# Case Review Mary

A review jointly commissioned by the HSE and Tusla into the circumstances whereby a vulnerable young adult ("Mary") with an intellectual disability, in receipt of services from both agencies, continued to reside with a former foster family following a report being received of a retrospective allegation of abuse, which did not relate to residents in the foster home.

February 2017

# Table of Contents Page

# Foreword

Since the events as they are outlined in this review started to unfold in 2014, a number of changes have occurred within the services identified, and additional procedures and safeguards have been implemented.

## Health Service Executive (HSE) Safeguarding Vulnerable Persons at Risk of Abuse – Safeguarding Teams

In December 2014, the Health Service Executive (HSE) published its Safeguarding Policy "*Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures".* The Policy sets out a number of key principles which help to promote the independence and rights of adults who may be vulnerable. These include: person centeredness, human rights, culture, advocacy, confidentiality, empowerment, and collaboration. The policy also outlines the procedures to be followed if there are concerns of abuse and/or neglect of a vulnerable adult, and aims for a consistent approach to ensure vulnerable adults are safeguarded and protected from abuse.

The Policy provides details of a number of structures to be developed in order to support the safeguarding agenda, including the establishment of a National Safeguarding Office and dedicated teams at community health organisation level. One of these supporting structures is the establishment of a National Safeguarding Committee which promotes collaborative working across sectors.

Since January 2016 there have been nine Health Service Executive Safeguarding Teams established, one in each Community Healthcare Organisation Area. Each team is led and managed by a principal social worker and has amalgamated with the social workers who were assigned to the existing HSE adult protection (elder abuse) service. These safeguarding teams accept cases of referral of vulnerable adults.

## Aftercare Steering Committees Tusla

In the area where these events took place, an Aftercare Steering Committee has been established by Tusla "*to fulfil the requirements of planning, implementing and monitoring a comprehensive, integrative Aftercare Programme for each young person leaving care"* (internal Tusla document, 2016). This committee is multi-agency in nature with representatives as follows:

- Disability Services: HSE
- Non-Government Organisations
- Education/Training e.g. SOLAS
- Residential Service: Tusla
- Fostering Service: Tusla
- Children in Care Team: Tusla
- Primary Care: HSE

- Department of Social Protection (Community Welfare Office)
- Housing
- Tenancy sustainment provider

## HSE National Independent Review Panel for Disability Services

The HSE is putting in place a National Independent Review Panel for disability services. This is modelled on the independent National Review Panel within Tusla, which reviews cases of children who are in the care of the State who die, or who are subject to serious harm.

It is envisaged that the category of serious incident that may be referred to the Independent Panel will include:

- Unexplained death in care
- Serious harm while in care (serious injury to a person which is an injury which creates a substantial risk of death or which causes serious disfigurement or substantial loss or impairment of the mobility of the body as a whole, or of the function of any particular bodily member or organ)
- Serious allegations of sexual or physical abuse by a carer in the employ of the state
- Serious allegations of poor care that pose a significant risk to the life or safety of service users.

The National Independent Review Panel will consider each individual serious incident and objectively review all aspects of care and treatment pertinent to the review and to professional, organisational and best practice standards. In addition to conducting direct reviews of care, the Independent Panel may also be asked to quality assure incident reviews or investigations undertaken at service level.

The Chair of the Panel has been appointed through the Public Appointments Service and is expected to take up the role early in 2017. The Chair will then commence the work involved in establishing the office of the Panel, and the process of recruiting other members to the Panel.

## Joint Protocol HSE/Tusla

In April 2015 the HSE and Tusla established a national interagency working group to review the HSE/Tusla Joint Working Protocol 2014 in relation to children and young people with disabilities. This group was later extended to include children and young people with mental health issues.

The terms of reference for the group were agreed as follows:

- To clarify and set out the respective roles, duties and legal requirements of the HSE and the Child and Family Agency, in relation to children and young people with a disability and/or mental health issues
- To establish areas of joint responsibility
- To revise the current Joint Protocol in accordance with the above

- To develop pathways for increased understanding and cooperation between the HSE and the Child and Family Agency
- To establish mechanisms for dispute resolution.

The draft report from the working group is currently being considered by both agencies and is expected to be implemented from February 2017.

## Local Interagency Joint Working Processes

In the area where the events took place, Tusla and the HSE have jointly established a number of processes and structures to assist in achieving effective joint working.

- Since early 2014, senior Tusla and HSE management meet on a bi-monthly basis as an interagency management group to oversee cooperation and collaboration across all areas of joint working.
- Principal social workers and disability managers meet on a quarterly basis to review a register of children with disabilities who are receiving a service from Tusla. This process was established in 2016.
- Senior Tusla and disability management meet to address specific issues in relation to common cases. This process was established in 2016.

## Tusla Integrated IT System

An integrated electronic communications system is in the process of being rolled out by Tusla.

# Author's Note

This review was established on May 23rd 2016 with a completion date of July 4th 2016. On application by the independent reviewer this was extended to July 22nd 2016, to allow for the absence of some interviewees on annual leave. The report was submitted to the commissioners at the end of July 2016. On foot of this the commissioners made submissions to the independent reviewer, in the period between October 2016 and January 2017. These (separate) submissions were concerned with addressing matters of factual accuracy, and seeking clarity around some of the findings of the report. In particular, the Tusla submission was concerned with what it perceived to be an imbalance in the review, insofar as it did not adequately acknowledge attempts made by Tusla to refer the case to the HSE, and focused attention on the activity of Tusla in the case, without giving due regard to the responsibility of the HSE Disability Services. The reviewer responded to the submissions and this document constitutes the final report.

# Executive Summary

This review was jointly commissioned by the Health Service Executive and Tusla, the Child and Family Agency. It relates to a period of time between 2014 and 2016 when a young woman, who had previously been in statutory care, continued to reside in her former foster care placement, after a credible retrospective allegation of child sexual abuse had been made against the foster father: the allegation did not relate to any children in the care, or foster care, of this man.

The purpose of the review as outlined in the terms of reference is:

1) To establish the full facts of the case;
2) To consider, in particular, issues of safeguarding and risk assessment in respect of this case;
3) To set out findings in this case with regard to risk, safeguarding and best practice;
4) To identify specific and general issues to inform any necessary learning, having regard to best practice in managing risk and interagency engagement.

The review was undertaken by an independent reviewer, Dr. Cathleen Callanan, assisted by two senior staff nominees from the HSE and Tusla respectively: Ms. Helena Butler and Mr. Oliver Mawe.

Dr. Callanan's background is in social work. She has forty years' experience in areas such as criminal justice, voluntary agency work, child protection, academia, and social care regulation.

Ms. Butler's background is in nursing. She has extensive experience in quality and risk management, and systems analysis.

Mr. Mawe's background is in social work. He is an experienced practitioner at operational and senior managerial level in a range of social work services, including child protection.

The reviewer and colleagues had no direct responsibility for the services associated with the case and no prior involvement with the case.

Responsibility for the contents of this review rests solely with the independent reviewer.

## Key Findings

The key findings of the review are summarised below. The rationale informing these findings is contained in more detail under the terms of reference sections of the report.

