National Review Panel

Review of a serious incident: abuse of children in a family setting

Summary report

December 2019

1. Introduction

This is a summary of a serious incident review that was conducted by the National Review Panel (NRP), an independent panel of consultants individually commissioned by Tusla. The NRP conducts reviews in accordance with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* issued by the Department of Children and Youth Affairs in December 2014. Under this guidance, the following deaths and serious incidents must be reviewed by the National Review Panel:

- Children in care;
- Children known to the Agency's social work department or an Agency-funded service; and
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991.
- In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, the Agency may refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:
- A child protection issue arises that is likely to be of wider public concern;
- A case gives rise to concerns about interagency working to protect children from harm; or
- The frequency of a particular type of case exceeds normal levels of occurrence.

2. Serious incident: abuse of children in a family setting

The review summarised here concerns a family where some of the children lived with their mother and her partner and were known to HSE social work services because of alleged neglect and parental alcohol use. The mother's other children lived with their father in another area and they often visited and stayed for holidays. The children in their mother's care came to the attention of the services because of a specific neglect incident. The children's mother attributed the incident to the stress she had been experiencing due to a recent difficult relationship with her family and former partner and undertook to give up alcohol and provide adequately for her children. A family support

worker carried out parenting sessions with her. She demonstrated a capacity to provide good care to her children and their names were removed from the child protection notification system. Over the following years the case remained open and the family was visited by a social worker who was also in regular contact with their school and with the area where their siblings children resided. While extended family members expressed concerns about the welfare of the children, the social worker saw no evidence of problem alcohol use by the children's parents or any other evidence of abuse or neglect during her planned and unplanned visits. No concerns were reported by the children's school when they were contacted in the first few years of social work involvement. The social worker saw the children on visits and on receiving reports that one of them was upset and worried, arranged for her to attend groups sessions in a youth service. In the meantime, relatives continued to report concerns about parental alcohol abuse, domestic violence, neglect and sexualised behaviour of some of the children. They made the reports through the social work department in the area where the children's siblings lived. When the reports were discussed with the children's mother, she denied or minimised them. She appeared to be very competent much of the time, with little visible evidence to substantiate the reports made about her. Four years after the social work service became involved; it became evident that the home situation had deteriorated. One of the older children alleged child sexual abuse by an unrelated friend of her mother's and neighbours reported neglect of the children. The social work department responded to the allegations of child sexual abuse and a family support worker was assigned to the family. Ultimately, the children's mother developed mental and physical health problems and on a home visit, the social worker found a very neglectful situation and the children were received into care. It became evident from the accounts they gave their foster carers later that they had experienced more serious neglect as well as physical abuse than had been observed by the social work department. The reviewers met some of the older children, who described a home situation quite different from that which was seen by the social worker, including frequent drinking sessions in the house, physical abuse and neglect.

6. Review Findings

The central question raised in this review concerns the gap between the perceptions of the social work departments involved in this case and the reported experiences of the children in the family. The reviewers are also aware that there were times when things were going well in the family and that parental alcohol misuse was not constant. It is also acknowledged that the social work department (SWD) was under extreme pressure while this case was active, particularly the duty service.

6.1 Initial response

The reviewers have noted that when the case first came to attention, the child protection threshold had been reached and that the follow up was inadequate. It found that a formal process including a child protection conference should have been put in place at the outset to develop child focused safety plans which should have then been regularly reviewed. Although the children's mother conveyed the impression that all the difficulties were the result of recent events, the history provided by relatives indicated that problems, which were serious in nature, had been going on for many years and that the children had been subject to neglect by their mother over a long period. The lack of concern reported by any of the other services involved with children at the outset, e.g. public health nurses and the children's school was also a factor which may have lessened the perceived gravity of the reports made by family members and contributed to an overly optimistic view of their mother's parental capacity. Yet her extended family continued to report concerns.

6.2 Assessment

The review has found that assessments were needed at critical points in the case: at the outset, over the following years and when one of the children disclosed child sexual abuse by an unrelated male. None of the assessments that were conducted were considered to be adequate. This, together with the lack of a formal process at the outset, had an influence on the way that the case was managed. The reviewers particularly note the view of the SWD that the children's mother was making positive progress regarding her alcohol use even though relatives were reporting otherwise and also note that her partner's alcohol use did not become a focus of discussion until much later. As their alcohol use and associated lifestyle led to dangerous situations for the family including lack of supervision and instability, this would have been an important aspect of assessment. The social worker told the reviewers that assessment practice at the time was not up to the standard that it is currently.

