Painéal Náisiúnta Athbhreithnithe
NATIONAL REVIEW PANEL

National Review Panel

Review of a serious incident: abuse of children in the care of the health board/HSE (2003 – 2011)

Summary report

December 2018

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: child sexual abuse of children in foster care

The review summarised here concerns four children who were in the care of the HSE and later Tusla and lived, some together and some at different times, in an approved foster family. Whilst in care and under ten years of age three of the children were raped by son of the foster carers who lived in the family home. He has since been convicted and imprisoned. When the first child disclosed her abuse, the two other children in the foster home at the time denied that anything untoward had happened to them and a decision was made to leave them in the placement under a safety plan which stipulated that the alleged perpetrator would live elsewhere and have no unsupervised contact with them. Four years later, one of these children, by then a teenager, disclosed that she had in fact been abused by the same person over a number of years prior to disclosure by the first child. The other child who had remained in the placement, also a teenager by then, continued to insist that nothing untoward had happened. During the ensuing Garda investigation, a fourth young

person who had lived with the foster family many years earlier disclosed that she too had been abused by the same perpetrator.

3. Terms of reference

The review adopted the following terms of reference;

- To review the quality of services provided in this case with a focus on assessment and decision making and in the context of compliance with policy directions, guidance and standards of good practice
- To provide a report for the Child and Family Agency

4. Level and process of review

This was conducted as a major review, given the numbers of individuals involved and the volume of material for review. The review team consisted of Dr Helen Buckley, Chair of the National Review Panel, a retired academic who specialises in child protection, Dr Ann McWilliams, a retired academic who specialises in child protection and children in out of home care, and Dr Imelda Ryan, retired child psychiatrist and clinical director of a specialist child sexual abuse service. None of the panel members had any previous professional involvement in this case. This review focuses principally on the period during which the four children lived with the foster carers. Following notification of the case, the NRP were asked to delay the review until the criminal proceedings against the perpetrator had been completed.

The methods used for the review consisted of an examination of records, including individual social work files, foster care files, records from the CSA assessment team and a videotaped interview. In addition, a total of twenty five interviews took place with: staff members of Tusla, one independent practitioner, two members of the Gardaí and a family member of one of the young people. A small number of the practitioners and managers who were involved in this case had retired and/or moved to other jurisdictions and could not be interviewed. The reviewers acknowledge that the first disclosure of abuse in this case took place more than eleven years ago and some practitioners who were interviewed understandably found it difficult to remember details that may have been pertinent but were not recorded comprehensively at the time.

5. Background and context in which the abuse occurred

The foster carers of the children concerned had three male children. They had been assessed first for short term placements and later for long term placements with the first assessment fifteen years prior to the first disclosure of child sexual abuse. The reviewers note that the fostering assessment reports were brief and lacked the type of detail that might at the time have been expected in assessments of foster carers. There was no evidence that the family's children had been included in the process or that the implications of placing female children into a family of boys were addressed. Prior to the disclosures of child sexual abuse, the foster carers had been highly regarded in the area as a model family, who had numerous short term and respite placements in addition to a number of long term placements. They had participated in foster care events and in the training of other foster carers. Child in Care Reviews, required under the Child in Care Regulations, were carried out regularly by the social work department in respect of all the foster children, though no reviews of the foster family had been held.

At the time of the first disclosure, child protection services in Ireland were operating under the 1999 version of *Children First, National Guidelines for the Protection and Welfare of Children*. The social work department concerned operated under a structure at the time which covered two separate geographical areas. The foster family lived a considerable distance from the office where the social workers for the children were based, and the reviewers were told that staff numbers were considerably lower than they are currently and that the social work department (SWD) was under heavy pressure with unfilled posts and a waiting list of cases for allocation during the period under review.

At the time of the first disclosure, the social work department had a sub-team of social workers and psychologists that had specialist training and carried out assessments of alleged child sexual abuse. When a case was referred for assessment, interviews would have been carried out by two workers often (but not necessarily) from different disciplinary backgrounds. Their report would then be presented to a consultation team which would confirm the outcome of the assessment.

6. Response to child sexual abuse allegations

At the time of the first allegation of child sexual abuse, there were two foster children in long term care in the foster home and two others who had regular respite weekends there. None of the social workers interviewed by the reviewers had had any concerns about the foster carers at this time and generally described the family in very positive terms. The person with whom social workers had most contact was the foster mother and they only occasionally met the foster father. The children's

social workers visited them regularly and appeared to have good relationships with them. None of the social workers had much knowledge of the foster carers' own children and were unaware of the fact that one or other of them was sometimes left in charge of the foster children. The child who disclosed alleged child sexual abuse had been in respite care with the family, and this arrangement ceased for both her and the other child in respite immediately after her disclosure.

