Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a baby whose family had contact with Tusla

Executive Summary

Elise

June 2023

1. Introduction

This case refers to a baby, here named Elise who died following a serious accident when she was three and half months old.

2. Background Summary

Elise was the only child of her parents, who had been living together for two years. Her father had a history of substance misuse and criminal activity. Elise was born prematurely and the case was first referred to the Tusla SWD because the hospital was concerned that her mother had not been visiting regularly. Having investigated it, the SWD closed the referral as no concerns were apparent.

A further referral was made soon afterwards which concerned an allegation of child sexual abuse made a few years earlier against Elise's father in another area. The investigation of this allegation had been closed but was likely to be re-opened at that point. A social worker was allocated to follow this up and requested information from the second area. The allegation was denied by the family but they nonetheless agreed a safety plan to protect Elise from any risk of sexual abuse. An initial assessment was ongoing at the time of Elise's death two months later, at which time her father was serving a prison sentence for an unrelated offence. There were no concerns at this time about Elise's day to day care and she was being visited regularly by the public health nurse who was monitoring her weight. The allocated social worker had some difficulty meeting Elise's parents and for that reason the initial assessment had not been completed by the time of Elise's accidental death. The social worker made further requests for information about the child sexual abuse allegation from the area where it was made but had not received this by the time of Elise's death. It appeared that no risk assessment had been carried out by that area after the allegation had first been made.

3. Review Findings

The review found that the SWD had responded appropriately to referrals. It also found that there was good interagency communication and management oversight. The SWD instituted a safety plan to protect her when informed of a potential risk but was hampered in progressing the assessment due to the reluctance of her parents to meet the allocated worker. Despite repeated requests, the lack of information from the area where the child sexual abuse allegation against Elise's father had arisen also delayed its completion. The reviewers believe that an assessment should have taken place in that area in order to establish any risk that Elise's father may pose not just to her but to other children. In

the experience of the NRP, there appears to be some inconsistency between areas about the completion of risk assessments of persons subject to allegations of child sexual abuse when the child and the alleged perpetrator live in separate administrative areas.

13. Conclusions

The review has reached the following conclusions:

- The SWD responded appropriately to the referrals that they received and put a detailed safety plan in place to protect Elise which was monitored albeit limited by difficulty contacting her parents.
- The SWD was hampered in completing their initial assessment in a timely way by the lack of information about the child sexual abuse allegation from the area in which it had arisen.
- The reviewers note that the policy whereby risk assessments on persons subject to abuse allegations are conducted in the area in which the alleged perpetrator resides was inconsistently implemented during the period under review.
- Although the potential and immediate risk to Elise and other children was removed once her father was incarcerated, the fact that the allegation had not been dealt with meant the issue would have been still outstanding following his release.

14. Key Learning Points

This report has attempted to reflect on the challenges faced by the family and the staff who worked with them. The review team consider that there are areas where lessons can be learnt.

- This case highlights the challenges that can occur when allegations by victims are made in one area and the alleged abuser and other children at potential risk are being dealt with by a different area. On the basis of the evidence available to the review, there is a need for greater clarity about the need to exchange detailed information about the allegations in a timely way in order for the appropriate services to be provided.
- Elise's parents were evidently difficult to contact. Professionals need to be aware that disguised compliance can be at play when parents and carers appear to be co-operative in order to assuage concerns and hinder professional involvement (Reder et al, 1993). The NSPCC suggest that professionals should establish facts and gather evidence about what is actually

happening or has been achieved. They recommend that unannounced visits can be helpful in conjunction with pre-arranged visits[1].

15. Recommendations

The reviewers are aware that the new CASP policy has been in operation in Tusla for many months and that it outlines the same process as previously for responding to allegations when the alleged victim and alleged perpetrator live in different administrative areas. The NRP recommends that when the operation of the new policy is reviewed, the level of adherence to this aspect of the policy is examined.

Dr Helen Buckley

Chair, National Review Panel

[1] https://learning.nspcc.org.uk/media/1334/learning-from-case-reviews_disguised-compliance.pdf