1. The dilemma experienced within Tusla with regard to what action might be taken legally in respect of an adult with intellectual disability not under a statutory care order, contributed to Mary remaining in her placement. (Page 48)

2. Deviation from procedures available to escalate the case to senior management in Tusla before 2016 contributed to Mary's continued presence in the placement.
   (Page 48)

3. Reliable safeguarding measures were not in place for Mary despite the fact that, in the initial phase of the period under review, Tusla responded comprehensively in terms of risk assessment when the allegations were first brought to their notice.
   (Page 49)

4. The review undertaken by Tusla of the safeguarding measures in place for Mary in 2015 was not completed within an appropriate time frame.
   (Page 49)

5. Individual staff demonstrated a clear desire to apply a person-centred care approach with respect to Mary's welfare.
   (Page 50)

6. Coordination of service delivery between the HSE Disability Services and the voluntary organisation was ineffective.
   (Page 50)

7. A clear and formal written referral from Tusla to the HSE in 2014 could have contributed to progressing the case and bringing clarity to the roles of both organisations.
   (Page 50)

8. When interagency cooperation was formalised in 2016 via the complex case meeting mechanism, it was efficient in making decisions.
   (Page 50)

9. There was a lack of a shared understanding among all the agencies involved with regard to referral pathways between Tusla, HSE Disability Services and the voluntary organisation.
   (Page 54)

10. The lack of clarity around role and function of post holders had a negative impact on the overall management of the case.
    (Page 55)

## The review has identified specific and general issues for learning.

A. Promotion of a shared awareness of intersecting policies and procedures for interagency working including the HSE Safeguarding Policy and the Tusla Aftercare Policy will facilitate a mutual understanding of roles, responsibilities and referral pathways, which would assist the management of complex cases

B. Formal arrangements to include meetings to address complex cases pertaining to people with disabilities with multi agency involvement would facilitate improved management, or shared management of specific cases

C. Requirements with regard to record keeping standards are an identified deficit requiring attention. Clear guidance needs to be provided to staff in relation to good record keeping practices

# Acknowledgements

The review team would like to acknowledge the cooperation of all agencies involved in providing documents and files as requested. In addition, the independent reviewer and colleagues involved in the review would like to acknowledge the forthright and cooperative manner of all participants at interview. The review was facilitated by the invaluable assistance of Ms. Annette Logan, the Support Officer assigned to the case.

# Background to Personal Social Services

This background is intended to assist the reader unfamiliar with the landscape of personal social services, in understanding the context within which the work of the review was undertaken.

## Child Protection and Welfare

Historically children came into care under the Child Care Act 1991 under the supervision of a social work department of regional Health Boards, and from 2005, the Health Service Executive, which was responsible for child protection and welfare until 2014. Since 2014 this function has been taken over by the Child and Family Agency, Tusla. While Tusla is an independent agency, there remain some shared services with the HSE, for example some recruitment programmes, and information technology.

Within the broad range of services for children and families provided by Tusla, there are a number of specialist services which, while they operate as separate teams, work collaboratively and often share reporting relationships with the same senior manager.

Larger social work departments typically have duty, intake and long-term teams. Broadly speaking, duty teams deal with all enquiries and make referrals to the relevant service, which may or may not be within Tusla. Intake teams typically deal with cases that are expected to be resolved within a period of weeks or months, but as these referrals are handled on a case-by-case basis, some can extend into a period of over a year. Long-term teams manage cases that extend over a lengthy period and may encompass the lifetime of a child in care.

Tusla draws on a variety of services within the arena of social care to support its work with children and families. These include other services from within the agency, and from within the HSE. The HSE and Tusla collaborate in a range of areas such as mental health, addiction treatment, and disability services. In addition, Tusla supports services within the community through grant aid, and depends on community networks to refer children and families to services: this is often done in an attempt to facilitate a degree of family support that would avoid reception of a child into care. Therefore, relationships of long standing develop between social work departments and a range of voluntary community services, including those providing residential placements. However, the direct provision of residential placements by Tusla is for children in care only.

## Fostering

Social work departments rely on their colleagues on foster care teams to recruit, assess, train and support foster carers in the community, with whom the social work department places children taken into care. Of the total number of 6,420 children in care in Ireland in

2015, 93% were in foster care and other placement arrangements (such as with family), with the remainder being in residential placements (Tusla Annual Report, 2016). Where a child being received into care has very particular needs, the number of foster carers able and willing to take on the care of such a child is limited. This arises for a wide range of reasons, including the level of commitment required from the foster carers, uncertainty about the capacity of the child to move on from the placement on reaching adulthood, the role of the family of origin in the child's life, and the impact on any other children the foster carers may have. Therefore, there is a high degree of interdependence between social work departments and foster care teams in establishing and sustaining such placements, where foster carers and the child in their care may need a high level of support.

The appointment of foster carers is overseen by a Foster Care Committee, which makes recommendations and approves long-term placements.

## Aftercare

The National Aftercare Policy (HSE, 2011b) states that all young people in care from the age of 16 upwards should have an aftercare plan, which sets out their needs as they leave care at 18 and move into adulthood. It also states that they should be assigned an aftercare worker. The Child Care Act 1991(Section 45) states that a health board (in which responsibility for childcare was vested at that time) may assist a child, "by causing them to be visited or assisted, by arranging for the completion of their education, by contributing to their maintenance, by arranging hostel accommodation or by cooperating with housing authorities in planning accommodation for children leaving care." While further legislation in this regard has been enacted by the Child Care (Amendment) Act 2015, at the time of writing this has yet to come into operation.

Young people leaving care may experience a range of needs requiring input from a variety of services. These may include additional supports from services such as mental health and/or disability services. In addition, some young people may not have the capacity to live independently at that point in their lives, and require supports in the community from voluntary or other organisations. While the aftercare service has a role in identifying such services, it does not have control over their provision, and is dependent on the cooperation of allied services. In addition, the service cannot coerce a young person into accepting assistance, given that a young person leaving care may choose not to avail of aftercare services.

## Retrospective Disclosures and Allegations of Sexual Abuse

In instances where a current allegation of sexual abuse requires investigation, or where there is an identified current risk to a child, a specialist service such as a sexual abuse assessment centre in Tusla receives such referrals and undertakes the investigation. Such services generally work closely with medical and allied health professionals.

Retrospective allegations of sexual abuse, which may go back many years, are assessed by the Tusla social work departments. In some cases specialist staff have been designated to address backlogs of retrospective allegations.

Further information can be found on www.Tusla.ie

## HSE Disability Services

There is currently no legislation underpinning the provision of services for people with disabilities. The Disability Act (2005) provides for an assessment of need for all children, and the provision of an individual service statement. The Disability Act does not provide any entitlement to residential services, respite services, day services or multi-disciplinary services. Individuals are placed on a waiting list for various services, which are resource dependent.

Specialist services for children and adults with disabilities include multi-disciplinary supports, respite, home support, day and rehabilitative training services for adults, and residential services. The services provided cater for people with an intellectual disability, people with a physical and/or sensory disability, and those with autism. Over 80% of specialist services for people with disabilities are provided by voluntary organisations. These organisations are funded by the HSE to provide services under Section 38 or Section 39 of the Health Act.