The social work department (SWD) responded quickly to the first allegation by visiting the home and discussing the disclosure with the foster mother, who adamantly denied that what was alleged could have occurred. She was requested to ask her son to leave the family home and complied. The child who had made the disclosure and the other long term foster children were interviewed by social workers and then assessed by the SWD's child sexual abuse team. The account provided by the child who had made the first disclosure was considered credible, a finding which was upheld by a paediatrician who later examined her. During interviews, the child who had made the disclosure stated that another (identified) long term foster child in the home with her had been assaulted by the same person. This was denied by the child concerned, who had been accompanied to her assessment interview by her foster carers. The other child in long term foster care who was interviewed denied that anything had happened. At that time, no contact was made with families whose children had formerly been in care with the foster family.

The Gardaí were notified immediately about the first disclosure. However, no joint meeting took place between the two organisations to plan a strategy and make decisions about how interviews and discussions with various parties, including the alleged perpetrator, were to be handled; nor was there any recorded ongoing discussion between the organisations as to the progress of the investigation. No discussions took place between the social workers and the alleged perpetrator, who was over 18 at this point. The review team was informed that it was not common practice at that time to have strategy meetings with the Gardaí, or to have contact with alleged perpetrators under investigation.

The SWD had to make a decision about the future plans for the two children who remained in long term foster care with the family. Given the children's denials that anything untoward had occurred and considering the stability of their placements to date, it was decided to leave them with the foster carers pending the decision of the DPP on whether or not to prosecute the alleged perpetrator. A safety plan was agreed with the foster carers according to which the alleged perpetrator was to live outside the family home and have no unsupervised contact with the children when he visited. The children's social workers were to visit monthly and take the children out of the home to satisfy themselves that there was on-going compliance with the safety plan and to provide

the children with an opportunity away from the foster home to tell their workers if anything was upsetting them. There appears to have been no dissent in relation to the decision made, or the terms of the safety plan. The parents of the children who remained in the foster home were told that abuse by a family member had been alleged but it has been asserted that they were not informed that it was the foster carers' son. The foster carers, though agreeing to the plan, continued to disbelieve the allegation and the relationship between them and the SWD which had formerly been friendly became what was described as 'business like'. A social worker described the atmosphere in the home as 'tense and unnatural' due to the obligation of the foster mother to supervise her son's contact with the foster children. A different social worker commented that the foster mother was 'calling the shots' in relation to social work contact. After the DPP made the decision not to prosecute, the foster carers requested an apology. The SWD made the point that the safety plan had to continue regardless of the DPP's decision.

7. Implementation of the safety plan

Over the following four years, the two children in long term foster care continued to make good progress, as evidenced in the records of their Child in Care Reviews. In response to queries from their social workers, neither of them disclosed anything of concern. The social workers for the children visited regularly, though not as often as originally planned. The fostering link workers, who's role was to support and work with the foster carers, visited with less frequency. There was no further overview of the safety plan by social work management, and the records indicate that the alleged perpetrator spent a lot of time in the family home. No family meetings took place even after the DPP had decided not to prosecute, which meant that neither the context in which the abuse took place nor its possible cause, were explored. There is no evidence that the safety plan was discussed at the regular Child in Care Reviews other than one reference to the foster mother's objection to discussing it at a review.

Four years after the first child made her disclosure one of the remaining foster children, then a teenager and still living in the foster home, disclosed that she had also been abused by the foster carers' son over many years. She said that no abuse had occurred since the first child disclosed, but that she had since been approached by the perpetrator and had rejected him. The foster carers disbelieved her disclosure. She was removed from the placement, an experience which she found to be very traumatic. When giving statements to the Gardaí, she named a child who had been in the foster home some years earlier and said that she had also been abused. The Gardaí followed this up, and the named child, now a young person, confirmed that this was the case.

The other young person in the foster home continued to state firmly that nothing untoward had happened and strongly resisted leaving the placement, to the point that the SWD had to go to Court for direction. The Judge advised a change of placement. Ultimately the new placement did not work out, and the young person then returned to their birth family. This arrangement was unsuccessful and the young person was then placed back, under the direction of the Court, with the foster carers under a supported lodgings arrangement, finally leaving at almost 18 years old.

The Gardaí subsequently brought a successful prosecution and the perpetrator was found guilty of assaulting the three children.

8. Findings

The review team acknowledges the grave and heinous sexual abuse perpetrated on the three children while they were in the care of the State. It also acknowledges the impact on all the young people and their families who are the subjects of this review. The outcome of the later disclosures, media coverage and criminal proceedings has been difficult for all those involved.

The review team is of the opinion that, following the first disclosure of child sexual abuse, the SWD made their decisions in good faith and with the belief that they were acting in the children's best interests. Individual social workers and their line managers showed considerable commitment to the children who were allocated to them and in some cases went beyond their brief to provide them with support. The review team also acknowledges the benefit of hindsight available to it in its approach to this case and notes that decisions were made eleven years ago, in a context where the two social work teams were under heavy pressure and in an environment that was less resourced and structured than it is at the present time and with fewer nationally implemented policies. Importantly, it must be acknowledged that the ability of the social work department to share detailed information with the foster carers in the eighteen months following the first disclosure of alleged child sexual abuse and also following the second disclosure was impeded by the norms operated by the Gardaí in their investigation of a crime. This issue continues to pose difficulties for social work departments throughout the country.