6.3 Quality of Practice

Before the children were taken into care, contact between the SWDs and the family was intermittent. The allocated social worker never saw the children's mother intoxicated, including on unannounced visits, nor received negative reports from the children's school or any other service so it was not deemed necessary to visit more frequently. However, the reviewers note that relatives continued to report concerns to the SWD in their local area which were passed to the area where the family lived. On the occasions when these were brought up with their mother, she denied and deflected them. Matters escalated when one child shared some difficulties with the social worker, closely followed by another child's disclosure of extra familial child sexual abuse. The reviewers

consider that the responses made at this point were inadequate, particularly in respect of the child sexual abuse disclosure. Although the child who disclosed was interviewed and believed, there were significant gaps in the way the incident was followed up.

The review has found that the allocated social worker carried out both announced and unannounced visits and spoke with the children in the family home. This was almost always in the presence of their mother and the children told the reviewers that they thought they would not have been allowed to see the social worker on their own.

6.4 Management

Although there is evidence that line management held oversight of the case during the duration of the period under review, and that the team leader was readily available for consultation and to meet with the family as appropriate, the lack of formal processing from the outset shaped the way that this case was managed. There did not appear to be a formal process for delineating responsibilities between the two social work areas involved and ensuring that agreed actions were followed up within agreed timescales. Communication between the areas fell short of the levels required for a case with a profile of ongoing and cumulative neglect, persistent suspicion of child sexual abuse and history of instability. Some actions agreed during supervision were allowed to 'drift'.

Furthermore, the lack of formal processing at the outset and the early deactivation of the children's names from the child protection system meant that the allocated social worker lacked the support of a multi-disciplinary system. They were therefore left to manage a very challenging and confusing situation and was vulnerable to the children's mother's strategic defensiveness in how she presented her family.

6.5 Interagency collaboration

Throughout the period under review the children were in contact with a wide range of services, including school and health staff, youth and project workers and speech and language therapists. Overall, these services reported few serious concerns up to the year before the children were taken into care. There was an expectation by the social work department that any concerns would be passed on, and that those reporting concerns would continue to do so. However, these expectations were implicit rather than explicit and were not formalised explicitly by the social work department.

The absence of meetings meant the omission of opportunities to aid communication, share and analyse information, provide feed-back and support for all involved and clarify expectations.

7. Conclusions

The children in this case experienced serious abuse whilst in contact with services which had responsibility to protect them and promote their welfare. This review has found the following:

- The ability of the social work services to identify and respond to what was happening for the children was complicated by a number of factors, including the outwardly competent presentation of their mother and her ability to conceal and minimise problems in her parenting. The research finding that children rarely tell social workers if they are being harmed (see Learning Points below), was borne out in this case where the children were unable to reveal their circumstances out of a sense of loyalty, dread of retaliation by their mother and the fear that they would be taken into care and separated from each other. The older children in this case told the reviewers that it had taken them some years to realise that their family was different.

- The review has found that the absence of formal processing of the initial referrals at the outset shaped the way that the case was managed over the ensuing period. Although the initial reports were triggered by a crisis situation, they also contained information of a serious nature going back a number of years. The lack of an early interagency forum, such as a child protection conference in respect of all the children, meant that coordination was lacking. The lack of a comprehensive assessment meant that in-depth knowledge was absent and facilitated the acceptance of the children's mother's self-reports even though doubts existed. Lack of formal and sustained case planning followed from these deficits. When the trajectory of the SWD involvement with this family is viewed, it now appears that the early view that the incidents which led to the first referral were a result of a period of chaos established the framework within which 'arm's length' contact between the social work department and the family took place over the following years. The accepted view that the children's mother was a relatively competent parent who had moved on from a difficult period caused by relationship problems belied the evidence reported by her family in respect of physical and emotional neglect over many years. The prevalence of this view, coupled with the absence of reported concerns from other professionals, meant that the

SWD perceived no evident need to visit frequently or apply a closer level of surveillance up to the final year.

