



**NIRP** National Independent  
Review Panel



**SBNI**  
Safeguarding Board  
for Northern Ireland

# Learning when things go wrong

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**National Independent Review Panel (NIRP))**

**Safeguarding Board for Northern Ireland (SBNI)**



## Two roles

1. Independent Chair safeguarding Board NI (Children)
2. Independent Chair National Independent Review Panel Republic of Ireland (Adults)

# SBNI Interagency Partnership

“Provides a mechanism for member agencies to work together and to co ordinate their activities for safeguarding purposes”

SBNI Regulations 2012



# Independent Chair

The SBNI chair is independent of the member agencies and has a line of accountability through the Minister to the NI Assembly



# Case Management Reviews

One of the key statutory functions of the SBNI is to carry out a review of cases where things have gone badly wrong, where a child/ren known to agencies have died or been significantly harmed



## **National Independent Review Panel (ROI)**

Was set up in the aftermath of the 'Grace' case  
in the Republic of Ireland to provide an  
independent mechanism to review the most  
serious cases  
(Non statutory and single agency)

# National Independent Review Panel

The independent Chair reports directly to the  
chair of the HSE Quality and Risk Committee

## Why do we need independent reviews?

- Service improvement/quality
- Increase public confidence in the services
- Standard infrastructure for reviews
- A safe mechanism within the system
- Increase support for staff
- Encourages reflection
- Strategic oversight





## What they should not be about

- Public humiliation
- Criminal investigation
- Disciplinary action

## NIRP Mission

The NIRP is committed to **promoting learning** and **best practice** by reviewing cases in a professional and timely manner, with a view to assisting the social care sector to **improve its services** and **prevent** similar situations occurring in the future.

## Purpose of any review





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# Purpose

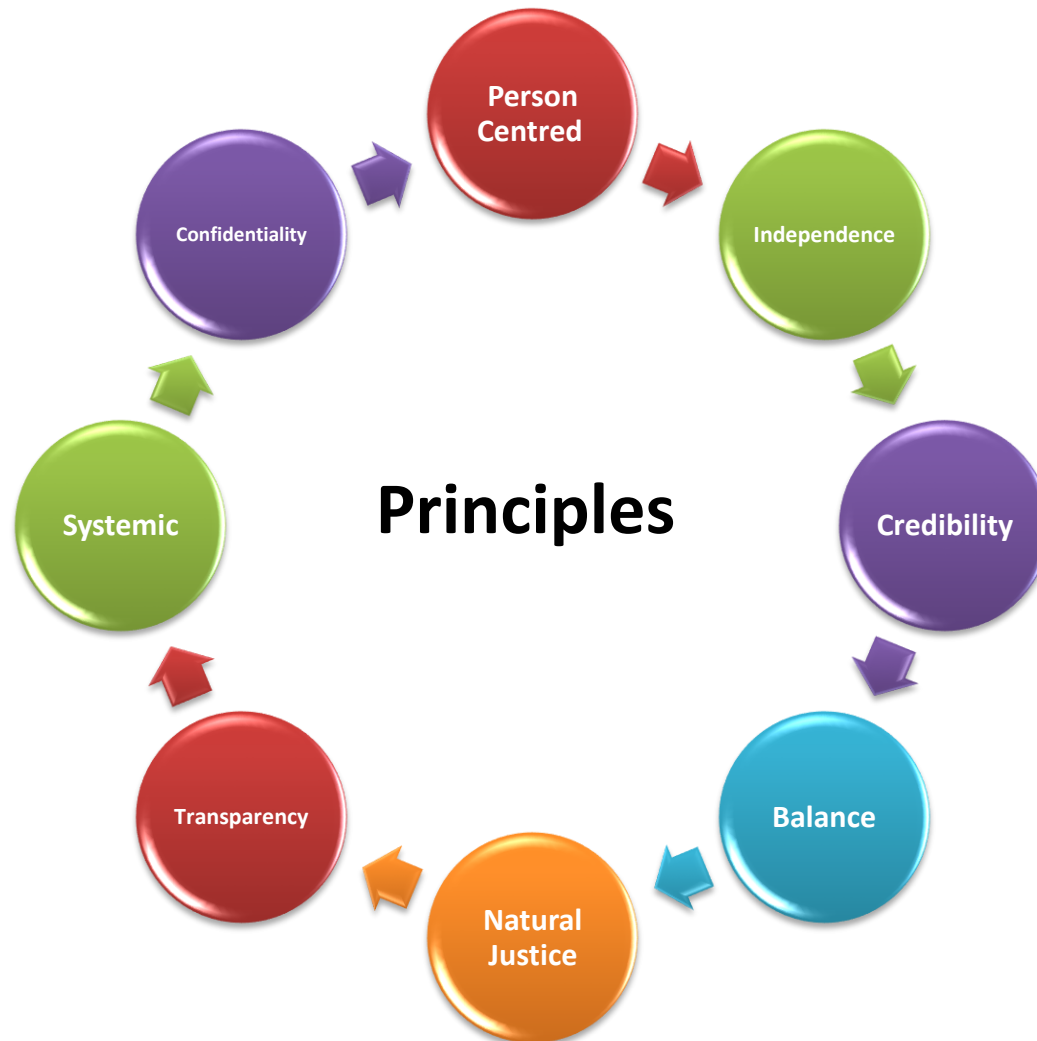
**The focus is person centred**

**The goal is to find what went wrong and why**

**The outcome is to identify potential for change**



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## Key issues

- How do you avoid a blame culture?
- How do you protect the privacy and dignity of the service user and their families?
- How to you manage expectations of various stakeholders?
- How do you share the learning?