Notwithstanding the foregoing, the review team is of the belief that serious errors of judgement occurred in this case; there was flawed assessment and decision-making and a lack of management oversight at critical points during the involvement of the SWD with the foster family.

This review has, in accordance with the terms of reference, focused on the quality of services particularly in relation to assessment and decision making, as well as compliance with policy directions, guidance and standards of good practice. The timespan under review principally covers

the years following the first disclosure of child sexual abuse up to the termination of the foster carers' role as foster carers and providers of supported lodgings. The following paragraphs will elaborate the findings of the review under the headings: Questions raised and answered by the review; Prevention of abuse and provision of safe care; Response of the SWD to initial disclosures of abuse; Assessment; Decision making and planning; Action and contact by the SWD in respect of the safety plan; review and evaluation of the safety plan; Decisions taken in respect of the re-placement of one of the children and, finally, Management.

8.1 Questions raised and answered by the review

Three principal questions are raised by this review. The first is whether or not the HSE social work department should have identified that child sexual abuse was occurring in this family prior to the first disclosure. The second question is whether or the remaining foster children should have been removed from the placement when the first disclosure was made. The third question is whether adequate protective measures were operationalised by the SWD for the remainder of the children's placements.

With regard to the first question, the reviewers believe that it would have been difficult for the children's social workers to identify that the three girls were being abused prior to the first disclosure. This is in part due to the nature of child sexual abuse which is conducted in conditions of secrecy and privacy. No behaviours were exhibited by the children to indicate that something untoward of a sexual nature was happening. There is evidence that the children's social workers had sufficiently regular contact and good relationships with the children at the time to enable disclosures to be made. The reviewers are also cognisant of the very many reasons why children choose not to disclose, sometimes for several years.

With regard to the second question, of whether or not the two remaining foster children should have been removed from the placement, the review has found that sufficient evidence existed at the time to indicate that the children should be moved, even though it would have been disruptive to their stability in care and to the attachments they had formed with the foster carers. This is because of the risks to which they would be exposed by remaining and the unsuitability of the foster carers as protectors given their expressed disbelief that abuse had occurred.

With regard to the third question, the review has found that the safety plan was neither sound nor implemented in a way that was sufficiently protective. It is noted that no evidence exists to indicate that the children were sexually abused after the first disclosure. However, the review cannot attribute this fact to the effectiveness of the safety plan developed by the HSE social work

department. It has, in fact, found that the measures taken by the social work department to protect the foster children were deficient in a number of respects. These findings will be detailed in the remaining sections.

8.2 Prevention of abuse and provision of safe care

The review has found that measures taken to prevent abuse and promote the provision of safe care in the foster home by the social work department were deficient in the following aspects:

The assessment reports, on the basis of which the foster carers were approved, did not reach the standards operating in some other health board areas at the time. The reports lacked detail and did not provide assurance that a thorough assessment of family functioning and the issues raised by placing young female children into a home where there were three growing boys would be addressed.

Although the foster carers were regarded as a model foster family and took part in the training of other foster carers, monitoring and review of the service they provided was lacking in many important respects over the years between their approval and the termination of their contract as foster carers. Contact between fostering link workers and the family was infrequent and took place with the female carer only for the majority of the time. Fostering link workers had scant contact with and little knowledge of the family's birth children. Despite a statutory requirement in the last nine years in which they provided foster care, no review of the foster carers took place even after the first disclosure of child sexual abuse.

Although it was generally agreed by the social work department that the foster children were benefiting from their placements, the needs of each of the full time foster children and the capacity of the family to meet them were not formally ascertained and documented when decisions to place them permanently were made. Child in Care Reviews took place regularly in respect of the full time foster children, and their care plans were updated accordingly. However, the safety plan in operation for the four years between the two disclosures was rarely referred to in the records of these meetings.

No review of the foster placement occurred following the first child sexual abuse disclosure. This meant that no exploration took place with regard to the cause or context of the allegation, the family's' understanding of child sexual abuse or the impact of the allegation and the capacity of the family to keep foster children safe.

8.3 Response of the Social Work Department to the initial disclosures of abuse.

While it is acknowledged that responding to child sexual abuse allegations is a complex business, the review found the steps taken at the time to be wanting in certain respects. Although the SWD acted quickly in response to the first allegation, there was an absence of coordination between the SWD and the Gardaí. No attempt was made to establish the context or cause of the perpetrator's alleged offending behaviour.

Opportunities to immediately engage with the foster carers about the veracity of the allegation were missed by the delayed and infrequent contact made with them in the aftermath by the fostering link social work service. Communication between the SWD and the parents of the other foster children implicated in the disclosure was unclear as to the identity of the alleged perpetrator and his relationship with the foster carers as well as the likelihood of his continuing presence around the children.

No review was conducted in respect of the children who had been previously placed with the foster carers to ascertain whether or not they had experienced abuse. This applies particularly to a child identified by one of the children in her account of another child's sexualised behaviour. This meant that potentially important information was missed. It also denied another child who had been placed with the family several years ago an opportunity to disclose her abuse.