Disability managers are responsible for the funding and monitoring of services to people with disabilities within a geographic area. The services arrangement between the HSE and voluntary organisations defines the quantum and quality of services to be provided in a particular year. Disability managers are assisted by case managers who are assigned to work with individuals and families, when additional services or changes in services may be required.

### Services for Children with Intellectual Disability

Children with an intellectual disability may receive education in special schools or in special classes, resource programmes, or mainstream classes in mainstream schools. All education provision for children with intellectual disability is the responsibility of, and funded by, the Department of Education and Skills. Special schools are often established by, and under the patronage of, a voluntary organisation specialising in service for people with intellectual disability.

A voluntary organisation delivering a service may provide multi-disciplinary supports for children attending a special school. Multi-disciplinary supports include psychology, speech and language therapy, occupational therapy, physiotherapy and social work, and are funded by the HSE. A small number of children with particular needs may require home supports and/or respite services, which are also funded by the HSE.

### Services for Adults with Intellectual Disability

The aim of national policy is that people with mild intellectual disability will receive services from mainstream providers. However, those with moderate, severe or profound intellectual disability may require specialist services funded by the HSE. Specialist services for people with intellectual disability may include rehabilitation training, day services, short stay, home support, residential services and multi-disciplinary supports. Short stay services are normally

provided in a residential environment but may also include in-home or a day service. Residential services may be for 5 days or 7 days.

There is generally a very limited number of places available in residential settings. The availability of long-term places is based on a number of factors, including the need to match residents in the same facility who will, in all probability, live out their lives together. Therefore, the need for a thorough assessment before admission is critical to the success of the placement. In addition, the move towards decongregation has meant that admissions to multi-occupancy residential settings are diminishing, in favour of placement within the community in single or shared accommodation, with levels of support appropriate to those residents.

Further information can be found on www.hse.ie

## Citizens Information Board (formerly Comhairle)

The Citizens Information Board (CIB) is the statutory body which supports the provision of information, advice and advocacy services to members of the public on the broad range of social services.

The Board was established as a statutory body under the Comhairle Act 2000 and its name changed from Comhairle to the Citizens Information Board as amended by the Citizens Information Act 2007 and the Social Welfare (Miscellaneous Provisions) Act 2008.

As a statutory agency, the Citizens Information Board comes within the remit of the Department of Social Protection. One of the aims of the service is to assist and support individuals, in particular those with disabilities, in identifying and understanding their needs and options.

Further information can be found on www.citizensinformation.ie

# Background to Case under Review

The case under review concerns a young woman who is referred to by the pseudonym "Mary"[1].

Mary was placed in foster care while a young child. At the time of her placement the extent of her disabilities was not fully known and only emerged as she became older. Mary had an intellectual disability that required a high level of care and attention. However, her foster carers (referred to throughout as Mr. and Mrs. A) adapted to her needs as they emerged, and the placement was considered by the Tusla social work department and the foster care department to be a successful one. There were other children also in foster care with Mr. and Mrs. A and they were considered to be receiving a high level of care.

Mary attended a school run by a voluntary organisation for people with intellectual disabilities, and later graduated into their day care programme for thirty hours each week. As with similar organisations nationwide, the voluntary organisation had a Service Arrangement with the HSE.

Mary did not have any meaningful contact with her birth parents but was in frequent contact with one sibling in particular, and other siblings on a less frequent basis. These relationships were encouraged by her foster carers and were considered to be very rewarding for her.

In January 2014 (by which time Mary was an adult), information was received anonymously by the social work department of Tusla in Mary's locality, alleging that Mr. A had, around fifteen years previously, sexually abused two young teenage girls within his extended family. Subsequently, two complainants came forward presenting themselves as the persons having initiated the anonymous allegation, and now wishing to put it on record. The complainants stated they had come forward out of concern for the welfare of children in the household of Mr. and Mrs. A, and the potential risk posed to them by Mr. A. At no time was any allegation made that children currently within the care of Mr. A had been subjected to abuse.

Two team leaders, one from Tusla child protection and one from Tusla foster care services, were nominated to conduct an enquiry into these allegations. They found the allegations credible and acknowledged in their subsequent report that Mr. A had denied the allegations, and had been supported by his wife in doing so.

A decision was made by Tusla to remove the foster children from the home and, later that year, Mr. A and Mrs. A were removed from the panel of foster carers. The children who were moved did not experience the same level of communication difficulties as Mary, and they did not disclose anything of concern in respect of Mr. A's engagement with them.

Mary was now an adult (since 2013) and the powers available to Tusla to remove the other children were not available in her case as she was no longer in statutory care; this issue was not resolved at this point. The placement was reviewed by Tusla between 2015 and 2016, the outcome of which precipitated a reconsideration of Mary's placement with Mr. and Mrs. A. In February 2016, a decision was taken by the HSE to remove her to a residential

[1] For ease of reference the pseudonym "Mary" is used without quote marks throughout the remainder of the text.

placement. The reasons why Mary remained in the placement from January 2014 (when the allegations were first made) to February 2016, form the scope of this review.

# Terms of Reference

The purpose of the review is:

1) To establish the full facts of the case;

2) To consider, in particular, issues of safeguarding and risk assessment in respect of this case;

3) To set out findings in this case with regard to risk, safeguarding and best practice;

4) To identify specific and general issues to inform any necessary learning having regard to best practice in managing risk and interagency engagement.

## Scope and Timeline of the Review

The instructions to the reviewer were that the scope of the review should encompass the examination of all relevant available reports and interviews, with all relevant parties, as deemed appropriate by the independent reviewer. Further, that the timeline of the review should refer in particular to the period from January 2014 ,when the allegation of abuse was brought to Tusla's attention, to February 2016, when the decision was made by the HSE to remove Mary from the former foster family home to a full-time residential placement.

# Methodology

On receiving the brief for this review, which referenced systems analysis as the methodology, the independent reviewer was directed by the Department of Children and Youth Affairs, and the Department of Health, in agreement with the commissioners, that the review was to be a case review. Therefore, the systems analysis methodology was used as a guideline only. In addition, the terms of reference required the reviewer to be cognisant of the national policy and procedures for safeguarding vulnerable people (HSE 2014b).

## Publications, Files and Interviews

On being issued with the terms of reference the independent reviewer met with the two nominees assigned by Tusla and the HSE, to consider the body of information they would require in order to progress the review. Having collated the list, these files and publications were then sourced by the support officer assigned to assist the review. As the review progressed, further records were identified to inform the process; these are included in the list provided in Appendix 2.

All three parties engaged in the review had individual copies of all files. The volume of material available from Tusla – both in terms of files and the number of interviewees – was considerably greater than from the HSE Disability Services and the voluntary organisation; this is reflected in the chronology and Appendices. The Tusla files included two case files in respect of Mary. There was no HSE Disability Services case file for Mary, and of the HSE files listed in Appendix 2, there was some duplication of material.

Details provided in this report have been obtained from a review of the relevant documentation and interviews with relevant personnel. Timings are based on records and the staff's recollections. Individual interviews were undertaken with staff members involved in Mary's case during the period covered by the scope of the terms of reference. A total of 17 people were interviewed. An anonymised list of interviewees is contained in Appendix 3.

The interviews were conducted by the independent reviewer and colleagues in a manner that aimed to obtain optimal levels of information while ensuring the interviewees were treated with dignity and respect, due process, and natural and constitutional justice. In accordance with the guidance in the systems analysis methodology, any individual accompanying an interviewee signed a confidentiality agreement.