- The review finds that the case always had an allocated social worker, who periodically checked with other professionals familiar with the children and kept in touch with the social work department in the area where the children in their father's care were living. However, it concludes that SWD's practice of keeping the case open with infrequent visiting over a four year period was ineffective.

- While alcohol use and domestic violence were not the only factors involved in the abuse of the children, the review concludes that the impact of these factors on the children was not properly assessed or understood by the social work department at the time, not only in terms of their physical and emotional environment but also the risks posed to the children. The review also finds that while their mother's drinking was a focus of discussion and her self-reports that she was not using alcohol provided reassurance, there was less attention paid to the children's father who by his own acknowledgement to the reviewers had a serious alcohol problem and was drunk a great deal of the time.

- The review concludes that the disclosure of child sexual abuse by one of the children was not properly assessed or followed up by the SWD in a way that would therapeutically assist her. A formal child sexual abuse assessment did not take place, although a referral was planned. The discovery of child sexual abuse and the circumstances in which it occurred, together with other reported concerns from the family should have acted as triggers for a much closer examination of the children's situations at the time. In particular, the SWD should have taken further steps at the time to assess the other children who had been in the household while the perpetrator was present. At a later point, the other two eldest children made disclosures that they had been abused by the same perpetrator. It is understood by the reviewers that arrangements for the assessment of child sexual abuse and follow up services have improved in the area since the period under review.

- The reviewers conclude that the continued reports of extended family members were not interrogated sufficiently during the period under review.

- The review has noted that once the children were in care, they were able to disclose what had happened to them, which indicates that they felt secure in their relationships with their social workers.

8. Key Learning points

8.1 Responding to reports from families

Research has noted an association between the source of a report and the likelihood of a response, showing that reports from professionals, mandated or otherwise, are more likely to be substantiated or considered critical than reports from families or members of the public (Whelan, 2017)[1] Reports from families can sometimes be complicated by their relationship with the alleged perpetrator which may cause them some worry and conflict, as well as concern that by making a report they may jeopardise their contact with the children. There may be delays in communicating information and their motives can be perceived as interfering or ill intended by the person whom they are reporting. As a learning point, it is suggested that professionals should routinely challenge their own perceptions about the reports made by extended family members and that work to address family conflict should, if possible, be part of an intervention. In view of more recent policy and practice changes regarding the manner in which referrals are currently made, including via portals and other electronic means, it is worth noting another point made in the above quoted Irish research (Whelan 2017) that newer streamlined arrangements for reporting tend to privilege professionals and are less user friendly for lay referrers, even though the latter group comprise the larger proportion of those seeking assistance.

8.2 Disclosures and assessment of child sexual abuse

Tusla social workers have adequate guidance and recourse to expert advice when assessing allegation of child sexual abuse but certain aspects of investigation remain challenging. There are some lessons here about identifying risks in children's environment, such as a combination of alcohol use and the presence of unrelated males in the family home. It is also recognised that children may often resist disclosure because of the potential consequences. McElvaney and Culhane (2015)[2] recognise the challenges in helping children to disclose child sexual abuse and have identified some factors which might enable children to tell someone, including creating opportunities for children to talk.

[1]Whelan, S. (2017) *At the front door: child protection reporting in a changing policy and legislative context*. Phd Thesis, Trinity College Dublin
http://www.tara.tcd.ie/bitstream/handle/2262/82640/PhD%20Sadhbh%20Whelan.pdf?sequence=1&isAllowed=y

[2] McElvaney, R. and Culhane M. (2015) A Retrospective Analysis of Children's Assessment Reports: What Helps Children Tell? *Child Abuse Review*

Responding to child sexual abuse does not end with disclosure and assessment. The child who disclosed in this case did not receive any follow up therapy until she was placed in foster care two years after her abuse was discovered. The above cited research outlines the importance of therapeutic assessment so that the need for and nature of future interventions will be identified.

Importantly, any investigation of child sexual abuse must include consideration of the safety of other children who would have had contact with the same perpetrator. It should also involve a thorough investigation of the environment in which the abuse took place to ascertain any risk factors that may still be present.