8.4 Assessment

Two types of assessment were immediately required in respect of the children following the first disclosure of child sexual abuse. Firstly, child sexual abuse assessment and secondly, risk assessment.

8.4.1. Child sexual abuse assessment

There was a standard method for responding to child sexual abuse allegations in operation in this area in 2007, and the assessments conducted after the first disclosure followed that format. However, this review has found that part of the process, specifically the final decision making stage, lacked the input of experienced and expert practitioners who were not directly involved with the management of the children's placements and could therefore have put forward a more objective view. In addition, the second child's assessment was compromised firstly by the fact that she had previously been spoken to about the first child's allegation by the Gardaí and her social worker and secondly by the fact that she was accompanied to the interview by her foster carers who had a vested interest in the outcome.

8.4.2 Risk assessment

Risk assessment in this case was narrow and inadequate. It omitted a number of critical factors including an understanding of the dynamics of adolescent sexual abuse and the implications for children of spending time in the presence of a person who had assaulted a child and about whom the SWD knew little. No attempt was made to assess the risk that the perpetrator posed to other children outside the family. Given the credibility attributed to the first child's disclosure by the SWD and the examining paediatrician, this should have been regarded as a significant threat. The obstacles to disclosure by the remaining foster children were not given sufficient consideration when decisions about their future care were made. Assessment also overlooked the impact that denial by the foster carers would have on both the emotional welfare of the foster children and the foster carers' own willingness and ability to protect them. It did not identify the very limited capacity of the SWD to monitor a domestic familial situation on the basis of monthly visits. The very valid risks of moving the children were weighed up against an inadequate calculation of the risks inherent in leaving them with the foster carers. It is also noted that stipulations outlined in Children First (1999) and the National Standards for Foster Care (2003) which were in operation at the time, were not followed in terms of either assessment procedures or the holding of a child protection conference.

8.5 Decision Making and Planning

The decision making in this case, specifically the decision to leave the remaining foster children in the foster home following the first child's credible disclosure of abuse, seems to have unanimously followed the prevailing view that the risk of moving the children outweighed the risk of leaving them, and that the protective factors would be the bond between the foster mother and the children and regular visiting by social workers. In the event the foster mother's denial of the second child's abuse belied the quality of attachment originally assumed. The review has noted the operation of cognitive dissonance whereby on the one hand the disclosures made by the first child about the perpetrator were considered credible by both the SWD and the paediatrician who examined her. On the other hand, however, the evidence given by the first child that the second had been abused was considered insufficient without a criminal conviction of the perpetrator.

The review has also concluded that the safety plan was unsound, for the reasons cited below.

8.5.1 The plan did not identify the obstacles that would be posed by the foster carers' refusal to believe that any abuse had taken place and their specific implications.

8.5.2 The plan did not fully consider the logistics of supervising contact between a child in the family and an adult man who was a family member and spent frequent periods in the house.

One of the social workers later referred to the tense and unnatural atmosphere in the foster home created by the plan but no such matters, including practicalities such as who oversaw the safety plan when the foster carers were away from the home, had been anticipated in the development of the plan.

8.5.3 The plan was silent about what would happen at times such as Christmas or family holidays when the perpetrator would be likely to spend longer periods at home or around the children.

8.5.4 The plan did not identify the potential for non-verbal and emotional abuse to be effected by the perpetrator even in a supervised situation.

8.5.5 The plan did not allow that the capacity of the SWD, which was already under pressure, would not stretch to providing the level of surveillance that it stipulated.

8.5.6 The plan did not identify the inherently limited capacity of the SWD, even if well resourced, to monitor a domestic situation in which a person who had sexually assaulted a young child would be frequently present in a home where the responsible adults did not believe that he posed a risk.

8.5.7 The plan ultimately became contingent on whether or not a prosecution would take place. This belied the fact, well known at the time that only a fraction of child sexual abuse reports proceed to prosecution. The differing thresholds that operate within the child protection system and the criminal justice system as to whether or not abuse has occurred should mandate that decisions taken within the former be independent of the latter.

8.6 Action and contact by the SWD under the safety plan

The operation of the safety plan and the level of monitoring the SWD were considered inadequate for a number of reasons as cited below.

8.6.1 Although the children's social workers visited them with relative frequency following the implementation of the safety plan, contact was not as often as envisaged.

8.6.2 Contact by fostering link workers, whose role was to support and work with the foster carers, was infrequent. No further attempts seem to have been made to help the family to come to terms with or accept that child sexual abuse had occurred and the perpetrator was not met by the fostering link workers even after the DPP's decision not to prosecute when the risk of interfering with a criminal investigation no longer existed.

8.6.3 No meetings or interventions took place with the entire family, which meant that the impact on the perpetrator's siblings of what had occurred and their views and capacity to protect were never considered. Monitoring focused on checking whether the two foster children

had been sexually abused. It never attempted to address the underlying issues that allowed the abuse to occur in the first instance.