All information gathered during the documentation and interview stages of the investigation process was treated confidentially and maintained securely.

On completion of the interviews a draft chronology was sent to the interviewees, apart from one person who had no active role in the case, and another who was not available to give a response. The chronology contained some commentary which one might not normally expect to see in a chronology, but this was intended to compensate in some measure for the fact that interviewees would not have an opportunity – because of the time limitation – to comment on a draft of the full report. Following feedback from the interviewees, amendments were made to correct any erroneous information contained in the chronology,

to indicate where information was contested, and to enhance the factual accuracy of the information.

## Limitations to the Review

Responses to the draft chronology were solicited from fifteen interviewees. Two interviewees did not respond.

The time allocated for the completion of the review did not allow for feedback from interviewees to a draft report. This was outside the control of the independent reviewer. However, information provided by Tusla is that one interviewee (identified in the body of the report as Senior Manager1) had sight of a draft report to inform their feedback.

The limitation identified above – the lack of sufficient time to circulate a draft – was based on the situation as it pertained at the end of July 2016 when it had been made clear to the reviewer that there was considerable urgency in completing this review within a tight timeline. The reviewer is not aware of the circumstances that allowed for the lapse of time until the final submission of the report.

# Term of Reference 1:
## To establish the full facts of the case

In order to establish the full facts of the case insofar as they can be determined, a chronology of activity relating to Mary's care during the period from January 2014 to February 2016 was completed.

The chronology was compiled from a study of the case files listed in Appendix 2, and interviews with those listed in Appendix 3. The chronology offers a broad outline of critical milestones, and points in time when actions may have had a significant impact on the outcome with which the review is concerned. The chronology is not a duplicate of the files, and where a contact between agencies may have been recorded on the file of one agency, it has not necessarily been duplicated in the partner agency. The reviewer attempted to overcome this through the process of interviewing relevant parties, and by the dissemination of a draft chronology for comment by interviewees. As referred to in the methodology section, the format of the chronology was intended to alert the interviewees to issues that may arise in the body of the report, and to try to some extent to overcome the shortcoming of not being able to circulate a full draft report. On receipt of the feedback, commentary from interviewees was added to the chronology. Given the complexity of the case and the number of participants involved, the chronology as it is presented here includes some observations by the reviewer, and flags some issues which it is hoped will illuminate the discussions in the subsequent sections of the review.

Issues or events which may have compromised the confidentiality of Mary and any other party, are stated in such a way as to protect the integrity of the process.

The chronology reflects the timeline of this review in that it covers the period from January 2014, when the allegation of abuse was brought to the attention of Tusla, to the point in February 2016 when a decision was made by the HSE to remove Mary from the (former) foster home. However, in order to illuminate some issues that arose within this time frame, the review drew on records prior to the time of the disclosure in 2014.

The full facts of the case insofar as they can be determined are outlined in the itemised chronology below. As this is lengthy and detailed, it is preceded by a résumé of events over the period in question.

### 2013

In 2013 preparations were made by the social worker assigned to Mary within the child protection and social work department of Tusla, for the expiration of Mary's statutory care. This preparation involved a meeting convened by Tusla, inviting the HSE Disability Services and a voluntary organisation which Mary attended for 30 hours per weekday care. These preparations were being made in the expectation that she would remain in her foster placement for the remainder of her life, as this was the wish expressed by her foster parents, and all the indications were that Mary was happy in the placement. The foster carers also had other children in their care.

## 2014

In early 2014 allegations of sexual abuse against Mary's foster father were received by Tusla from adult relatives. The allegations were investigated by Tusla. While the foster father denied the allegations they were deemed to be credible, and plans were put in place for the removal of the foster children from the placement. These children did not report any issues of concern about the interaction of the foster father with them, and they also appeared to have been happy in the placement. Mary was now an adult and the authority of Tusla to make decisions on her behalf had expired. There followed in 2014 a series of interactions between Tusla, the voluntary organisation where Mary was receiving day care, and the HSE Disability Services. These interactions were focused on the issue of placing Mary elsewhere in a context where no vacancies were available within the service where she was known, on agreeing the level of risk, and on establishing with which agency responsibility lay, for making and executing decisions. This was not resolved by the end of 2014.

## 2015

There were periodic cross checks between the agencies involved in 2015, which sought to clarify the level of risk but did not advance an alternative placement.

A concern remained within Tusla as to the unresolved nature of Mary's situation, and an internal review was initiated to determine if there were sufficient safeguards in place to allow her to remain in the placement. The Tusla commissioner of the internal review was also concerned that, depending on the outcome, the HSE Disability Services might be required to arrange a residential placement for Mary, and alerted the HSE Disability Services accordingly.

## 2016

The internal review commissioned by Tusla in 2015 resulted in a draft report being submitted in January 2016, which concluded that there were sufficient safeguards in place to protect Mary. However, in reassessing the situation in the light of the original assessment in 2014 that there was a risk, the greater weight was given to the original assessment, and a complex case meeting of all the agencies involved was convened by Tusla, to determine how this should be addressed.

There was agreement between the agencies that Mary should be moved from the placement. Those concerned with arranging the move for Mary were aware that it should be gradual and carefully planned, in view of the level and type of disability she experienced. Such a graduated transfer, however, depended on Mr. A giving certain undertakings, including temporarily leaving the family home. He did not feel able to comply with these requirements, and therefore the HSE made a decision to transfer Mary to a residential placement within a few days.

**Case Participants**

A considerable number of professionals was involved in the case under review. The table below is intended to signpost the reader to their location within the system. To protect anonymity, titles are used which are sometimes less specific than those normally assigned to the incumbent: so, for example, the term *manager* is used to cover a range of managerial posts. To distinguish between Tusla and the HSE, numbers are used to identify the former, and letters are used to identify the latter.

## Tusla

| | Organisation | Staff | Role |
|---|---|---|---|
| TUSLA | Tusla: Child Protection and Welfare | Team Leader1 | The team leader who met with the complainants in 2014, and completed the assessment of the retrospective allegations with Team Leader2 |
| | Tusla: Foster Care Team | Team Leader2 | Completed assessment of the retrospective allegations with Team Leader1 |
| | Tusla: Child Protection and Welfare | Social Worker1 | Case holder while Mary was in care up to 2013 |
| | Tusla: Child Protection and Welfare | Team Leader3 | Team leader who was line manager to Social Worker1 and reported to Principal Social Worker1 (PSW1) |
| | Tusla: Child Protection and Welfare | Principal Social Worker PSW1 | Principal social worker responsible for oversight of the case |
| | Tusla: Child Protection and Welfare | Principal Social Worker PSW2 | Principal social worker with duties not including this case |
| | Tusla: Aftercare and Foster Care Team | Manager1 | Manager in Tusla with oversight of aftercare services who commissioned a review of Mary's placement in 2015 |
| | Tusla: Foster Care Team | Principal Social Worker 3 PSW3 | Principal social worker who undertook the review of Mary's placement in 2015 |
| | Tusla: Team for young people out of home | Social Worker2 | Social worker who participated in the review with PSW3 in 2015 |
| | Tusla | Senior Manager1 | Senior manager in Tusla with overall responsibility for services in the area |
| | Tusla | Aftercare Coordinator | Principal social worker responsible for the coordination of aftercare services |

