Plan* (Ryan Report Implementation Plan)[11] refers specifically to reviews of deaths and serious incidents in relation to children in the care of the State and outlines that:

> the HSE has not had a unified system in place to set up reviews in a timely or independent manner. This undermines public confidence, limits learning for professionals and is poor governance on such a serious matter. A system must be put in place.

The summary of actions to be taken in the Ryan Report Implementation Plan includes the following:

1. Action 36: The Health Information and Quality Authority will develop guidance for the HSE on the review of serious incidents, including deaths of children in care and detention.[12] These will be reported to the Authority and the Department of Health and Children (DoHC)/Irish Youth Justice Service (IYJS) (by November 2009). The HSE and IYJS will develop a panel (internal and external) of appropriately skilled professionals to undertake investigations [that is, to carry out the reviews referred to above] (by December 2009).
2. Action 37: In all cases of serious incidents or death of a child in care or in detention centres, the Health Information and Quality Authority will review the initial circumstances and how the HSE and IYJS set about the investigation. It may, in circumstances set out in its guidance, conduct an independent investigation of serious incidents or death (ongoing).

The HSE does not have a national, systematic or standard way of deciding which cases should undergo review and what form a review should take. To date, there have not been any reported deaths of children in the detention schools in Ireland. Serious incidents in the Irish Youth Justice Service (IYJS) are managed using the IYJS serious incident policy and the IYJS child protection policy.

This part of the document (Part 2) will discuss the literature concerning international practice and the strengths and limitations of child death and serious incident review. The final section of part 2 highlights current practice and processes in reviewing child deaths and serious incidents. The combination of international experience and the national context have been used to develop this guidance.

11 Office of the Minister for Children and Youth Affairs (OMCYA) (2009).
12 This guidance will be amended to reflect the Irish Youth Justice Services (IYJS) detention context.

2 International Practice on Death and Serious Incident Review Processes

A review of the literature has highlighted that New Zealand, Australia, Canada, the United States and the United Kingdom have processes in place for reviewing deaths of children including those in care. The first child death review team was developed in the USA in 1978 following increased concern about child deaths as a result of abuse[13] and the under reporting of child abuse deaths[14]. For example, 41% of children who died from maltreatment between 1995 and 1997 in 16 US states had prior or current contact with the system[15].

In general, there are three main approaches and reasons for reviewing deaths and serious incidents relating to children. These are reviews of deaths of all children, individual case review and reviews of governance and accountability. These are outlined below.

2.1 Reviews of all Deaths of Children

These are universal reviews which analyse, monitor and evaluate all deaths of children on a population-wide basis. The information arising from these reviews is analysed and shared to influence and develop programmes to deter or prevent child deaths.

Currently, there is no systematic review of all children's deaths within the wider population in Ireland.

The Ombudsman for Children's Office (OCO) completed a review of international practice with a view to ascertaining how Ireland could learn from experience in other jurisdictions in implementing a comprehensive death review process. The OCO review seminar paper[16] and their options paper[17] highlight questions for consideration by the Government and other stakeholders prior to a population-based child death review process being commenced in Ireland.

However, it should be noted that the Authority's mandate is specifically to develop guidance for the review of serious incidents, including deaths of children in care and detention and therefore a universal death review process does not form part of this guidance.

2.2 Individual Case Review

Individual case reviews outline the specific circumstances leading to the death, or serious incident, and ascertain whether abuse or neglect was a contributing factor to the child's death or serious incident. In some instances, these reviews also address systemic issues. These reviews are completed for children in care, known to the child protection services, or any child in the general population.

13 Hochstadt (2006).
14 Rimsza, Schackner, Bowen and Marshall (2002).
15 Wang (1999).
16 Ombudsman for Children's Office (OCO) (2008).
17 Ombudsman for Children's Office (OCO) (2009).

2.3 Governance and Accountability Review

Governance and accountability reviews are completed to ensure that high standards of governance and accountability are adhered to among professionals and service providers. These reviews are used to determine whether recognised child protection procedures, standards, guidelines and protocols were followed when managing the case and they scrutinise the case management decisions and actions of agencies for their adequacy and appropriateness, in terms of service provision to the child.