8.6.4 Although Child in Care Reviews were held regularly, the records do not show any evidence that the safety plan was specifically discussed. Specific child protection reviews under Children First guidelines, operating at the time, were not held.

8.6.5 A number of risks emerged during the four year period between the first and second disclosure, which were not identified or acknowledged by the SWD. These included the inability of the SWD to implement the safety plan as intended and the entrenched denial of the foster carers.

8.7 Review and evaluation of the safety plan

The reviewers could not find any evidence that the safety plan was formally reviewed at a senior management level after the first eighteen months following the disclosure. A review was planned for a date three months after the decision making meeting, but this did not take place. A meeting was held one year after the decision was made to leave the two children in the placement and discussed various matters but did not explicitly review the plan. A meeting was also held with the foster carers following the decision of the DPP not to prosecute, to reiterate the need for safety, but no further follow up to these meetings occurred.

8.8 Decisions regarding the re-placement of the fourth child

The decision to re-place the fourth child, who by then was a teenager, with the foster carers after the breakdown of alternative placements was undesirable, albeit that it had been stipulated by the Court and the young person had clearly expressed a preference for it. In the opinion of the reviewers, the decision made earlier to leave the two children in the foster home following the first disclosure and the continuation of young person's relationship with the carers over the intervening period coupled with personal family circumstances led to the inevitability of the second placement there.

8.9 Management

Most of the weaknesses in this case stem from systemic flaws in management, which failed to recognise the seriousness of the allegation made and failed to respond proportionately to that. The first disclosure, which was made in an environment where its implications were very far reaching, should have been addressed with a high level, coordinated and persistent response. Had such a response been made, the basis for removing the children would have been clarified at a much earlier stage, the earlier abuse could have been discovered and adequate responses could have been put in place for children who were formerly placed with the family and other children in the community at

risk of the perpetrator. Management oversight in this case was not in evidence after the decision by the DPP not to prosecute the first time. In addition, deviation from the Foster Care Standards and Children First had a significant effect on the way that the case was managed at the front line.

9. Summary of conclusions

9.1	**When the foster carers were first assessed, measures taken to promote a safe environment for potential foster children were deficient.**
9.2	**For a number of reasons including the secrecy associated with sexual abuse and the reluctance of children to disclose, it would have been difficult for the children's social workers to identify that abuse was occurring prior to the first disclosure.**
9.3	**The social work department responded quickly to the first disclosure of abuse but some of the steps taken at the time were deficient.**
9.4	**Sufficient evidence existed at the time of the first disclosure to warrant the removal of the remaining foster children from the placement but this did not occur.**
9.5	**Although no evidence exists to indicate that the two children remaining in the foster placement were abused during the four years after the first disclosure, the safety plan developed to protect them was considered unsound.**
9.6	**The child sexual abuse assessment lacked the input of expert practitioners external to the management of the children's placements. The likelihood that the secnd child would disclose child sexual abuse at her assessment was seriously compromised by the way the case was handled.**
9.7	**Risk assessment in relation to the children remaining in foster care was narrow and lacked critical components.**
9.8	**Decision making in this case was based on inadequate assessment and was flawed.**
9.9	**The ongoing implementation of the safety plan and the level of monitoring of the children's safety were inadequate.**
9.10	**Failure to review the safety plan meant that emerging risks were not identified.**
9.11	**The Court ordered re-placement of a young person in the foster home at a later stage, was inevitable but undesirable.**
9.12	**Many of the errors and weaknesses identified in this review stemmed from systemic flaws in social work management, starting with an inadequate response and followed by a lack of oversight.**

10. Recommendations

The NRP is aware that the events under review in this report took place up to eleven years ago, and that a number of significant reforms have been introduced into the child protection and welfare system in the interim including two revisions of the Children First Guidance, the establishment of Tusla and the development of national standards and inspections by the Health Information and

Quality Authority (HIQA). Many of the deficits identified in this report have been at least partially addressed through these reforms and the recommendations below are made in this understanding. However, the findings of this review also pertain to practice, including risk assessment and decision-making at the frontline and management levels which may not necessarily be improved by systemic reform or increased regulation. For that reason, the report has identified also areas of learning for practice which are detailed in Section 11.

10.1 Foster Care

The NRP is aware that considerable policy reform has occurred in relation to the delivery of foster care services. It recommends, however, that the National Policy and Procedures: Fostering Link Worker's Role (2012) should be reviewed, highlighting the importance of safe care and frequent visits to the foster family. Guidance should also be issued in relation to the number of additional children placed for respite or short term foster care by Tusla at any one time. It further recommends that any practice guidance for fostering link workers should emphasise the need for clinical objectivity in their engagement with foster carers and vigilance regarding the possibility of abuse occurring within a placement.