## HSE

| | Organisation | Staff | Role |
|---|---|---|---|
| HSE Disability Services | HSE Disability Services | Case Manager A | Manager in HSE Disability Services |
| | HSE Disability Services | Case Manager B | Manager in HSE Disability Services |
| | HSE | Manager A | Manager in HSE with responsibility for a range of services |
| | HSE | Senior Manager A | Senior Manager in HSE with overall responsibility for disability services |
| | HSE | Principal Social Worker A | Principal social worker for the adult safeguarding team rolled out in January 2015 |

## Voluntary Organisation

| | Organisation | Staff | Role |
|---|---|---|---|
| Voluntary Organisation | Voluntary Organisation | Director | Responsible for overall delivery of services |
| | Voluntary Organisation | Principal Social Worker voluntary organisation | Responsible for delivery of social work services |

Where staff who had responsibility for other children in the care of Mr. and Mrs. A were in attendance at, for example, professionals meetings, they are not included in the list of participants. Only those involved in the discussions around Mary's care are included.

To provide some context to the following chronology, it is useful to note that in February 2013 Social Worker1 completed a formal referral to the Tusla Aftercare Service. On March 13th 2013, Social Worker1 convened a professionals' meeting in order to formulate an aftercare plan to present to court, in anticipation of Mary being 18 years old later that year. Among those present at that meeting were Case Manager A of the HSE Disability Services, and the director of the voluntary organisation (in a different role at that time).

The notes of the March 2013 meeting indicated that Mary was in a good placement with foster carers committed to her ongoing care. They further noted: "[Mary] will not receive support from the Aftercare Services of Children and Family Services (HSE[2]) as the Disability Services are best placed to offer this support due to her complex needs". In addition, they note that contact would be made with Comhairle (now the Citizens Information Board) regarding the possibility of an advocate being made available to Mary.

In May 2013 Social Worker1 sought legal advice as to what action might be taken should Mary's parents seek to have her returned to them on reaching adulthood. This was intended to protect her and to ensure that she continued to enjoy the level of care available in her foster care placement. The legal advice at that time was that an application for wardship would not be appropriate as a "just in case" protection measure, and that at a recent review

[2] This predates the creation of Tusla when services for children and families were still within the HSE.

of Mary's care in the District Court the judge had stated that he did not think it would be in Mary's interest to be made a Ward of Court.

| January 2014 | Participants |
|---|---|
| An anonymous allegation was received by Tusla on January 10th in the locality where Mary was living. This information was not passed on by the duty team to Team Leader1 for a further five weeks; it came to the attention of Team Leader1 because there was another child in that placement who had an allocated social worker. There was no suggestion that this or any other child in the placement had been harmed and the allegation did not concern any child who had lived in this home. At interview Team Leader1 acknowledged that given the level of demand on the service, the delay was regrettable, but understandable.<br><br>At this point there was no social worker allocated to Mary, as she was over eighteen, and the expectation up to that time was that she would remain in her former foster placement indefinitely. However, Mary's case had not been closed on the system in Tusla, and this was explained by Team Leader3 at interview as arising from an administrative requirement, whereby payments to the foster carers were still coming from the social work department, as their application for Carer's Allowance had not yet been sanctioned. | Team Leader1<br><br>Team Leader3 who was line manager to Social Worker1 and reported to PSW1 |

| February 2014 | Participants |
|---|---|
| On foot of the information passed on to her in February, Team Leader1, having sought legal advice, agreed on the need to inform Mr. A that such information was now on record. | Team Leader1<br><br>Legal Advisor |

| March 2014 | Participants |
|---|---|
| Team Leader1 passed on the information to Social Worker1, who had been Mary's social worker when she was in care, and therefore known to the family, to arrange a meeting with Mr. A.<br>Before Team Leader1 met with Mr. A, a person came forward claiming to have been the anonymous informant, a relative of a person allegedly abused by Mr. A, and offering to arrange for the allegations to be communicated in person to Team Leader1. In discussion with PSW1 and PSW2, it was agreed that Team Leader1 would go ahead and meet the complainant.<br><br>Based on her meetings with the complainant, Team Leader1 arranged to interview Mr. A to complete the assessment with Team Leader2.<br><br>Team Leader1 received legal advice as to how the purpose of inviting him to a meeting might be presented in a letter of | Team Leader1 who was following up the retrospective disclosure<br><br>Social Worker1 who had been Mary's social worker while she was in care<br><br>PSW1 principal social worker responsible for oversight of the case<br><br>PSW2 principal social |

| | |
|---|---|
| appointment to Mr. A, and what role Mrs. A should have in the proceedings. | worker/colleague of PSW1 |

| April 2014 | Participants |
|---|---|
| In early April 2014 Team Leader1 and Team Leader2 (from the foster care team as there were underage children in the placement with Mr. and Mrs A) met with Mr. and Mrs. A and presented them with the information given by both complainants. The record indicates that Mr. A denied the allegations and Mrs. A fully supported her husband.<br><br>The file records that Mr. A agreed to move out of the family home for the period until the next scheduled meeting with Team Leader1 and Team Leader2, two weeks from that date. At that follow-up meeting it is recorded that Mr. A agreed to move out for a further period to allow the social workers assigned to the foster children in the home to make an assessment of their needs, and to consider alternative placements. At this point, as Mary was an adult, Team Leader1 and PSW1 were concerned that, should the situation arise, they did not have authority to remove her from the placement in the absence of her capacity (because of her intellectual disability) to give consent to such a move.<br><br>Social Worker1 made enquiries about the availability of a residential placement in the voluntary organisation where Mary was receiving day care. In doing so Social Worker1 sought the advice of Case Manager A in HSE Disability Services, who responded that such places were hard to secure, as beds now had to be registered[3], and that she should revert to him if she had any difficulty. The Tusla record indicates that the conversation was concerned with discussing a problem that had arisen with Mary's placement and Case Manager A is quoted as saying "If it's an emergency, it's an emergency" There is no corresponding record in the HSE Disability Services file.<br><br>Team Leader1 sought the advice of her colleagues in the service specialising in child sexual abuse, and it was suggested by them that it was not realistic to expect Mrs. A to act in a safeguarding role against her husband, given that she had complete faith in his innocence.<br><br>On foot of legal advice it was agreed that a professionals' meeting would be convened to discuss how to move matters forward. PSW1 recalled at interview that the legal advice given to Tusla at that time was that wardship proceedings were not an appropriate mechanism for securing authority to remove Mary from the | Team Leader1 investigating the retrospective disclosure<br><br>Team Leader2 assisting in the investigation of the retrospective disclosure<br><br>Mr. and Mrs. A: foster carers<br><br>PSW1 principal social worker responsible for oversight of the case<br><br>Social Worker1 who had been Mary's social worker while she was in care<br><br>Case Manager A of HSE disability services<br><br>Voluntary Organisation<br><br>Legal Advisor<br><br>Team Leader3 who was line manager to Social Worker1 and reported to PSW1 |

[3] Residential beds now have to be registered by the Health information and Quality Authority and service providers do not have discretion to increase their number of beds.

