Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of a serious incident experienced by a baby whose family had contact with Tusla

Ruth

Executive Summary

March 2022

1. Introduction

This case refers to a baby, here named Ruth who was subjected to a serious assault when she was ten weeks old. Subsequent investigations revealed that Ruth had sustained multiple bone fractures of mixed age. Ruth's injuries were life-threatening and will have long lasting effects.

2. Background Summary

The first referral concerning Ruth, as yet unborn, was made by the medical social worker in the local hospital in Area A which sent a referral to SWD A when Jane was 32 weeks pregnant. The referral was prompted by the fact that Jane was 16 years of age and her boyfriend, who was in the care of Tusla, was then 17 and living in a residential unit near where Jane lived. He was originally from Area B, some distance away. His allocated social worker was based in SWD B. The referral noted that Jane had previously attended CAMHS. Records in SWD A indicated that Jane had been hospitalised two years earlier following a suicide attempt and had a history drug and alcohol use, school absenteeism and self-harming. She had recently attended all her ante natal appointments and was reportedly no longer smoking or drinking and had a good relationship with her mother. The only area of current stress identified was the fact that Jane's family were caring for an elderly relative who lived with them. The medical social worker had referred Jane for support to the local Teen Parenting Support Programme[1].

This referral was categorised by the SWD in Area A (SWD A) as low priority and put on a waiting list. When contacted by SWD A for information, Jim's allocated social worker from SWD B in Area B replied by email outlining her concerns about the imminent arrival of the baby, citing Jim's background issues related to anger and Jane's mother's alcohol misuse. She pointed out that if Jim withdrew from current supports, it would be a risky situation for the baby to be in. She expressed concern about the decision to waitlist the case. SWD A also ascertained from Jim's residential unit that on leaving care at 18 he intended to live with Jane, their baby and her mother.

Six weeks after the first referral from the hospital and shortly before Ruth's birth, a public health nurse in Area A made a further referral following a routine home visit to Jane's elderly

[1] The Teen Parents Support Programme is a support service for young parents and their families from pregnancy until the baby is 2 years of age. The programme offers support, information and advocacy in all areas of a young parent's life including health, relationships, parenting, child care, social welfare entitlements, education, training and anything else about which the parents are concerned.

relative who lived with the family. She had observed that the housing conditions were poor and that little family support would be available to Jane. This referral was categorised as medium priority and placed on a waiting list in Area A. The case record indicated that further contact was to be made with Area B but there is no evidence that it occurred.

The case had not been allocated by the time that Ruth suffered injuries at 10 weeks of age. Jim later pleaded guilty to causing Ruth's injuries and received a custodial sentence.

3. Review Findings

The review found that the responses to the referrals sent to SWD A prior to Ruth's birth were inadequate. Although appropriate action was taken in gathering information from Area B and Jim's residential unit, the concerns that had been identified were not followed up and there was no face to face contact with the family. The two referrals made before Ruth's birth were treated separately and information about potential risks was not fully integrated or taken into consideration when assigning priority to the case. Communication between social work departments was poor and the waitlisted case was not reviewed adequately.

The reviewers were told that this was a particularly difficult time in SWD A which was under pressure and that a recent unexpected incident forced the relocation of the department which meant that past records were difficult to access at that time. The reviewers requested records from the other services outside Tusla which were involved in the case but did not receive them for reasons connected to data protection.

4. Conclusions

The review has reached the following conclusions:

- Baby Ruth's injuries had life changing effects. It is particularly disturbing to note medical evidence that her injuries had been sustained over a period of time.
- The initial response to the referrals sent to SWD A before Ruth's birth was inadequate. The level of prioritisation was applied without sufficient consideration of the family's history and information provided about Ruth's father.
- Given the risks indicated in the information provided to the SWD, further assessment, including pre-birth assessment should have been completed and appropriate supports identified.

- The waitlisted case should have been subject to review, and ongoing contact with the other services involved with the family should have been maintained.
- There was inadequate communication between the two SWDs and other agencies.

- It was regrettable that the review team was prevented from seeing the records held by other services involved which may have contributed to a fuller picture of interventions with the family.
- The review findings need to be considered in light of the information provided by Social Work Team Leader 1 of serious disruption in the SWD during the weeks following the referrals which were made in relation to unborn baby Ruth.

5. Key Learning Points

The review team is aware that a number of reforms have been introduced in Tusla in recent years. These include the implementation of Signs of Safety. In addition a number of actions were taken by Tusla following the internal review of this case. These included training on thresholds to promote national consistency, the implementation of a review system for waiting lists and an independent review of the waiting list. Whilst acknowledging the above, the review team consider that there are areas where lessons can be learnt.

- The main factors linked to teenage pregnancy include socio-economic deprivation; poor participation in education; low educational attainment; limited access to reliable and positive support from adults; being a child of a teenage mother; low self-esteem; and experience of sexual abuse. These factors are also found more often in the children who are in state care than young people who are not in care[2]. Where these factors come together, the risk can be very high. Teenagers who become parents may experience greater educational, health, social and economic challenges than those who are not parents.
- A study carried out by Biehal et al. (2015, p.126) illustrated that young people in care who become parents require wide-ranging strategies to give them '...a stable home base, positive educational experiences, greater self-efficacy and self-esteem and a more positive

[2] SCIE Research briefing 9: *Preventing teenage pregnancy in looked after children* **https://www.scie.org.uk/publications/briefings/briefing09/**

investment in their future'[3]. SWDs should be pro-active in this regard and should ensure that appropriate plans are put in place without delay.