10.2 Response to allegations of child sexual abuse

The NRP understands that the Department of Children and Youth Affairs is piloting an integrated model for the investigation, assessment and management of child sexual abuse allegations in order to prevent repetitive interviewing of children across different agencies and to provide ease of access to medical and therapeutic services. For this to become effective and address the issues raised in this report, the new model must be based on a clear understanding and mutual respect for the role and expertise of each agency contained within it. No one agency should perceive itself as having a lead role in the process and decisions taken regarding case management should emanate from a consensus approach that is sensitive to the needs of abused children and their carers and is respectful of the uniqueness of each child and family. These matters should be formalised in the terms of reference under which the integrated service is developed.

10.3. Response to complex cases

It is necessary for Tusla to develop an overarching multi-agency policy response to the investigation and on-going management of *complex* cases, for example those in which allegations involve multiple children in alternative care or in the community including unidentified children who may have been abused. It is suggested that such cases be overseen by a senior management group involving Gardaí and the social work department, with access to external expertise as appropriate. This group should scope the scale and depth of the investigation to be conducted in response to the identification of a complex case and should be supported by an operational group which will undertake child

protection conferences, identification of children additional to those referred who may also have experienced abuse, screening of other children in placements as necessary, communication with families, conduct of specialist child abuse assessments and coordination of inputs from all relevant social work teams. Ongoing review will form a central element of the work of the management group.

10.4 Professional Development

The NRP is cognisant that Tusla is currently implementing one national and consistent approach to practice, namely the Child Protection and Welfare Strategy incorporating the Signs of Safety Practice Framework. It is recommended that professional development, specifically in relation to risk assessment and knowledge/skills related to child sexual abuse is included as a core element of the new approach.

11. Learning points from this review

11.1. Assessment of foster carers

The assessment of foster families must be a comprehensive and thorough process that involves all family members and any other members of the household[1]. A detailed evidence based report which includes information from a number of different sources should be compiled by the assessing social worker. The report should clearly identify and analyse the family circumstances, their skills and ability to meet the criteria as set out in the National Standards for Foster Care (2003) and the HSE Foster Care Committees Policy, Procedures and Best Practice Guidance (2014). The Foster Care Committee, if granting approval, should set out the conditions that govern approvals. Following the placement of a child, there is a need for regular and frequent visiting (both announced and unannounced) by the allocated fostering link worker, sufficient to ensure adequate support to the foster family and supervision of the foster placement. Link workers should ensure that they meet with individual family members (including birth children) from time to time. Visits should address the impact of fostering on family dynamics as well as the practical day to day issues[4][5]. Foster carers' professional development should be reviewed regularly by the fostering link worker and on-

[1] Williams, D. and O'Donohoe, S. *Recognising and Supporting the Birth Children of Foster carers in the Fostering Process. Messages, Challenges and Opportunities*. http://www.ifca.ie/files/6714/8094/7565/Recognising_and_supporting_the_birth_children_-_Williams_and_ODonohoe.pdf; Höjer, I, Sebba, J, and Luke, N. (2013)*The impact of fostering on foster carers' children An international literature review*file:///C:/Users/HP/Downloads/sub88e_KA.pdf ; Irish Foster Care Association. *Safe Care An information booklet on safe care in foster care*.http://www.ifca.ie/files/5214/2653/7780/IFCA_Safe_Care_Booklet.pdf; Tusla (2014) *Alternative Care Practice Handbook*

going attendance at training should be required, especially in relation to safe care and challenging behaviour (including sexualised behaviour). In addition, stringent reviews of foster carers should be carried out against the Nationals Standards for Foster Care (2003) particularly in, but not limited to, situations where concerns have arisen. These practices will help to ensure that all family members are fully supported in the fostering task and that on-going evaluation occurs. Practitioners need to be clear about the different roles and areas of responsibility for link workers and children's social workers. Relationship boundaries between foster families and professionals also need to be carefully maintained.

Whilst there is no formal specified limit on the number of children living in a household at any time, the number of children placed on a long-term basis is restricted to two (except in the case of siblings) (DOH, 2003). The placement of any additional children in a family should be carefully considered and limited in order to ensure that the best interests and needs of all children in the household, including both birth children and foster children, can be adequately met. The SWD should have clear information about who is living in the household at all times.

11.2 Abuse of children in care including sibling abuse

Substantiated abuse of children in foster care is rare, but it is important to acknowledge that it can take place even when the placement appears successful or when children appear happy and have been settled for some time. While there is evidence that suspected abuse in foster care comes to official attention more frequently than abuse in the community because of the amount of surveillance to which foster carers are subject, there is also evidence to show that social workers can be over optimistic about the quality of care provided by reputable foster carers, and that professionals sometimes avoid facing up to the implications of concerns that are raised. An American study found instances of perceptual blocks by social workers who were under pressure because of large caseloads and avoided facing up to the seriousness of abuse allegations because of the dearth of available alternative placements for the children concerned[2]. It is also necessary to note that the perpetrators of abuse may not be the foster carers, but could be their children or other foster children. However, the foster carers are ultimately responsible for the protection of children in their care. Biehal (2014)[3] points out that professionals face many dilemmas when deciding on the safest course of action for a child when the consequence could be serious disruption and recommends that time is taken with colleagues to carefully weigh the evidence in individual cases. Biehal also suggests that agencies need to raise awareness of the circumstances in which

dePanfilis, D, Girvin, H (2005) Investigating child maltreatment in out of home care: Barriers to effective decision making. *Children and Youth Services Review:* 27 (4):353-374

[3] Biehal, N. (2014) Maltreatment in Foster Care: A review of the evidence. *Child Abuse Review,* 23:48-60

carers need additional high quality supervision and support. One of these could be where female children are placed in a family with older boys, or where there are numerous children in the household. Poor assessment and supervision of foster carers increases the risk of child abuse.