| | |
|---|---|
| placement. While there is no written legal advice on record to that effect, Team Leader3 explained at interview that this would be normal practice for routine telephone legal consultations. | |

| May 2014 | Participants |
|---|---|
| In May 2014 Social Worker1 contacted the voluntary organisation "in relation to the new referral", to be informed by the principal social worker there that no residential places were available, and inviting Social Worker1 to put her concerns in writing to the voluntary organisation. At interview, Team Leader3 related her experience that as referrals to the voluntary organisation were made from discipline to discipline (one social work department to another, for example), this contact constituted a referral. This may explain why there is no document on file that would constitute a written formal referral, nor is there a copy of any application made on behalf of Mary on the Tusla file, the HSE Disability Services file, or the voluntary organisation file. Social Worker1 pointed out also that there was no formal referral form in use.<br><br>Social Worker1 sought guidance from her line manager, Team Leader3. This elicited the response that Team Leader3 would speak to her line manager PSW1, about having "adult services" take the lead in the case, and scheduling a professionals' meeting at which the case would be handed over to adult services. This meeting was held on May 13th; the voluntary organisation principal social worker did not attend but sent apologies. The record does not include an invitation to the HSE Disability Services to that meeting, which was confirmed by Case Manager A at interview.<br><br>A legal consultation held on May 27th was attended by the solicitor for Tusla, PSW1, Team Leader3, and two other social workers who were assigned to another child in the care of Mr. and Mrs. A. The notes from that meeting indicate that consideration should be given to whether the best safeguard for Mary would be a residential placement in the voluntary organisation with which she was already involved as a day care participant. The notes indicate that the voluntary organisation was considered to have a duty of care to Mary and that they should carry out a comprehensive risk assessment in relation to her. Social Worker1 pointed out to the review that the exact wording of the letter had been given to her at this legal consultation. A further professionals' meeting was scheduled for June 26th to which the voluntary organisation and HSE Disability Services were, according to the minutes of the May 27th meeting, to be invited.<br><br>The legal consultation refers to asking Mr. and Mrs. A about their future plan in relation to each of the children in their care – | Social Worker1 who had been Mary's social worker while she was in care<br><br>Team Leader3 who is line manager to Social Worker1 and reports to PSW1<br><br>PSW1 principal social worker responsible for oversight of the case<br><br>Voluntary organisation principal social worker<br><br>Legal Advisor |

| | |
|---|---|
| to remain as a couple fostering all of them – or Mrs. A possibly being assessed independently of her husband as a foster carer. The minutes (taken by Team Leader3) contain a rider that they are the main points and agreed actions only and not a verbatim account. | |

| June 2014 | Participants |
|---|---|
| On June 10th 2014 Social Worker1 wrote to the voluntary organisation Principal Social Worker advising that as Mary was now over eighteen years, it was essential that the voluntary organisation carry out a risk assessment of the situation based on her level of need and ability, and consider whether the best safeguard for her would be placement in a residential setting with them.<br><br>On June 19th a case conference was held in the voluntary agency, the minutes of which indicate a decision that a letter would be sent to PSW2 stating that they were not in a position to carry out a risk assessment and "are not responsible to offer [Mary] full-time residence" but would offer assistance in any other area of concern. All the participants at this meeting were staff internal to the organisation and there are no apologies or absentees, suggesting that no other organisation was invited to attend.<br><br>A further professionals' meeting took place on June 26th. The minutes of that meeting indicate that HSE Disability Services were not in attendance but, contrary to the minutes from the May meeting, there is no record of an invitation to them. Case Manager A informed the review team that no invitation was received; there is a formal letter of invitation to the voluntary organisation. The voluntary organisation was not in attendance and the minutes of the meeting reflect a shared view by the participants, that the voluntary organisation had a central role in taking responsibility for "...the ongoing assessment of need and duty of care…". The decision of the meeting was that a letter would be sent to the voluntary organisation and HSE Disability Services "…outlining the concerns."<br><br>The minutes of this meeting indicate that the voluntary organisation was to be asked by Tusla to undertake a risk assessment. At interview Team Leader3 agreed that the voluntary organisation would have had no authority to require Mr. and Mrs. A to comply with any assessment. In addition, she believed that Tusla did not have the option of making a formal referral for a residential place for Mary as she was not a child under their care, and that in any event she understood the case to have been transferred to the HSE Disability Services from the time of the professionals' planning meeting in 2013. Her understanding was that the voluntary organisation was the | Social Worker1 who had been Mary's social worker while she was in care<br><br>Team Leader1 investigating the retrospective disclosure<br><br>Team Leader2 assisting in the investigation of the retrospective disclosure<br><br>Eight (internal) staff members in attendance at the voluntary organisation case conference<br><br>Team Leader3 who was line manager to Social Worker1 and reported to PSW1 |

| | |
|---|---|
| primary care giver in this case, and that being so, if any assessment of Mr. A was to be done, it should have been done by them. Case Manager A informed the review team that no formal referral had been received and that it was not his understanding that the case had been transferred from Tusla during the meeting of 2013.<br><br>There are notes in the social work file of a legal consultation held on June 27th 2014. These notes are identical to those from the May 27th meeting referred to above, so there is some lack of clarity around when they were compiled. However, in discussing this at interview with Team Leader3 (who took the notes) this appears to by a typographical error and the indications from what follows in the file are that the notes may refer to May.<br><br>Mr. A had now returned to the family home.<br><br>Case Manager A informed the review team that, while he was aware that Mr. A had left the family home, he was not aware of his return. He became aware of this in January 2015 at which point he states that he had been reassured by Tusla that Mary was not at risk. | |

| July 2014 | Participants |
|---|---|
| The assessment of the retrospective allegation of child sexual abuse against Mr. A is on record with a date of July 21st 2014.<br><br>On July 1st 2014 the director of the voluntary organisation wrote to Tusla expressing concerns about the level of expectation Tusla had in relation to how far the voluntary organisation could become involved in taking responsibility for Mary, and referring back to the meeting in 2013 from which he believed this misunderstanding may have arisen. This letter was, however, directed to PSW2 who was not the principal social worker with responsibility for the case. The letter was passed on to Social Worker1 for information and to respond. Social Worker1 responded on July 31st. This letter, which had been compiled under the supervision of PSW1, suggested that in light of the other children now having been removed from the home of Mr. and Mrs. A, the voluntary organisation should assess the safety of Mary in that placement. This letter was copied to the principal social worker of the voluntary organisation and to Case Manager A and Case Manager B in HSE Disability Services.<br><br>On July 2nd, Team Leader3 wrote to the principal social worker of the voluntary organisation (and copied to Case Manger A , HSE Disability Services) the recommendation of the two professional meetings, that the onus was on the voluntary organisation as the primary service provider to carry out a comprehensive risk assessment in relation to Mary. | Director voluntary organisation<br><br>PSW2 principal social worker/colleague of PSW1<br><br>Social Worker1 who had been Mary's social worker while she was in care<br><br>Team Leader3 who was line manager to Social Worker1 and reported to PSW1<br><br>Case Manager B: Manager in HSE Disability Services<br><br>Case Manager A: Manager in HSE Disability Services (note: there was no reporting relationship |