Current practice in Australia, New Zealand, Canada, the United States and England and Wales is briefly outlined below. In general, reviews of deaths of children in care are part of a wider system of child death reviews. All the countries surveyed have a system for reviewing deaths and serious incidents but their approach, the driving forces, mandate, scope of the inquiry, composition of the inquiry team, quality of the information systems and arrangements for publishing enquiries vary considerably. However, the international practice does provide evidence of good practice and benchmarks for review processes.

General information concerning international practice in child death review is outlined in Table 1 overleaf and additional specific information in relation to each of the jurisdictions is included.

Table 1 International Practice

Review Processes	New Zealand[17]	Australia[18]			Canada[19]	United States[20]	England and Wales[21]
		Victoria	South Australia	New South Wales	British Columbia		
Legislative Basis	No but makes recommendations to the Minister of Health	No but makes recommendations to the Minister for Children and the Minister for Community Services	Yes	Yes	Yes	No	Yes
Who Completes the Review	Child and Youth Mortality Review Committee	Victorian Child Death Review Committee	Child death and Serious Injury Review Committee	New South Wales Child Death Review Team and Ombudsman	Child Death Review Unit (CDRU) of the BC Coroners Service	State and or local child death review team. In place everywhere except Idaho	Child Death Overview Panel in Local Safeguarding Board Area (LSCB) LCSB also has to consider whether a serious case review should be conducted
What is reviewed	All child deaths	All deaths of children and young people who were child protection clients when they died or within three months of death	All deaths and serious injuries whether or not the child is known to the child protection system	All deaths of children known to the care system or their siblings.	All deaths of children	All child deaths	All child deaths are reviewed by the Death Overview Panel. All child deaths and serious injuries when abuse or neglect is known or suspected to be a factor undergo serious case review

18 Child and Youth Mortality Review Committee (CYMRC) (2008), Scottish Executive.
19 Frederick (2007), Scottish Executive (2005), Calvert (2008), Ombudsman for Children's Office (OCO) (2008).
20 BC Coroners Service (2008), Scottish Executive (2005).
21 Hochstadt (2006), www.childdeathreview.org, Webster et al (2003).
22 Cm (2003), Naughton (2008), Department for Children Family and Schools (2008a, 2008b, 2009).

Review Processes	New Zealand[17]	Australia[18]			Canada[19]	United States[20]	England and Wales[21]
		Victoria	South Australia	New South Wales	British Columbia		
Ages Reviewed in years	between 4 weeks and 24 years			Under 18	Under 18		Under 18
General reporting process	Yes. Yearly report sent to the Minister for Health	Annual Report with quantitative and qualitative analysis which determines whether procedure, standards, guidelines and protocols were followed, scrutinises decisions, actions and service provision in individual cases	Annual Report tabled in Parliament by the Minister Although the Committee includes the review of serious injury, it has not reported on its incidence or conducted in-depth reviews	Annual Report and special themed reports Can comment on the involvement of service providers involved, the actions of individual workers and recommend disciplinary measures. The NSW Ombudsman can present a special report to parliament detailing an individual case	Annual Reports and special themed reports	Different arrangements in different States Goal is to assist families and the child protection services, develop prevention strategies and influence public policy	Studies of serious case reviews published by Department of Children, Schools and Families, Completed reviews sent to Ofsted for evaluation. Ofsted publish their evaluations of serious case reviews

3 Strengths and Limitations of Child Death and Serious Incident Review

Multidisciplinary and multi-agency review processes can reduce the misclassification of deaths, identify specific interventions for surviving family members, develop public policy to address the prevention of child deaths from abuse and improve the systems providing services to children.[12 23 24]

There is an important inter-relationship between measuring and understanding child death and serious injury.[25]

Having a systematic review process allows deaths and serious incidents to be examined consistently and facilitates critical thinking. The UK Department for Children, Schools and Families document *Working Together to Safeguard Children*[26] guidance for serious case reviews states that good day-to-day practice within the health and social services can help ensure that reviews are conducted successfully. This includes:

- establishing a culture of audit and review
- having clear, systematic case recording and record systems in place
- developing good communication between professionals and agencies
- communicating with the local community and the media to raise awareness of the positive and helping work of statutory services so that attention is not overly focused on tragedies
- make sure that staff understand what can be expected in a review.

