



National Review Panel

**Review undertaken in respect of a serious incident relating to a
young person in the care of HSE/Tusla**

Alannah

Executive Summary

Resubmitted: April 2025

1. Introduction

This case refers to a young person, here called Alannah who was in the care of HSE/Tusla. This case was reviewed by the National Review Panel due to a serious incident whereby Alannah was sexually assaulted by the male carer with whom she had lived for a number of years. She was a teenager at the time.

2. Background Summary

When Alannah was a pre-teen, she was placed, along with siblings, in the care of extended family who were later approved as relative carers. It was known at the time of the placement and fostering assessment that the male carer had a number of historical criminal convictions largely related to incidents that occurred when he was under the influence of alcohol. He had attended counselling about his alcohol use which he claimed was under control and his partner confirmed that it was no longer a problem. The other checks undertaken with his GP and referees were all positive. Alannah did well in care over the following years. She had an allocated social worker who maintained intermittent contact and the family had a fostering link worker. Child in Care Reviews took place as did a review of the foster carers. It was noted that the social work department was under serious pressure at the time with staff shortages.

When Alannah was in her teens, the prospect of her return to her mother was seriously considered but due to concerns about her mother's boyfriend, a risk assessment was to be undertaken. While this was being arranged, the incident that is the subject of this review took place. Alannah was raped by her male carer at home while her female carer and the other family members were away. He was under the influence of alcohol at the time. Her female carer was supportive in very difficult circumstances and assisted her to get the appropriate services.

At this point, Alannah and her siblings returned home to her mother and refused to consider any other placement options. A safety plan was put in place by the SWD, but it was not clear how well this was monitored over time. An assessment concluded that her mother's boyfriend presented low risk but that safeguards were to be put in place. Some questions were later raised about the adequacy of this assessment. Alannah's mother also agreed to undertake a parenting capacity assessment by an independent agency which ultimately concluded that she could successfully parent the children with supports. Although some of the following years were stressful for the family, particularly at the time of the criminal court hearing, it was a relief for them when the carer was convicted. In the circumstances, Alannah and her family coped well.

Once she reached adulthood, Alannah received aftercare services but was initially refused an aftercare allowance from Tusla. On appeal, this decision was overturned and this allowed Alannah to move away from home to study which was a positive experience for her. She was very determined to pursue higher education and live her life to the full.

3. Review findings

The review found that the serious sexual assault to which Alannah was subjected whilst in the care system had a profound impact on her and her family as well as all staff who worked with her. The reviewers are also aware that this serious incident has elicited a lot of reflection of all involved. It is important to note the historic nature of the review and that the SWD for much of the period covered by the review were operating in an environment of serious staff shortages with a significant number of vacancies which resulted in gaps in service delivery. There was also a lack of administrative support available to staff. However, it is incumbent on the review team to point out shortcomings in the service provided to children and families. The review team have reached the following conclusions:

- When Alannah and her siblings were removed from home, the SWD tried to ensure that their needs would be met by their placement with family members.
- Whilst acknowledging the benefit of hindsight, the reviewers conclude that an overly optimistic view was taken during assessment and foster care approval of the male carer's alcohol consumption and its potential impact. His history should have raised serious doubts about his suitability to be approved as a relative carer.
- As time went on, insufficient supervision and support were available at times to the relative carers following the children's placement with only limited contact maintained. There was a failure to fully address issues that were identified in the review of the carers.
- There were a number of shortcomings in compliance in relation to the SWD's adherence to The Child Care (Placement of Children with Relatives) Regulations 1995 and the National Standards for Foster Care (2003).
- There was a delay in the completion of assessments in relation to the children's return home and in relation to the relative carer following the allegations of sexual abuse.
- The reviewers believe that when Alannah and her siblings returned to their mother's care, they should have been responded to under Children First Guidelines as there was insufficient assurance at the time that they were not at ongoing risk of significant harm.
- The provision of a social work service to both families was variable in nature. There is evidence that Alannah was offered a good aftercare service.

- Information exchange was fragmented in a small but significant number of instances, resulting in important information being inadvertently withheld.
- The decision not to award the aftercare allowance to Alannah initially, whilst in keeping with the policy at the time, showed a lack of flexibility and understanding of the trauma that she experienced whilst in the care of Tusla.
- The SWD offered a number of services to support Alannah and her family in the immediate, medium and long-term but she and her family were not always open to engaging with these services.
- Notwithstanding the deficits outlined above, the reviewers conclude that the incident that gave rise to this review, namely the serious sexual assault of Alannah who was in the care of the state, could not have been predicted by any of the services involved with her.

4. Learning points

The NRP is aware that the serious incident under review in this report took place several years ago, and that a number of significant reforms have been introduced into the child protection and welfare system in the interim. Some of the deficits identified in this report have been at least partially addressed through these reforms and the recommendations below are made in this understanding. However, the findings of this review also pertain to practice and the following areas of learning for practice are addressed below.