| | |
|---|---|
| On July 7th 2014, Team Leader3 wrote to Case Manager B in HSE Disability Services (who is not on record as having been involved up until that time) requesting an urgent meeting in the light of the voluntary organisation not assuming responsibility for Mary's placement. Case Manager B responded that he would discuss it with his colleague Case Manager A (with whom Social Worker1 had previously consulted: see April 2014 above), and revert to Tusla. A handwritten note on an email from Case Manager B to Case Manager A, dated later that month, indicates that Case Manager A was to discuss the matter with Team Leader3 and Social Worker1.<br><br>At interview Team Leader3 expressed the view that she understood the case to have been transferred to HSE Disability Services at this point, and that Case Manager B was in a position of seniority in relation to Case Manager A. Case Manager A, in responding to this review, agreed that Case Manager B had seniority in the organisation. Case Manager B alerted the review team to the fact that his authority did not extend to assigning Case Manager A to this case.<br><br>On July 31st Social Worker1 wrote to the director of the voluntary organisation and copied the principal social worker there, requesting an urgent follow up by the voluntary organisation to assess Mary's safety in her current home. | between Case manager A and Case Manager B) |

| August 2014 | Participants |
|---|---|
| In early August the voluntary organisation's principal social worker responded to the letter from Social Worker1 (see July above) to state that they had no placement for Mary and that they did not, in any event, have any authority to undertake a risk assessment or remove her from her home. The letter requested a meeting with Social Worker1 or PSW2 (who was not responsible for the case) to discuss the matter further.<br><br>On August 14th Social Worker1 responded to the voluntary organisation principal social worker "to acknowledge your concerns" about Mary and requesting that "...Adult Disability Services carry out a risk assessment of need for [Mary] who is a vulnerable adult", and further stating, "I recommend that you seek legal advice in relation to what action is to be taken by the Adult Disability Services to safeguard [Mary's] needs". This letter is copied to the director in the voluntary organisation, and compiled by Social Worker1 with the agreement of Team Leader3, her line manager.<br><br>The diary record of Case Manager A indicates that he made contact with Tusla about the case in August, and was awaiting a response. No-one is specifically named as a contact in Tusla, but | Principal Social Worker voluntary organisation<br><br>Social Worker1 who had been Mary's social worker while she was in care<br><br>PSW2 principal social worker/colleague of PSW1<br><br>Case manager A: Manager in HSE Disability Services<br><br>Citizens Information Board ( formerly Comhairle) |

| | |
|---|---|
| Case Manager A later clarified to the review that he had specifically requested to speak to Social Worker1. In interview, Case Manager A indicated that this contact was by way of calling into the Tusla office (without appointment), where, however, the social worker was not available to meet him. Case Manager A did not recall from whom his enquiries were made, but informed the review that he had always sought out Social Worker1 on these occasions.<br><br>At interview it was confirmed by Team Leader3 that Case Manager A from HSE Disability Services would often call to the Tusla offices. While agreeing with Team Leader3 about this style of engagement, Case Manager A advised the review that these meetings were not casual in that a number of cases would be discussed between them.<br><br>A Tusla case note from August 2014 indicates that Social Worker1 had been in contact with the advocacy service the Citizens Information Board, it appears in an effort to solicit an advocate for Mary, and would make further contact with them. | |

| September 2014 | Participants |
|---|---|
| In September 2014 the voluntary organisation's principal social worker wrote to HSE Disability Services expressing concern about Mary's continued residence in the former foster home, information that had come from Tusla. The response from the HSE Case Manager A by email, was that Disability Services was seeking a recommendation from the voluntary organisation on how to proceed. However, having been copied into the email response, Manager A in the HSE intervened to state that it was not sufficient for the HSE Disability Services to refer the matter back to the voluntary organisation, and suggesting that the matter should be brought to the attention of Manager1 in Tusla (who had responsibility for aftercare services). In responding to this, Case Manager A indicated that he had spoken to the principal social worker in the voluntary organisation about setting up a meeting with PSW1( who had oversight of the case) and Social Worker1 in Tusla, to progress the matter. The voluntary organisation's principal social worker informed the review that she had no recollection of this, nor had she any record of it. There is no record of a referral to Manager1 in Tusla as recommended by Manager A in the HSE. However, Case Manager A indicated to the review that he had not pursued the suggestion of contacting Manager1 in Tusla as he did not know that Manager1 had any responsibility in respect of aftercare services, and had thought that Manager A was mistaken in her understanding of who the appropriate person was to contact. In addition, on occasion when he had made contact with PSW1, he had done so in the absence of PSW2 who he believed to have responsibility in the case. | Principal Social Worker voluntary organisation<br><br>Case Manager A: Manager in HSE Disability Services<br><br>Manager A: Manager in HSE with responsibility for a range of services<br><br>Manager1: Manager in Tusla who was responsible for aftercare and commissioned a review of Mary's placement in 2015<br><br>Social Worker1 who had been Mary's social worker while she was in care<br><br>PSW1 principal social worker responsible for oversight of the case |

| | |
|---|---|
| The principal social worker from the voluntary organisation wrote to Social Worker1 to advise that the organisation did not have a mandate to intervene in the case and that they had referred it to HSE Disability Services.<br><br>The record of a subsequent telephone call between the principal social worker in the voluntary organisation and Case Manager A indicates (also confirmed at interview) that Case Manager A in HSE Disability Services took it in good faith, that PSW2 was fully informed of the details in relation to Mary, when this was not the case. Case Manager A explained to the review that this was because PSW2 had chaired the meeting in 2013 at which Mary's future had been discussed. He further stated that it was not until 2016 that he was fully aware that PSW2 was not the person with oversight of the case. PSW1 confirmed at interview that PSW2 would not have been very well informed about the details of the case.<br><br>In response to a draft of this chronology, Case Manager A stated that any information contained in retrospective accounts as described here, were based on contemporaneous case notes all of which are contained in the HSE Disability Services file.<br><br>In a retrospective account of events (written in 2016) Case Manager A advises that: "The matter was discussed at an internal meeting in the Disability Services office on 19th Sept 2014". The note from that meeting states: "[Mary] has to be removed". Case Manager A pointed out to the review team that 24 cases were discussed at that meeting and that there is a contemporaneous record of that meeting. The HSE Disability Services file contains a note of such a meeting with the names other than Mary's redacted.<br><br>A retrospective account written by Case Manager A in 2016 refers to having contacted Tusla the week commencing September 22nd on foot of this internal meeting, and having left a message asking to be contacted. No-one is identified in the record as the person for whom the message was left. However, Case Manager A's record indicates that he was informed (whether on foot of this enquiry is not clear) that the social worker involved was away until October 6th. This attempt to contact Social Worker1 is reflected in an email from Case Manager A dated September 24th 2014 to the office of Manager A in the HSE.<br><br>Entries in the file of the principal social worker in the voluntary organisation indicate that they were informed by Case Manager A in September that he would get an update from Tusla (where PSW2 is referenced). This correspondence is reconciled in November 2014 (see below). | PSW2 principal social worker/colleague of PSW1<br><br>Team Leader1 investigating the retrospective disclosure<br><br>Team Leader2 assisting in the investigation of the retrospective disclosure<br><br>Team Leader3 who was line manager to Social Worker1 and reported to PSW1 |