Reviews may also have a positive impact on day-to-day practice. A culture of accountability is essential to meet the needs of children at risk. While reviews are not the solution to child protection and welfare issues, they support systematic analysis of service provision by service providers themselves and help develop a more balanced understanding of the issues amongst the general public. The Scottish Executive completed an in-depth review of international approaches to child death and significant case reviews[27] and stated that if reviews are to achieve the aims of improving prevention and meeting the needs of children at risk from harm, they should make a specialist contribution to a continuing programme of needs analysis, service design and evaluation.

The World Health Organization[28] highlights that having a comprehensive death and serious incident review process in place for children has not been shown to impact on the number of deaths in a country. In fact, the level of child death through abuse in the countries included has remained largely stable with only minor decreases and shifts in numbers and rankings (WHO 2008 cited in Brandon: 2009). This is illustrated by Gillian Calvert (2008), Convenor of the New South Wales (NSW) Child Death Review Team, who cautions against promoting the underlying assumptions that promote the death

23 Webster et al (2003).
24 Frederick (2007).
25 Brandon (2009).
26 Department for Children Family and Schools (2009).
27 Scottish Executive (2005).
28 World Health Organization (WHO) (2008).

review process as the panacea. She states that the NSW Commission for Children and Young People was set up on the 'untested and unstated' assumption that an outside body retrospectively reviewing the behaviour of staff in relation to a child, the relationships between agencies and the policies and procedures they operate within, would help understand how to prevent deaths of abused and neglected children. Yet, the death rate in NSW from fatal assault remains unchanged.

Some deaths and serious incidents do give rise to systematic concerns, governance issues and enhance our understanding of what makes children vulnerable. In other instances, an individual child's death does not give rise to wider systemic concerns and reviewing these cases will clearly not enhance our understanding in any meaningful way.

The assumptions made about reviews and the evidence to support these assumptions are outlined below: [15 16 26 29]

3.1 An assumption that child deaths are preventable and that you can predict which children will die from abuse. The Scottish Executive (2005) concluded that there is no evidence that child death and significant case reviews directly aid in predicting what children are at risk.

3.2 An assumption that reviewing events leading up to deaths will tell us how to prevent deaths. For example, Brandon's study[30] of 161 serious case reviews of child death and serious injury found that most of these "worst outcome" cases were too complex to be predictable and preventable. Not all fatal assaults are the same and external factors may be more critical such as criminality, domestic violence, poverty and mental health.

3.3 An assumption that reviewing child abuse tells us about the system for protecting children. Other research methodologies and data are available to inform us. Evidence-based practice seeks solutions from what has gone well as well as what has gone wrong.

3.4 Child deaths occur too infrequently to effectively measure their impact on child welfare services and policies. Fish, Munro and Bairstow[31] among others question the value of inquiries into single deaths since they repeatedly identify the same problems in practice and make similar recommendations.

3.5 Building a child protection system based on a review of child deaths and serious incidents, is designing based on the exception rather than typical experience. While positive change can occur following experience of individual cases, it is important that policy is not driven by exceptions but typical instances.

3.6 It can shift the system from learning from error to blaming for error.

29 Calvert (2008).
30 Brandon (2009).
31 Fish, Munro and Bairstow (2008).

The Scottish Executive highlighted that there is no perfect universal model of death and serious incident review and concluded that it is better to identify the conditions that have to be met in order to implement an effective system rather than suggesting a series of ad hoc changes.

Many of the procedures for conducting child death and serious incident reviews are particular to historical and professional contexts in a country and these cannot be directly applied to another country. The following section looks at current practice and contextual issues in Ireland.

4 Review of Existing Arrangements Following Deaths and Serious Incidents in Relation to Children in Ireland

Currently, child death and serious incident reviews do not take place routinely in Ireland. There have been a small number of published inquiries into children's deaths including; the Kelly Fitzgerald Inquiry (1996) and the Dunne Family Inquiry Monageer (2009).

