Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a death of a child whose family were known to Tusla

Thomas

Executive Summary

December 2025

1. Background

This review concerns a young child, here called Thomas who died tragically and accidentally. At the time of his death, a referral about him and his family had been on a waiting list in the local Tusla social work department for six months. Thomas' parents were separated, and an allegation of suspected physical abuse by his father during a visit was reported to the SWD via a family support service with whom his mother was involved. Thomas later denied that the incident had happened, but the SWD made the decision to investigate the allegation. It was considered low priority as the children lived mostly with their mother, who had indicated that she was protective of them, and saw their father infrequently. In addition, a project worker from the family support service remained involved.

At the time, the SWD was under significant pressure with a high number of referrals and a shortage of staff. A series of actions that had been directed by the principal social worker, including the compilation of further information and meeting with family members remained outstanding. Although the review team was told that regular waiting list reviews by the team leader took place, there were no notes to indicate what, if any, action was to be taken as a result.

2. Findings

The reviewers were given detailed information about caseloads and referrals and acknowledges that the delay in undertaking the actions directed by the principal social worker was related to pressure in the SWD. Nonetheless it is necessary to point out practice deficits such as the long delay which can dilute momentum and lessen the chances of an accurate account of what happened. The quality of recording was lacking and did not reflect the application of Signs of Safety.

It was noted that reviews and audits of wait listed cases took place at this time, reflecting the level of pressure caused by high demand and reduced staffing.

3. Conclusions

The review reached the following conclusions:

- Thomas' death was accidental and unpredictable and unaffected by the availability or quality of a service provided by Tusla.
- The role played by the Tusla SWD in Thomas's case up to the time of his death was minimal. It received one referral that was screened and waitlisted. The referral remained on the waiting

list for further follow up at the time of Thomas's death. This delay is unacceptable in the context of a child continuing to have contact with an alleged perpetrator without sufficient evidence to determine the need or otherwise of a safety plan.

- Thomas's referral was screened as physical abuse and classed as a low priority. Given the nature of the alleged abuse and the history, the review team believe that this was an incorrect level of prioritisation.

4. Key Learning Points

The review team is aware that a number of reforms have been introduced in Tusla in recent years. Whilst acknowledging the above, the review team consider that there are areas where lessons can be learnt.

- Cleaver et al., (2011)[1] provide a framework through which the impact of domestic violence and alcohol abuse can be understood. They note the following, 'Although there is substantial evidence showing that a combination of parental mental illness, learning disability and problem substance misuse increases the risk to children's safety and welfare, the best predictor of adverse long-term effects on children is the co-existence of family disharmony and violence.' These authors further highlight that excessive amounts of alcohol can also produce violent mood swings from, for example, caring, loving, entertaining to violent, argumentative and withdrawn. As a consequence, parents with a drink or drug problem may behave in an inconsistent and frightening manner towards their children.

- Research has found that children exposed to domestic violence are at increased risk for physical abuse and other forms of child maltreatment.[2] Studies have found that generally estimated rates of co-occurrence within community samples were lower than for samples from domestic violence refuges and child welfare settings but were still significant.

Dr Helen Buckley

Chair, National Review Panel

[1] Cleaver, H., Unell, I. and Aldgate J. (2011) *Children's Needs Parenting Capacity.*
[2] https://www.rcdvcpc.org/co-occurrence-of-child-abuse-and-domestic-violence-exposure.html