Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

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

Rosa

Executive Summary

Resubmitted: April 2025

1. Introduction

This case refers to a child, here named Rosa. Rosa had been known to Tusla services since birth and was listed on the Child Protection Notification System (CPNS). The SWD in Area A's involvement with Rosa and her family spanned about 15 months in total. Rosa was six months old when the family moved to another jurisdiction and the SWD in Area A continued a remote monitoring and handover process for a further six months. Following this it appears that her mother, here named Ellie gave birth to another child and went on form another relationship with a new partner. Rosa died when she was two years old following an assault which was the subject of a criminal investigation where she then lived.

2. Background Summary

Rosa was one of a number of siblings. Her mother, Ellie, had a difficult childhood and gave birth to her older children when she was a teenager. During this time, Ellie had faced a number of challenges including poor mental health, alcohol misuse and domestic violence which resulted in the children's admission into care. She later met Tim, Rosa's father who also had a troubled childhood. He had a history of cannabis use and had been charged with possession of a knife.

Tim and Ellie's relationship was described as a positive one but when Ellie was six months pregnant with Rosa, she was referred to the SWD by the maternity unit because of her history. A child protection conference held just after Rosa's birth concluded that although she was healthy and being well cared for, Ellie's previous history including her inconsistent engagement with services, together with the couple's history of volatility and their housing difficulty were risk factors. Rosa's name was listed on the CPNS. A child protection plan was drawn up, outlining specific goals and actions with time scales. The case records show that Social Worker 3 visited the family on a regular basis. He noted that despite the cramped living conditions, Rosa was thriving and appeared to be well fed and well clothed. Over the following months, housing continued to be a problem for the family including several moves and a short stay in Area B.

When Rosa was four months old, a review child protection conference took place and was attended by the relevant services. The conference had been brought forward due to the concerns about housing. A safety plan was completed and addressed plans for Rosa to stay with relatives should the family become homeless. The reviewers note that the action agreed at the first child protection conference to hold a network meeting had not happened, nor was it referred to at the review conference. It was concluded that the instability in their housing situation was stressful and a potential risk to their

emotional equilibrium. For this reason, the conference recommended that Rosa's name should remain listed on the CPNS until the family's housing became more permanent.

When Rosa was six months old, Ellie informed the SWD that she was pregnant again and shortly afterwards the family moved to Area C in another jurisdiction. Social Worker 3 made contact with social services in Area C regarding transfer of the case and requesting a welfare visit to be undertaken in the interim on the basis that Rosa's name was on the CPNS. The Area C SWD advised that a transfer of the case would only be considered when the family had been living in their area for three months. They agreed to carry out a welfare check in the meantime but were unsuccessful. In the meantime, Social Worker 3 kept in contact with the Ellie and Tim, however it is not known whether there were further attempts from the SWD in Area C to meet with the couple.

When Rosa was approximately seven months old, the Area C health visitor visited the family and reported that that Rosa was doing very well and that the family were settled. A supervision record between Social Worker 3 and Team Leader 2 notes a request for Social Worker 3 to conduct a pre-birth assessment in relation to Ellie and Tim's unborn child. However, shortly after this Social Worker 3 left the department. Social Worker 4 was allocated to manage the transfer of the case to the new SWD. Social Worker 4 maintained telephone and text contact with Ellie and Tim and also liaised with the Area C health visitor. Just prior to the formal transfer, Social Worker 4 left the department and Social Worker 5 took over the transfer process but does not appear to have had any contact with the family. Overall, there is limited documentation on file in relation to how this case was transferred to Area C.

Shortly before Rosa's first birthday and about five months after the family moved to Area C, a final child protection conference was held via video conference. This served as a formal transfer of the case. The conference was attended by both parents and some of the relevant professionals from both areas. Rosa had continued to thrive and the couple's housing situation, although temporary, was secure. This was a significant improvement in their situation which led to the decision that the family would be considered a 'welfare support client' and would not be registered on the child protection system in Area C. The case was then closed in the SWD in Area A and Rosa's name was removed from the Child Protection Notification System there.

The NRP was notified of Rosa's death following an assault when she was two years old. It appears that Ellie, who by now had another child, had separated from Tim, and had become involved in a new relationship during the intervening period.

3. Review Findings

The review found that the initial referral to Tusla was responded to promptly and appropriately. The record of the initial child protection conference refers to a pre-birth assessment which was recommended at an early stage but had not taken place by the time of her premature birth. As much of the background knowledge in relation to Tim's life history and the detail of Ellie's parenting history was unknown at the time of Rosa's birth, a pre-birth assessment could have contributed important information and assisted in evaluating current risk factors.

Ongoing assessment of Rosa's care was carried out largely within the day-to-day practice of Social Worker 3 and the public health nursing service, which was in regular contact with the family and reported that Rosa was thriving in the care of her parents. A safety plan was drawn up when Rosa was about four months old but was limited in nature as it only addressed a single issue of threatened homelessness and did not address the risks already identified in relation to Ellie's mental health and history of alcohol abuse and involvement in abusive relationships.

It is acknowledged that it was not feasible for the SWD to have ongoing face-to-face contact with the family once they had moved out of Area A, particularly as there were restrictions in place due to the pandemic. This made ongoing assessment difficult for the SWD.

The review team notes that a protocol for handling inter-jurisdictional child cases was developed in 2011 to manage child protection clients who transfer from one jurisdiction to the other. The protocol was updated in 2021 but the 2011 version was applicable at the time the family moved. The protocol sets out a clear pathway for transfers in which the child is on the CPNS to occur. It is difficult to ascertain from the file all the processes that took place to affect the transfer but it is clear that the above-mentioned protocol was not followed. The conference which served as a transfer conference was poorly attended by staff from Area A (this was a tele-conference due to Covid-19 restrictions) and the information shared at the conference was insufficient to enable a full assessment of the risks to Rosa and the unborn baby.