## Other processes

- Accountability
- Discipline
- Criminal prosecution





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# NIRP Review Process



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2018

# Incident Management Framework

Care | Compassion | Trust | Learning



Seirbhís Sláinte | Building a  
Níos Fearr | Better Health  
á Forbairt | Service

## Criteria for Notification

**Category 1 Major/Extreme**

**SIMT has been established**

**Child/Adult Social Care service user**

**HSE/HSE funded services**

**Potential systemic failings**

**Concern is enduring**

**Potential for breakdown in public confidence**

## Criteria for Review

**Social care service users**

**HSE/HSE funded services**

**Potential significant failings**

**Risk for public concern**

**Opportunity for widespread learning**



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## **Review Plan**

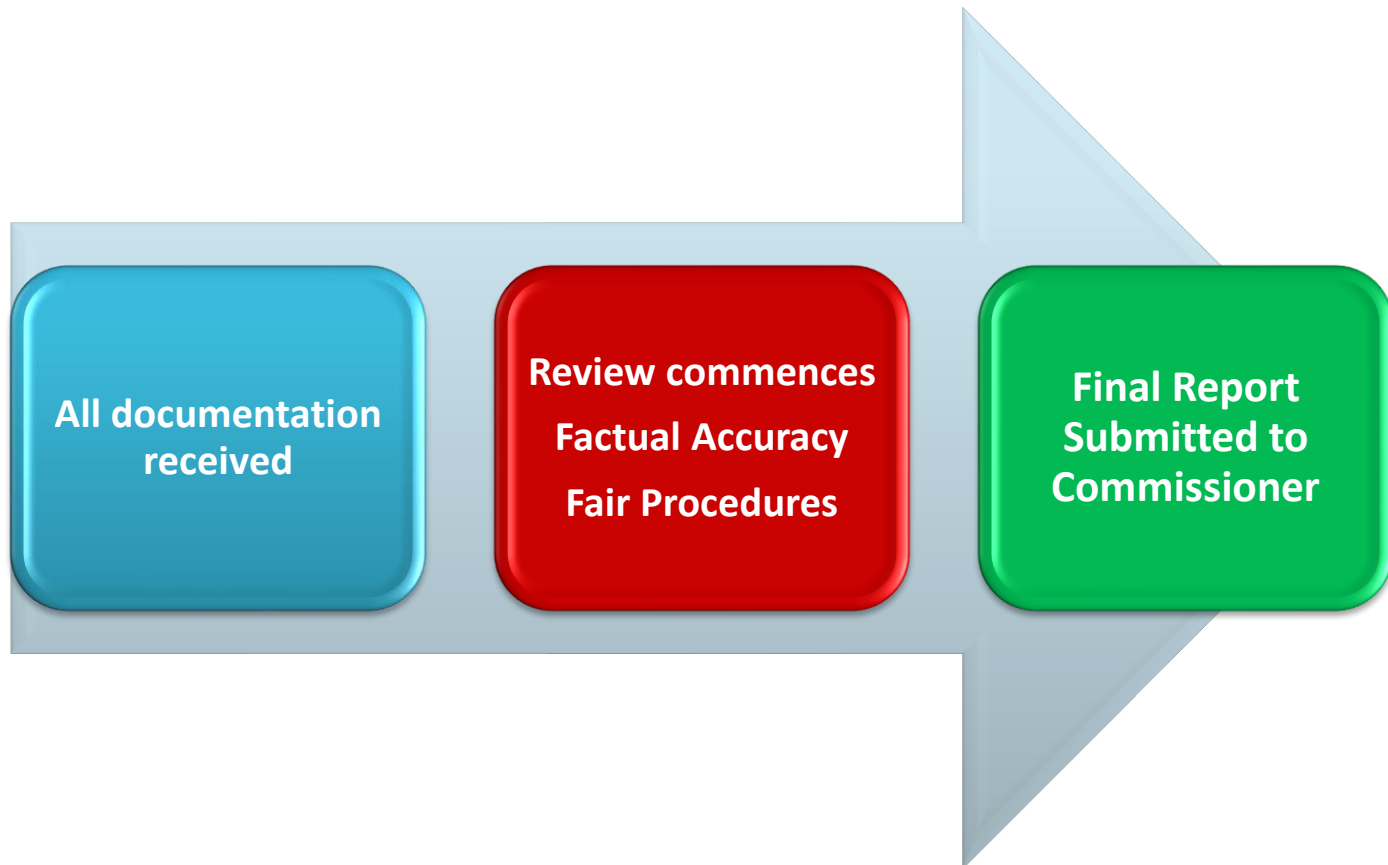
**Terms of Reference**  
**Scope**  
**Timescale**

**Methodology**  
**Roles**  
**Other Processes**

**Consent**  
**Person Centred Review**  
**Family Involvement**

**Confidentiality**  
**GDPR**  
**Escalation**

# Timeframe





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# The Report

Layout

Dissemination & Publication

NIRP Register

# Thank You