There are two published inquiries into individual cases of child abuse: the Kilkenny Incest Case (1993) and the West of Ireland Farmer Case (1998). There have been inquiries into child abuse in sport (1998), into residential care [the Madonna House inquiry (1996)], into medicine [Dr A. report (2008)], into clerical sexual abuse [the Ferns Inquiry into clerical abuse (2005), Report by Commission of Investigation into Catholic Archdiocese of Dublin (2009)] and the recently published Report of the Commission to Inquire into Child Abuse (2009). Other reviews have been undertaken regionally by the HSE but their findings have not been made public. All of these reports are listed at the end of the bibliography.

There is no standardised, national, independent or transparent system for the review of deaths and serious incidents in relation to children in care and known to the child protection system in Ireland. The guidance in part 1 provides for a standardised national, transparent and independently monitored system for reviewing deaths and serious incidents in relation to children in care and known to the child protection system in Ireland.

Currently, there are 16 different agencies with mandates and functions relevant to child death review in Ireland (Appendix 1). In other jurisdictions, deaths and serious incidents of children in care are completed as part of wider child death and serious incident review processes. The Ombudsman for Children has recommended that a universal child death review mechanism should be considered in Ireland. Both the coroner and the HSE have a direct role in reviewing the deaths of children in care and detention and their respective roles are outlined below. The HSE has the responsibility for reviewing serious incidents.

4.1 Role of the Coroner

In Ireland, legislation is in place to ensure that all sudden, unexplained, violent and unnatural deaths should be reported to the Coroner Service. If the death is due to unnatural causes, an inquest should be held. An inquest should also be held for all deaths of children in the care of the State. The purpose of the inquest is to establish the facts surrounding the death and to place those facts on the public record, to make findings on the identification of the deceased, the date and place of death and the cause of death. A general recommendation designed to prevent a similar death occurring may be made by the coroner or jury. The new Coroner's Bill also provides that coroners may make recommendations and that Departments of State and public bodies will be obliged to respond to those recommendations within particular timeframes.

4.2 Role of the HSE

The HSE provides child protection and welfare services, in accordance with legislative obligations, to promote the welfare of children not receiving adequate care and protection and national policies and guidelines, which inform and support the provision of services.

The Ombudsman for Children [15] [16] outlines that both the HSE Incident Management Policy and Procedure[32] and *Children First: National Guidelines for the Protection and Welfare of Children*[33] have direct relevance to child death and serious incident review and are outlined below. However, they are not employed systematically or consistently in the Irish system.

4.2.1 HSE Incident Management Policy

The HSE Incident Management Policy states that all managers should monitor incidents and how they are managed, to allow the HSE as a whole to learn from incidents and continually improve their services. The HSE Incident Management Procedure has five phases; identification, immediate management, reporting, incident investigation and closing the incident management loop. The five phases are relevant but the incident investigation phase, and closing the incident management loop, have particular relevance to this guidance. The HSE also has a Serious Incident Management Procedure. These policies and procedures have relevance for managing deaths and serious incidents relating to children in care and known to the child protection system.

Specific guidelines for child death and serious incident review in relation to this policy and procedure will need to be developed internally. The governance and management structure, and the roles and responsibilities outlined in the policy, should ensure that the reviews of all incidents are completed to the required standard in a timely fashion, conclusions are reached, actions identified, a designated person is responsible for actions and that these actions are completed within the timeframes for implementation.

32 Health Service Executive (HSE) (2008).
33 Office of the Minister for Children and Youth Affairs (OMCYA) (2009).

4.2.2 Children First: National Guidelines for the Protection and Welfare of Children

The primary guidelines for child protection, *Children First: National Guidelines for the Protection and Welfare of Children*, were first published in 1999. In 2005, the Office of the Minister for Children and Youth Affairs (OMCYA) undertook a national review of compliance with Children First. The OMCYA[34] found that, in general, difficulties and variations on the implementation of the guidelines arose due to local variation and infrastructural issues rather than from fundamental issues with the Children First guidelines themselves. This is probably due to the fact that the Children First guidelines were implemented in the former health board structure, which consisted of 10 individual health boards. A standardised business process addressing implementation issues has recently been completed internally by the HSE, the single entity which replaced the health boards.