8.3 Disclosure of abuse to professionals

It is known from research (Allnock and Miller, 2013)[3] that children are far less likely to disclose abuse to a professional than to family or friends, and that they are highly unlikely to disclose to social workers unless the incident or behaviours have first been reported by a third party. When children are in environments where other family members have witnessed abuse and have not reported it, they may consider that abuse is normal and thereby remain silent about it. Fear, shame, embarrassment and a sense of not being believed are also barriers. The above mentioned study also found that children and young people would have liked someone to ask them direct questions and believed that professionals should notice more and ask more questions about various signs and symptoms. The research also showed that the manner in which professionals communicated with the young people was key to the experience of disclosure being viewed as either positive and helpful or negative and unhelpful. Characteristics of a more positive response to disclosure were: engaging with the young person, not just the parents; using age and developmentally appropriate words and communication styles; providing a safe place to talk; and informing the young person of the actions they were going to take and the progress of the investigation and case.

Other research also indicates that children do not seek help from formal agencies or professionals because they do not know they exist; they are unsure what help they can get from them; or they worry about losing control of the information they share. It is suggested that service development should focus on innovative ways of ensuring that services address children's concerns; they could provide a forum for young people to talk to someone about abuse they are experiencing, whilst also

[3] Allnock, D. And Miller, P. (2013) No one noticed, no one heard: a study of disclosures of childhood abuse. London: NSPCC. Allnock, D. And Miller, P. (2013)

giving them the space and time to think about their options before providing details that may cause them to lose control of the situation.

The latter study pointed out that services should be well-publicised in places where children and young people spend time. This includes places like schools and youth clubs, but in view of the increasing use of technology, internet websites such as social networking sites should also be part of any awareness-raising strategy

8.4 Families who are 'uncooperative' or 'hard to engage'

The Child Protection and Welfare Practice Handbook 2011 under 3.2. *Risk Factors in Child Protection,* refers to families who are 'uncooperative' or 'hard to engage' and includes under this heading families who do not demonstrate positive change despite intervention and support from child protection services. Under messages from research the different ways families can be 'hard to engage' or 'uncooperative' are outlined as follows; Ambivalence, Avoidance, Confrontation, Hostility, threatened or actual violence, 'Disguised' or 'false compliance', and adults diverting attention away from children.

It continues that a family's lack of engagement or hostility can hamper a practitioner's decision making capabilities and follow-through with assessment and plans. The guidance notes that other research studies describe instances with practitioners focusing too much on small improvements made by a family rather than keeping the family's full history in mind. It suggests that when assessing uncooperative parents, a written contract could be used that explicitly states the child protection concerns, the action that the parents should take and the consequence of continued lack of cooperation.

The practitioner also needs to be mindful of the impact the hostility to outsiders may be having on the day-to-day life of the child and to consider what the child is experiencing. The child may:

- Be coping with his or her situation with hostage like behaviour;
- Have become de-sensitised to violence;
- Have learned to appease and minimise
- Be simply too frightened to tell;
- Identify with the aggressor

8.5 Alcohol and Domestic Violence

Cleaver, Unell and Aldgate (2011)[4] 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 with family disharmony and violence. This is reinforced by the findings from serious case reviews ... domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds and it is the combination of these factors which is particularly toxic. In contrast, when families remain cohesive and harmonious, research would suggest that many children, despite experiencing difficulties during childhood , are resilient and do not go on to have more problems in adulthood than other people.' (p66)

Cleaver et al. further note 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.

9. Recommendation

The reviewers are cognisant that significant reforms have been made since the period that was under review, particularly with regard to the introduction of Signs of Safety and new procedures for responding to child sexual abuse. Many of the practice issues raised in the review can be addressed by the learning points outlined above, but the following recommendation is considered important for policy makers

- The National Case Transfer Policy (2016) should be refined so that it can offer a clear direction in complex cases such as this, where a family of children with child protection needs is split geographically between two different administrative areas. Absolute clarity will be required in relation to governance issues, accountability and reporting. It will be necessary for one area to take the lead for planning but with other key stakeholders (second SWD and partner agencies) fully engaged.

[4] Cleaver, H., Unell, I. and Aldgate J. (2011) *Children's Needs Parenting Capacity.*

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