While it is recognised that children may not feel able to disclose abuse, the opportunities for them to confide in workers are greatly reduced if visiting is infrequent or the environment is not conducive to sharing sensitive information. Ultimately, the protection of children in foster care from harm will depend on the quality of practice delivered by the agency that places them.

It is estimated that sibling abuse occurs three to five times more often than father-child incest. In this review the foster children could have been considered siblings of children of the foster family due to the long term nature of their placements. As John Caffaro a recognised expert in sibling abuse (2005) has pointed out, this type of abuse detected less often than other types of intrafamilial abuse due to lack of disclosure and also because the incest taboo between siblings is weaker, with neither a generational nor a power differential in many instances. It is suggested that working through sibling abuse issues usually requires a number of different approaches such as individual, sibling, family and group meetings, while safety and accountability must be prioritised.

The special vulnerabilities of children in care must be considered. Allegations of serious concerns and abuse and neglect of children in foster care should be addressed under *Children First, National Guidance for the Protection of and Welfare of Children 2011* and the National Standards for Foster Care (2003). Allegations of serious concern involving foster families should be notified to the Foster Care Committee without delay. The FCC reconsiders the carers/relatives approval status in the light of the conclusion of the assessment/investigation outcome (Standard 10.19).

11.3 Factors that help children disclose

It is well known that significant numbers of children delay disclosing sexual abuse, and that there are a number of factors that hinder them from doing so. In this case, the social workers for the children were aware that their potential reluctance to reveal that they had been abused could have been connected to the losses that telling would invoke, particularly the loss of security and stability that a change of placement would have incurred. It is also known that lack of parental support impedes disclosure. There is less knowledge about the factors that actually help children to disclose, particularly in informal settings, and it is worth considering available research on this topic. In an Irish study, McElvaney and Culhane[4] have identified enabling factors extraneous to formal assessment interviews as: educating young people about what to do with a friend discloses

[4] McElvaney, R and Culhane, M. (2017) A Retrospective Analysis of Children's Assessment Reports: What Helps Children Tel? *Child Abuse Review, 26: 103-115*

experiences of sexual abuse; creating opportunities for children to talk; asking them about their general wellbeing; reinforcing messages from parents, teachers and all professionals who have contact with children that responsibility for the abuse rests with the abuser. Other research[5] has identified that providing young people with information about child sexual abuse that is developmentally appropriate as well as positive emotional support and understanding to pre-empt feelings of guilt and shame. It is also suggested that prevention programmes should not only target children but also educate those to whom children are likely to make disclosures to help them make supportive responses.

11.4 Responding to allegations of child sexual abuse in foster care

When responding to allegations of child sexual abuse at practice level, certain elements need to be prioritised. This case has shown that repetitive interviewing is often unproductive and that the timing and pacing of interviews is critical. Moreover, the question of who accompanies the child to interviews needs to be carefully considered. As this report has highlighted, it is unrealistic to think that a child who is brought to interviews by parents or carers whom she or he knows to be disbelieving and on whom she or he is dependent for his or her care is likely to disclose that abuse is occurring in a family home.

If an allegation of abuse should arise in a foster home, an assessment should be carried out into not only the safety, but also the impact of the allegation on other children in the foster home. The assessment should take account of the emotional consequences of the removal of a child from the placement as a result of disclosure. A careful record should be kept of the timing and content of discussion with a foster child's biological parents regarding any allegation of abuse. It is important that such conversations contain clarity regarding the outcome of investigations and assessments.

11.5 Risk assessment

The NRP is aware that Tusla is in the process of implementing the Signs of Safety practice framework which is designed to 'provide an appropriate, proportionate, timely response to children at risk / in need'. Traditionally, conducting a risk assessment means identifying current and pre-existing dangers, measuring the likelihood and potential severity of future harm arising from those dangers, and considering whether existing protective factors are sufficient to reduce the likelihood of harm. Assessments must be of sufficient depth and quality to justify a decision; even if that decision is conditional. The risks posed in this case were not substantially examined in terms of their implications for the two children remaining in the foster home. The implementation of Signs of Safety will be of assistance to staff that have to undertake risk assessments but importantly, what

[5] Lemaigre, C. et al (2017) 'Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse and Neglect.* 70:39-52

this review illustrates is the need for *awareness* and *recognition* of when a risk assessment is necessary. It also highlights that any assessment must consider the *possibility* that a child is at risk and might require immediate measures to be taken. If a decision is taken to leave children in a home where it is believed sexual abuse has occurred, it is essential that a robust safety plan based on an in-depth risk assessment is put in place. For such a plan to be effective there needs to be authentic engagement with families with mandatory therapeutic supports for the perpetrator and all family members to help them accommodate to the fact that sexual abuse has occurred within their home.