The OMCYA published a revised edition of Children First in December 2009 as outlined in the Ryan Report Implementation Plan [10]. The revised edition of Children First (2009) make provision for strategy meetings, child protection conferences and child protection reviews for individual case management purposes. The revised Children First also includes provision for serious incident reviews which provide a system wide review of the functioning of the child protection system.

In Children First (2009), a serious incident review is defined as follows:

> A serious incident review is a review of the response, manner and quality of services provided to children and families. The purpose of the review is to learn lessons from the handling of specific cases so that deficits in the system can be addressed.

Children First (2009) states that a serious incident review should be carried out in the following circumstances:

- when the case of suspected or confirmed abuse involves the death of a child in care or known to the child protection services
- when the case of suspected or confirmed abuse involves the serious injury of a child in care or a child known to the child protection services
- when a child protection issue arises which is likely to be of significant public concern.

Children First (2009) outlines the specific objectives of a serious incident review, which include:

- to establish the facts of the case
- to assess decision-making and interventions made in the case
- to check whether necessary procedures have been followed
- to check whether services provided were adequate and appropriate
- to make recommendations in light of the findings.

34 Office of the Minister for Children and Youth Affairs (OMCYA) (2008).

In addition, Children First (2009) states that the Health Information and Quality Authority may undertake a separate investigation as set out in Section 9 of the Health Act 2007.

The Minister for Children and Youth Affairs has given a commitment to legislation being drafted to ensure that all staff employed by the State and in agencies who are in receipt of state funding will have a duty to comply with the Children First guidelines, share information in the best interests of the child and a duty to co-operate with relevant services in the best interest of the child by the end of 2010.

4.3 Conclusion

Employing the already existing structures and systems would maintain accountability, consistency, good governance and learning within the system and facilitate optimal use of staffing and fiscal resources.

Both the HSE Incident Management Policy and Children First are already in place in the HSE. These should support a safe and effective system for reviewing serious incidents, including deaths of children in care if they were employed systematically and consistently throughout the organisation.

The Ryan Report Implementation Plan (OMCYA: 2009) states that the Authority will develop *National Quality Standards for the Child Protection Services* and this guidance on the review of serious incidents including deaths of children in care will be included in these national standards.

Robust local and national child protection structures and systems are required to provide a standard, unified, independent and transparent system for the review of serious incidents including deaths of children in care in Ireland.

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Appendix 1
Inventory of organisations with mandates and functions relevant to child death review

Central Statistics Office

Coroner Service

Economic and Social Research Institute

An Garda Siochana

Garda Siochana Ombudsman Commission

General Register Office

Health Information and Quality Authority

Health Research Board

Health Service Executive

Irish Human Rights Commission

Irish Youth Justice Service

National Sudden Infant Death Register

National Suicide Research Foundation

Office of the Director of Public Prosecutions

Office of the Minister for Children and Youth Affairs

Office of the Ombudsman for Children

Royal College of Physicians in Ireland-Faculty of Paediatrics

Appendix 2
Information to be provided to the Health Information and Quality Authority's Social Services Inspectorate by the Health Service Executive at Initial Notification

SSI should be notified **within 48 hours** of the death or serious incident occurring. The following information should be provided and future reports returned to:

Serious Incident Review (Child Protection and Welfare), Social Services Inspectorate, Health Information and Quality Authority, George's Court, George's Lane, Smithfield, Dublin 7.

Child's name: Date of birth:	
Child's address:	
Brief history of involvement with the child protection services:	
Care status and placement details if relevant:	
Length of time in present care arrangement:	
Brief details of circumstances surrounding death or serious incident (including date and place):	
Plan for review:	
Signed: Title: Contact details: Date:	

For further information please contact:

Health Information and Quality Authority

Unit 1301, City Gate,
Mahon,
Cork
T: +353 21 240 9300
E: info@hiqa.ie
URL: www.hiqa.ie