- An NSPCC report shows that children under 1 year old are 8 times more likely than average to be the victims of child homicide in England and Wales. The threat is highest in the first twelve weeks of life and the perpetrators are most likely to be their parents. It is unclear exactly why this is so, though the infant's frailty and their total dependence on adults are crucial factors in conjunction with the high level of demands that a new baby places on a family. The most common cause of infant death or long term disability is a non-accidental head injury with such head injuries resulting in death in between 13–30 per cent of cases. At least half of the infants who survive this type of injury are left with major neurological impairments. These findings are similar to that of other European countries, where infants are also more likely to be at risk of fatal injury, physical abuse and neglect than older children. This data highlights the importance for preventative services to be involved with families at risk during pregnancy[4].
- Child welfare policy has placed increasing emphasis on the importance of early intervention. This is relevant in the context of pre-birth assessments. Such assessments measure the potential risk to a baby following birth and identify how identified risks may be alleviated through the provision of suitable supports. The ultimate goal is to enhance parenting capacity in order to ensure positive outcomes for children and parents[5] [6]. Some studies have shown that a number of issues have arisen in relation to pre-birth assessments and these need to born in mind. Firstly, pre-birth assessments and child protection conferences which have been undertaken late in pregnancy have resulted in birth mothers having limited opportunities both in influencing the care plan and in demonstrating their ability to change[7]. Mason et al. (2019) argue that this raises questions

[3] Biehal, N., Clayden, J., Stein, M. & Wade, J. (1995) *Moving On: Young People and Leaving Care Schemes*. HMSO, London

[4] Cuthbert, C., Rayns, G. And Kate Stanley *Prevention and protection for vulnerable babies*. NSPCC file:///C:/Users/HP/Documents/ann%20netbook/docs%20june%202014/nrp/2011AllBabiesCountPreventionAndProtectionForVulnerableBabies.pdf

[5] Mason, C., Robertson, L. and Broadhurst, K. (2019) *Pre-birth assessment and infant removal at birth: experiences and challenges A literature review.* Nuffield Foundation. file:///C:/Users/HP/Documents/ann%20netbook/docs%20june%202014/nrp/current%20reports/MK/Literature-review_Born-into-Care_Dec-2019.pdf

[6] Ward, H., Brown, R. and Westlake, D. (2012) *Safeguarding Babies and Very Young Children from Abuse and Neglect,* London: Jessica Kingsley Press.

[7] Brown, R. and Ward, H. (2014) 'Cumulative jeopardy: How professional responses to evidence of abuse and neglect further jeopardise children's life chances by being out of kilter with timeframes for early childhood development', *Children and Youth Services Review*, 47(P3), pp. 260–267.

about the fairness, the quality of assessment and effective planning[8]. Studies also show that social workers find short-timescales for pre-birth assessments difficult to meet (especially in complex cases) given their high caseloads[9]. Other issues that have been identified include the lack of clarity about the correct processes including inadequate guidance, tools and training regarding pre-birth assessment. The statutory requirements regarding unborn babies also caused confusion as well as the challenges in engaging parents. Finally, issues in relation to poor inter-agency communication during pre-birth assessments have also been noted[10].

- SWDs should ensure that their practice meets an evidence-based standard. This means integrating current research evidence, professionals' clinical expertise and client preference, in reaching decisions[11]. For this to be effective, managers should, through regular supervision, engage with staff in order to maintain a focus on frontline activity, and guide them in relation to decision-making and adherence to regulations and protocols. In addition, a system for regular reviewing of cases on waiting lists is critical.
- Good record-keeping is the responsibility of frontline workers and their managers and this is particularly the case in respect of decision-making. The written record is important in providing concrete and lasting information of the worker's and manager's thinking, the actions agreed and the reasons for them.[12]

6. Recommendations

The reviewers make the following recommendation:

- The Tusla alternative care guidance (Alternative Care: A Practice Handbook, Tusla, 2014) highlights that children in care may have less access to good quality sex education and advice than many other children. This matter requires to be addressed. Likewise, the practice handbook contains guidance on the type of support that should be offered to teenage mothers who are in care. Support should also be made available to young fathers

[8] Mason, C., Robertson, L. and Broadhurst, K. (2019) *Pre-birth assessment and infant removal at birth: experiences and challenges. A literature review.* Nuffield Foundation.
file:///C:/Users/HP/Documents/ann%20netbook/docs%20june%202014/nrp/current%20reports/MK/Literature-review_Born-into-Care_Dec-2019.pdf
[9] Ward, H., Brown, R. and Westlake, D. (2012) *Safeguarding Babies and Very Young Children from Abuse and Neglect,* London: Jessica Kingsley Press.
[10] Lushey, C. J., Barlow, J., Rayns, G. and Ward, H. (2018) 'Assessing Parental Capacity when there are Concerns about an Unborn Child: Pre-Birth Assessment Guidance and Practice in England', *Child Abuse Review*, 27(2), pp. 97–107.
[11] Mosson, R., vonTheile Schwarz, U., Richter, A., Hasson, H. The Impact of Inner and Outer Context on Line Managers' Implementation Leadership. (2018). *BJSW.* 48 (5) pp 1447-1468
[12] Wilkins, D., How is supervision recorded in child and family social work? An analysis of 244 written records of formal supervision. (2017) *Child and Family Social Work*, 22, pp 1130–1140

in care and aftercare, acknowledging that the onset of parenthood brings a whole new set of responsibilities. The reviewers recommend that these matters are addressed in policy.

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