11.6 Working with denial

Research shows that protection of a child is significantly diminished when she is not believed by a parent/carer. Parental denial also contributes to increased trauma of the victim. There is a substantial literature on non-offending caregivers responses to accusations of sexual abuse by other family members. While most of it relates to birth children in families, it is applicable to foster children as well. Research shows that it is not unusual for non-offending caregivers, mothers in particular, to resist the notion that someone they love was abused by someone also close to them. Common reactions are confusion, anger, depression, self-blame and disbelief[6]. This can be for many reasons, often to do with the context of their lives[7]. Inappropriate and sometimes ambivalent responses by mothers are explained by the losses they experience; their loss of identity and self-esteem as good parents, their loss of standing within their families and communities and the loss of their child's innocence[8]. The tendency for mothers to project their guilt in the form of anger against professionals has also been identified[9]. It is suggested that their own experiences and responses should be acknowledged and that over time, assistance in the process of grieving should be provided. In the same way that children can take time to disclose, mothers may move through various phases of denial to suspicion to understanding that something has happened. The overall message is that mothers and, in many cases, fathers need considerable personal validation and support in the aftermath of a disclosure and that formal and informal networks as well as individual and family therapy are mediating factors. Having deemed a disclosure of sexual abuse credible, every effort should have been made with the foster carers to move them from the rigid position of denial that they adopted from the outset.

[6] Carol A. Plummer, (2006) ' Non-abusive mothers of sexually abused children: the role of rumination in maternal outcomes. *Journal of child sexual abuse,* Vol.15

[7] Ramona Alaggia, (2001) Cultural and religious influences in maternal response to intrafamilial child sexual abuse: Charting new territory for research and treatment.*Journal of Child Sexual Abuse,* Vol. 10,

[8] Carol Anne Hooper (1992) *Mothers surviving child sexual abuse.* Tavistock.

[9] Hanife Serin (2018) 'Non abusing mothers' support needs after child sexual abuse disclosure' *Child and Family Social Work.*

11.7 Decision making and group think

In this case, the lack of discussion and debate was striking in respect of the meeting held to discuss future arrangements for the children in care following the first disclosure. The review has highlighted that the full range of risks attached to leaving them in the foster home was not considered or even speculated upon at that time or at any time over the following four years even when it became apparent that the abuser was frequently present in the household, The foster mother was controlling and minimising contact by the fostering link workers and the SWD was not sufficiently resourced to fulfil its part in the safety plan. Milner and Kelly (1996)[10] have offered a theoretical model to explain the concept of 'group think' which has resonance for what occurred in this case. They illustrated the sequence of stages and events whereby a decision unfolds and is upheld. According to their theory, when a choice is framed in terms of losses, the course of action taken is likely to carry more risk. In relation to this review, that theory could be applied to the choice about future placements for the children in care and the losses they would inevitably experience if they were moved. Milner and Kelly have described how this group polarisation and subsequent group pressure for conformity ensures that the initial dominant position of the group will remain the group choice, unlikely to be substantially altered. In this particular case, the absence of review or of a forum for discussion of the case at a coordinated level meant there was no means by which original decision could be re-evaluated.

11.8 The nature of adolescent offending

When responding to an allegation of sexual abuse perpetrated by a young person, particularly when allegations have been considered credible, practitioners need to have an understanding of the dynamics of adolescent offending. While there are many different manifestations, common criteria include: power differentials in terms of age, physical size and maturity; role differentiation in terms of power and authority; predatory patterns which include 'setting up' the victim, and elements of coercion including threats and bribes. It is also important to acknowledge that adolescent sexual abuse is often underreported or dismissed as developmentally normal or a 'once off' occurrence, and when it occurs in families there is a desire by parents to protect the offender either out of shame or because of a deliberate secrecy which conceals the fact that incest may be occurring. Adolescent offenders may differ considerably from each other, but it is known that some are psychologically or emotionally troubled, some have experienced abuse themselves and some are developmentally delayed. They are often thought to be empathy deficient[11]. It is generally agreed

[10] N. Kelly and J. Milner (1996) Child Protection Decision Making, *Child Abuse Review,* Vol 5:91-102

[11] Varker et al (2008) Empathy and adolescent sexual offenders: A review of the literature. *Aggression and Violent Behaviour,* 13:251-260

that urgent intervention is essential to prevent the patterns of offending to become ingrained in the young person[12]. Given what is known about adolescent sexual offending, for example its recidivist nature, the high likelihood that perpetrators have abused more than one victim and their good response to treatment, all adolescents who have sexually abused and come to the attention of Tusla should be referred to an age appropriate specialist service for thorough evaluation and management.

Dr Helen Buckley

Chair, National Review Panel

[12] http://www.cyc-net.org/cyc-online/cycol-0905-charles.html