Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

Review undertaken in respect of the death of two children who had contact with Tusla social work services

Summary, Conclusions and Learning Points

December 2021

Introduction

This review refers to the deaths of two children who were known to Tusla services prior to their deaths. A high level of risk had been identified in the case which was allocated and subject to a number of child protection conferences and child care proceedings. The children's names were listed on the Child Protection Notification System and a safety network had been established. A number of services was involved in the case and all communicated well together. The review found that the initial response by the social work department to referrals was both prompt and comprehensive and a well formulated assessment was completed. During the period of SWD involvement with the case, Covid 19 restrictions were operating to varying degrees and the social work service is to be commended for its efforts to fulfil its responsibilities in a very challenging situation. Regular contact was maintained by the social workers with the family, despite their reluctance to engage. Contact was also maintained with the support network by the allocated social workers and when meetings were not possible, contact was made by telephone. The social worker who had most involvement demonstrated both skill and sensitivity in her work with the family. Positive management oversight was apparent.

The review has reached the following conclusions:

- The tragic deaths of the children who are the subjects of this review could not have been predicted by any of the services involved.
- Despite significant challenges posed by Covid 19 restrictions, the social work services involved responded quickly to the more recent domestic violence incident and immediately instituted an appropriate safety plan.
- The social work department was cognisant of the complex dynamics in this case and was clearly mindful of the potential risks to the children despite their parents' attempts to minimise the incident that had led to the concerns. The social workers were supported by their line managers and worked diligently with the family and wider network to try and keep the children safe. Their work was child focused and inclusive and met the challenges imposed by both Covid 19 restrictions and a language barrier. Interventions and proposed supports were hampered by both parents' persistent denial of domestic violence.
- The records demonstrate that the social workers did their best to work with the family in a culturally sensitive manner.
- There was evidence of exemplary co-operation between the social work department, An Garda Síochána, the children's school and the medical services. The Gardaí and emergency medical services in particular displayed a clear understanding of the dynamics of domestic violence and associated risks and acted appropriately and supportively.

Key Learning Points

This report has attempted to reflect on the challenges faced by the family and the staff who worked with them. The review team consider that there are areas where lessons can be learned.

- **Implementation of the Tusla National Model of Practice**

Signs of Safety has been adopted by Tusla as a practice framework for child protection and welfare and has a strong focus on the capacity of families and communities to keep children safe. This review has highlighted some issues about the use of Signs of Safety that require reflection. In this case, the mother of the children was from an ethnic minority group in which men and women identify with traditional gender roles that do not always accord with western norms. While a basic principle of SoS is that family members chose their own support persons, the fact that three men also from ethnic minorities were selected by the male parent, an alleged perpetrator of domestic violence, to act in protective roles raises questions about how their involvement may be perceived by the female victim. It was noted that a considerable gap existed between the perceptions of network support persons and professionals at the child protection conference, with some support persons indicating a degree of doubt about the evidence of domestic violence and the majority assigning a much lower risk rating to the situation. As outlined, this had no impact whatsoever on the safety plan or the later interventions by the SWD in this case but is a point worth considering in relation to the reliance that can be placed on support persons. It could also be asked whether it is wise for the social work department to send a letter an alleged victim of domestic violence who is living with the alleged perpetrator, as happened in response to the first referral.

- **The impact of domestic violence.**

The risks associated with domestic violence were well understood and responded to appropriately by the social work, medical and justice services in this case but are worth re-visiting as learning points.

  - Prolonged and/or regular exposure to domestic abuse can have a serious impact on a child's development and emotional wellbeing, despite the efforts of the victim parent to protect the child (Cleaver et al. 2011). Children who live with domestic abuse are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life[1].
  - The link between child physical abuse cases and domestic abuse is high, with estimates ranging between 30% to 66%.

[1] https://www.tusla.ie/uploads/content/Tusla_Child_Protection_Handbook2.pdf

- The most dangerous time for a victim of violence is when she is on the verge of leaving and for six months afterwards. Seventy six per cent of homicides occur after separation
- Perpetrators of domestic violence may try to groom professionals, setting out to undermine the inaccuracy of information about alleged incidents and blame incidents on matters beyond their control, switching from politeness and respect to intimidation and threats. Their aim is to divert attention from both the victim and the severity of the abuse[2].

- **Domestic violence in minority ethnic groups**

  Women in minority communities may be more vulnerable to domestic violence due to the additional barrier of reporting and receiving help; for example, uncertain immigration status; no recourse to public funds; language/literacy barriers; housing issues; community/ faith honour; cultural issues (e.g. female genital mutilation and forced marriage)[3]. Violence is not inherent in minority ethnic cultures but being a member of a minority group can hamper the uptake of help, for example the relationship with police and statutory services can be based on fear and mistrust. Limited knowledge of (and hence access to) the legal system creates added barriers for women. Inaccurate information about rights and entitlements is of advantage to perpetrators and might cause obstacles in the process of finding help. Language can be a significant barrier to seeking support and access to culturally appropriate and multilingual information is vital. Women from minority ethnic groups often rely on their own communities (possibly including their abuser) for support. They may also seek advice and support from their pastor, priest or religious leader and prioritise their opinion in relation to family matters, including domestic violence. Support services need to work in solidarity and partnership with minority ethnic groups to remove barriers and improve services. Tusla needs to develop specialist expertise towards minority ethnic groups and recognise and plan for diverse needs. It is important to find balance between recognising a woman's right to live a life free of violence and affirming ethnic identity and different needs.

Dr Helen Buckley

Chair, National Review Panel

[2] https://www.tusla.ie/uploads/content/Domestic_Practice_Guide_on_DSG_bassed_violence.pdf
[3]