The engagement of SWD in Area A with the family appears to have been positive and consistent. Social Worker 3 was readily available to the family. Tim was noted to be somewhat suspicious of social work involvement, however it is also apparent that he felt able to contact Social Worker 3 when needed. However, there is no evidence that recommended network or safety planning meetings were arranged which meant that the impetus provided by the child protection conference process was not followed up in any systematic way in the day-to-day work with the family. There is no doubt that the family were well monitored and supported by professionals but the non-occurrence of these meetings, which

would have involved the parents in a collaborative effort to effect positive change, limited the possibilities for this change to take place. There was limited contact following the family's move to Area C.

In general terms there appeared to be a high degree of cooperation between Tusla, the public health nursing service, An Garda Siochána and the voluntary agencies involved with the family.

4. Conclusions

The review team acknowledges the loss that has been experienced by Rosa's family and the professionals that worked with her and has reached the following conclusions.

- The review team has not had access to case documentation following Rosa's move to a different jurisdiction, however, based on the documentation provided to the NRP there is no evidence to suggest a relationship between the work that was undertaken by the SWD in Area A and the tragic outcome for Rosa and her family. It is of note that the potential for Rosa to be in a situation where her needs could not be met was acknowledged, understood, and addressed by SWD A from first contact.
- Although no pre-birth assessment was carried out, the initial analysis by SWD A of the potential risk to Rosa's well-being was appropriate and the initial child protection conference following Rosa's birth led to her name being listed on the Child Protection Notification System. However, a pre-birth assessment would have provided historical information in relation to both parents that would have been helpful. This has a particular relevance as the allocated social worker at the time of the case conference had taken up the role 24 days previously, had never met the family and was reliant on information contained in the files.
- The multi-disciplinary and overarching function of the child protection conference process and the resultant child protection plans was carried out comprehensively and in line with regulation. There was evidence of both support and monitoring considerations within the documented meeting minutes and the child protection plan offered a systematic means of achieving both.
- The housing situation that this family found themselves in was detrimental to their ability to develop a safe and nurturing environment for Rosa and a support system for the adults. It seems that the problem lay not only with the shortage of supply of suitable housing but also in the way that Ellie and Tim approached the issue. That is, they did not always interface with housing departments appropriately (e.g. missing appointments, not fully completing

applications), and their plans as to where they wanted to live lacked a sense of direction and purpose which seems to have dissipated their energy and confused the housing departments involved. It is acknowledged by the review team that the SWD were not responsible for housing and advocated where they could but it clearly added a significant stress to a young couple who were already vulnerable.

- The inter-jurisdictional protocol was not understood or followed by either Area A or C. This resulted in a five-month period where there was no substantive social work service to the family. It cannot be concluded that this resulted in any harm to Rosa however it is clearly neither advisable nor in keeping with good practice standards for child on the CPNS to be without statutory oversight for that period of time. It also contributed to the incomplete information given to case conference members which meant that the decision to remove Rosa from a child protection register was not well informed.

5. Learning Points

The importance of thorough historical and ongoing assessment reports is brought into focus in this case. Following the family's move to Area C Social Worker 3 left the department and two further social workers were allocated over the following three months prior to transfer. Neither of these social workers had the opportunity to meet the family although Social Worker 4 did have some interaction over the phone. High quality assessment reporting minimises the risk of significant information being lost when there are changes in personnel. In particular, Ellie's vulnerability would have had a clearer focus had more been understood and recorded about her complex and traumatic background history.

With the benefit of hindsight, it is clear that the primary carers' ability to make good choices in relation to their partner(s) is a crucial aspect of their parenting capacity and needs to be central to any assessment made regarding the welfare of children. Witnessing domestic abuse is stressful for children and a parent living with an abusive partner may be less emotionally available to them[1] Furthermore, there is international research that suggests a strong correlation between domestic abuse and child abuse[1]. For these reasons concerns about a parent's choice of partner needs to always be at the forefront of any child protection considerations.

The Signs of Safety Model utilised by Tusla needs to be followed through in order to be fully effective. Specifically, the involvement of parents/caregivers in the ongoing safety planning process allows for the greatest opportunity for positive change:

[1] HSE Practice Guide on Domestic, Sexual and Gender Based Violence

Child protection professionals have a tendency to feel like they are responsible for solving the problems within the family and this leads to a tendency to prescribe too much. In this approach the idea is for professionals to as much as possible get their concerns out in the open and get the parents and their network to come up with their best thinking and ideas through conversation. The key question that anchors the ongoing conversation is, "what will show everyone the child is safe and no one needs to worry?" Adopting a questioning rather than definitive approach around issues and solutions builds conversation that grows the capacity for parents and support people to take greater ownership of the issues and actions in safety planning.[2]

In relation to Rosa, although the monitoring and support offered to the family was good and consistent, a more 'live' engagement with the safety planning process, with the family, may have affected a more lasting and positive change in their ability to provide Rosa with a stable and nurturing environment.

6. Recommendation

Tusla management in each area must ensure that the most recent version of the Protocol for Handling Inter-jurisdictional Child Cases is highlighted to any key personnel in the SWD who may need to refer to it.

Dr Helen Buckley

Chair, National Review Panel

[2] Signs of Safety – Safety Planning Workbook pg. 7 Dr Andrew Turnell, Resolutions Consultancy Pty Ltd. (2013)