- Burns et al. (2021)¹ highlight that there is a lack of a formal structure for oversight and review of private care arrangements in Ireland which may result in children being placed in inappropriate placements. These authors note that such placements may receive little or no supervision from state agencies and are likely to be in receipt of fewer supports and services than formal care placements. Burns et al. also argue that private family arrangements place children in a precarious legal position due to the absence of legally based contact arrangements and placement stability. In addition, the family carers are largely responsible for meeting the financial burdens associated with such arrangements. This is relevant as Burns et al. refer to some studies of informal kinship care internationally and found that poverty is associated with such care (MacDonald *et al.*, 2018). Burns et al. argue that the reliance by state authorities on private care arrangements care is an abdication of their responsibility

¹ Burns, K., O'Mahony, C. and Brennan, R. (2021) Private Family Arrangements' for Children in Ireland: The Informal Grey Space In-Between State Care and the Family Home *The British Journal of Social Work*, Volume 51, Issue 4, June 2021, Pages 1203–1220, <https://doi.org/10.1093/bjsw/bcab032>

under Article 8 of the European Convention on Human Rights (ECHR) and related case law to put in place measures that will support the possibility of reunification of the child with his or her natural parent(s). Finally, young people turning eighteen in such placements are disadvantaged as they have no entitlement to aftercare supports under the Child Care (Amendment) Act 2015 given that they are not in state care.

- The assessment of foster (relative) families must be a comprehensive and thorough process that involves all family members². A detailed evidence-based report which includes information from a number of different sources should be compiled by the assessing social worker. All identified concerns need to be fully explored. The report should clearly identify and analyse the family history, current circumstances, their skills and ability to meet the criteria as set out in the National Standards for Foster Care (2003) and the HSE Foster Care Committees Policy, Procedures and Best Practice Guidance (2014). The Foster Care Committee, if granting approval, should set out the conditions that govern approval. Any plan by the SWD to vary these conditions should be presented to the FCC for their consideration.
- Following the placement of a child or young person there is a need for regular and frequent visiting by their allocated social worker in order to build a good working relationship. From time to time, children should be seen on their own as appropriate although it is acknowledged that some may be resistant to this which may in turn lead to their increased vulnerability. Therefore, it is important that workers take the time to build trust and to facilitate young people to be actively involved in making decisions about their own lives as far as possible. While children may not always feel able to disclose any concerns, the opportunities for them to confide in workers are greatly reduced if visiting is infrequent or the environment is not conducive to sharing sensitive information. Ultimately, the protection of children in foster (relative) care from harm will depend on the quality of practice delivered by the agency that places them. The special vulnerabilities of children in care must always be to the forefront. Allegations of serious concerns and abuse and neglect of children in foster (relative) care should be addressed under *Children First, National Guidance for the Protection of and Welfare of Children 2011* and the National Standards for Foster Care (2003).

² Williams, D. and O'Donohoe, S. *Recognising and Supporting the Birth Children of Foster carers in the Fostering Process. Messages, Challenges and Opportunities.* http://www.ifca.ie/files/6714/8094/7565/Recognising_and_supporting_the_birth_children_-_Williams_and_ODonohoe.pdf; Höjer, I, Sebba, J, and Luke, N. (2013) *The impact of fostering on foster carers' children an international literature review*; Irish Foster Care Association. *Safe Care An information booklet on safe care in foster care.* http://www.ifca.ie/files/5214/2653/7780/IFCA_Safe_Care_Booklet.pdf; Tusla (2014) *Alternative Care Practice Handbook*

- Following placement of a child, the allocated fostering link worker should ensure adequate support to the foster family and supervision of the foster placement is in place. Link workers should ensure that they meet with individual family members (including birth children) of the carers from time to time. Visits should address the impact of fostering on family dynamics as well as the practical day to day issues. Foster carers' professional development should be reviewed regularly by the fostering link worker and on-going attendance at training should be required, especially in relation to safe care and challenging behaviour. O'Brien (2015)³ identified particular challenges in relation to relative/ kinship care including receipt of fewer services, namely support, supervision and training, when compared to non-kin foster carers and in managing intra-familial dynamics. Biehal (2014)⁴ has also highlighted circumstances in which carers need additional high-quality supervision and support such as when there are numerous children in the household.
- Robust reviews of foster carers should be carried out in accordance with the National Standards for Foster Care (2003). Such reviews will help to ensure that all family members are fully supported in the fostering task and that on-going evaluation occurs. Practitioners need to be clear about the different roles and areas of responsibility for link workers and children's social workers and to ensure that the recommendations of such reviews are carried out in a timely fashion with regular audits taking place to ensure same.
- It is important in cases of child sexual abuse that the SWD and An Garda Síochána work closely together and share information in a timely fashion to ensure that each agency can fulfil their functions appropriately and without delay. Such contacts need to be fully recorded in the records.
- The NRP understands that an integrated model for the investigation, assessment and management of child sexual abuse allegations in order to prevent repetitive interviewing of children across different agencies and to provide ease of access to medical and therapeutic services is being introduced in a number of regions. For this to become effective decisions taken regarding case management should emanate from a consensus approach that is sensitive to the needs of abused children and their carers and is respectful of the uniqueness of each child and family.
- Whilst substantiated abuse of children in foster care is rare, it is important to acknowledge that it can take place even when the placement appears successful or when children appear

³ O'Brien, V. (2015) Formal and Informal Kinship Care: Complexities, Dilemmas and A Way Forward in *Ensuring the Rights of the Child and Family Centred Services*. p174-191.

⁴ Biehal, N. (2014) Maltreatment in Foster Care: A review of the evidence. *Child Abuse Review*, 23:48-60

happy and settled. While there is some evidence that suspected abuse in foster care comes to official attention more frequently than abuse in the community because of the surveillance involved in foster care, there is also evidence to show that social workers can be over optimistic about the quality of care provided by reputable foster carers, and that professionals sometimes avoid facing up to the implications of concerns that are raised. An American study found instances of perceptual blocks by social workers who were under pressure because of large caseloads and avoided facing up to the seriousness of abuse allegations because of the dearth of available alternative placements for the children concerned⁵.

- Research shows that it is not unusual for non-offending caregivers, mothers in particular, to find it difficult to accept that someone they love was abused by someone also close to them. Common reactions are confusion, anger, depression, self-blame and disbelief⁶. This can be for many reasons, often to do with the context of their lives⁷. Inappropriate and sometimes ambivalent responses by mothers are explained by the losses they experience; their loss of identity and self-esteem as good parents, their loss of standing within their families and communities and the loss of their child's innocence⁸. The tendency for mothers to project their guilt in the form of anger against professionals has also been identified⁹. It is suggested that their own experiences and responses should be acknowledged and that over time, assistance in the process of grieving should be provided.
- The NRP is aware that there is now a robust aftercare policy in place. It is important that there is a timely referral to aftercare services when a young person is 16 years old so that the aftercare workers can build a relationship with the young person, their families and current services to assist in assessing need and planning for the future. There is a need for greater flexibility in relation to the granting of the aftercare services and allowances.
- Research has shown that birth parents can feel unsupported by the child welfare system. The relationship between parents and social workers can be affected by a number of factors such as their early life experiences, experiences of mental illness, substance abuse, social marginalisation, perceptions of power and authority, and feelings that they are unable to

⁵ dePanfilis, D, Girvin, H (2005) Investigating child maltreatment in out of home care: Barriers to effective decision making. *Children and Youth Services Review: 27* (4):353-374

⁶ Plummer, C.A. (2006) 'Non-abusive mothers of sexually abused children: the role of rumination in maternal outcomes. *Journal of child sexual abuse, Vol.15*

⁷ Alaggia, R. (2001) Cultural and religious influences in maternal response to intrafamilial child sexual abuse: Charting new territory for research and treatment. *Journal of Child Sexual Abuse, Vol. 10,*

⁸ Hooper. C. A. (1992) *Mothers surviving child sexual abuse.* Tavistock.

⁹ Serin. H. (2018) 'Non abusing mothers' support needs after child sexual abuse disclosure' *Child and Family Social Work.*

cope. Models of interventions such as motivational interviewing and solution focused approach may prove helpful ¹⁰.

- Low levels of engagement with child welfare services from fathers has been identified in studies as an issue resulting in limited resources for children's care and possibly poor assessment and management. Whilst there is limited evidence about what works in engaging men, there are some encouraging pointers from family support and child protection practice contexts. These include early identification and early involvement of fathers; a proactive approach, including an insistence on men's involvement with services; and the use of practical activities¹¹.
- Good record keeping is an integral and important part of social work practice. This case has highlighted the importance of good recording which provides an accurate and timely record of all aspects of a case. The benefits of good recording include records of events in children's lives as well as providing assistance in the assessment, planning, decision-making and review of practice. Other benefits are noted in the Alternative Care Practice Handbook (Tusla, 2014). Research has shown that recordkeeping practices have an impact on client outcomes such that poor case notes can result in poor decision-making and adverse client outcomes (Preston-Shoot 2003)¹².

5. Recommendations

The review team has made the following recommendations:

- Tusla need to consider developing a policy and guidance in relation to private care arrangements
- This is not the only case where the NRP was not notified of a serious incident in a timely fashion. There is a need for greater clarity in SWDs in Tusla about what constitutes a notifiable serious incident.

Dr Helen Buckley

Chair National Review Panel

¹⁰ Robb. L. (2014) Resistance, a complex challenge for practice, WithScotland.org

¹¹ [Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. and Tolman, R.](#) Engaging fathers in child welfare services: A narrative review of recent research evidence.

¹² Preston-Shoot, M. (2003) A Matter of record? Social Work in Action, Vol., 2003 – 3 pp. 31-50