| | |
|---|---|
| Team Leader1 and Team Leader2 (who had undertaken the assessment of the retrospective disclosure) contacted Team Leader3 to express their concerns that Mary was still in the placement. Team Leader3 responded that she and Social Worker1 were making every effort to progress this, but it was the function of the voluntary organisation and the HSE Disability Services to take action. In addition Team Leader3 pointed out that Mrs. A was very aware of her duty to protect Mary. | |

| October 2014 | Participants |
|---|---|
| In October Social Worker1 contacted the Citizens Information Board again, but the details or outcome of this are not clear from the record.<br><br>Team Leader1 emailed PSW1 to reiterate her concerns about Mary remaining in the placement, and pointing out the ethical obligations of Tusla in a context where Mary had been taken into care by them.<br><br>Social Worker1 reverted to the Aftercare Service to seek advice on any assistance that could be offered to Mary in the absence of progress around a residential placement. The Aftercare Coordinator responded that while "her disability places her beyond the remit of general Aftercare provision", the service was nonetheless open to offering practical and financial support, and believed it was essential that they would become involved. She added that she had already mentioned it to Manager1 and suggested now that the concern should be escalated to Senior Manager1 in Tusla, to negotiate directly with senior colleagues in HSE Disability Services to advance a placement for Mary. Manager1 reported at interview that he had no recollection of this case having been brought to his attention prior to the later time in early 2015, when he initiated the placement review.<br><br>In a diary entry for October 2014 and also in a retrospective account of events (written in 2016), Case Manager A notes having contacted Tusla twice over the month of October 2014, but receiving no response. There is no social worker or contact person in Tusla named in these accounts. However, Case Manager A recalls that he looked on that occasion for Social Worker1. He became aware in December 2014 that she transferred elsewhere at the end of the year. His understanding at that time was that the case was still open to Tusla, and that there had never been any transfer to HSE Disability Services. | Social Worker1 who had been Mary's social worker while she was in care<br><br>Team Leader1 investigating the retrospective disclosure<br><br>PSW1 principal social worker responsible for oversight of the case<br><br>Aftercare Co-ordinator<br><br>Case Manager A: Manager in HSE Disability Services<br><br>Senior Manager1: Senior Manager in Tusla with overall responsibility for services in the area |

| November 2014 | Participants |
|---|---|
| The diary entries of Case Manager A indicate that he had not received any feedback from Tusla to his earlier enquiries. In a retrospective account of events (written in 2016) he indicated that he had followed up the situation twice with regard to Mary, when he was in the Tusla offices on another matter in November 2014 but was unable to speak with the social worker involved. No social worker is identified in this account but Case Manager A responded to the review that he had sought out Social Worker1.<br><br>In November 2014 Case Manager A contacted the voluntary organisation principal social worker for an update on the case. The voluntary organisation principal social worker reminded him of their conversation in September 2014 (see above) whereby he had undertaken to make enquiries of Tusla, and Case Manager A indicated to her that he had not yet discussed the case with PSW2 (not the PSW assigned to the case). This correspondence is reconciled in January 2015 (see below).<br><br>At the November meeting of the Foster Care Committee, a decision was made to remove Mr. and Mrs. A from the panel of foster carers and they were advised accordingly. | Case Manager A: Manager in HSE Disability Services<br><br>Principal Social Worker voluntary organisation<br><br>PSW2 principal social worker/colleague of PSW1<br><br>Foster Care Committee |

| December 2014 | Participants |
|---|---|
| In a retrospective account written by Case Manager A in 2016, he refers to having followed up on the case with the Tusla office in December 2014. The information he received was that the social worker assigned to the case had transferred elsewhere, and that no-one else had been assigned to the case. | Case Manager A: Manager in HSE Disability Services |

| January 2015 | Participants |
|---|---|
| In an account written retrospectively (in June 2015) the principal social worker in the voluntary organisation refers to having met Case Manager A in January 2015, who told her he still had no update but would look into it.<br><br>In a retrospective account of events Case Manager A indicates that he had discussed the case of Mary with PSW2 (not the PSW responsible for the case) in January 2015, and the latter had responded that he had no concerns about her safety. This is also referenced on Case Manager A's diary for the period where it is noted "[Mary] not at risk" √<br><br>The file of Manager1 (with oversight of aftercare) states that in January 2015 the Aftercare Coordinator alerted him to the situation whereby a vulnerable adult continued to reside in a placement with foster carers whose names had been removed | Principal Social Worker voluntary organisation<br><br>Case Manager A: Manager in HSE Disability Services<br><br>PSW2 principal social worker/colleague of PSW1<br><br>Aftercare Coordinator<br><br>Manager1: Manager in Tusla who commissioned a review |

| | |
|---|---|
| from the panel of foster carers, from whom other children had been removed. The file of Manager1 indicates that he then sought and received a copy of the original assessment of the allegations completed by Team Leader1 and Team Leader2 in 2014. | of Mary's placement in 2015 |

| February 2015 | Participants |
|---|---|
| The file of Manager1 in Tusla indicates that at a management meeting between Tusla and the HSE on February 4th 2015, Manager1 advised the group that he intended to proceed with an up-to-date assessment of the situation with regard to Mary's safety in her placement. This was on foot of a meeting he had had with the Aftercare Coordinator referred to above, during the course of which Mary's circumstances had come to his notice. This group included Case Manager A from HSE Disability Services, Senior Manager A from the HSE, and Senior Manager1 from Tusla. According to these notes, Case Manager A confirmed that he was aware of the person with whom the review was concerned, and the meeting asked to be kept updated on progress. However, while this information appears in the notes of Manager1 of that meeting, it is not reflected in the minutes, nor is there mention of any follow up in the minutes the two further meetings in June and August 2015. In responding to this to the reviewer, Manager1 pointed out that it would not be normal procedure for children or persons in receipt of services to be named in minutes of such a meeting, where high level decisions were made. In addition, his intention in bringing it to the meeting was to flag the possibility to HSE Disability Services that a placement might be required at short notice for Mary, depending on the outcome of the placement review. On receiving the draft chronology of this review, Senior Manager A informed the independent reviewer that he did not have any recollection of discussion around this case. Case Manager A also had no recollection of the discussion but they both stated that they were prepared to accept the notes of Manager1 in good faith.<br><br>Manager1, in agreement with Senior Manager1, commissioned a review of Mary's placement and attached for the information of the reviewers *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (HSE 2014b), which had been launched in December 2014. The review was to be undertaken by PSW3 from the foster care team, who was already familiar with the case and had been present at the professionals' meeting in May 2014 (see above) where it had been discussed.<br><br>The review was to start in March but was delayed because of long-term leave by the social worker originally asked to assist, and did not start until April when Social Worker2 from the accommodation team (attached to the Tusla out-of-home | Manager1: Manager in Tusla who commissioned a review of Mary's placement in 2015<br><br>Case Manager A: Manager in HSE Disability Services<br><br>Senior Manager1: Senior Manager in Tusla with overall responsibility for services in the area<br><br>Senior Manager A: Senior Manager in HSE with overall responsibility for disability services<br><br>PSW3: Principal social worker who undertook the review of Mary's placement in 2015<br><br>Social Worker2: Social Worker who participated in the review with PSW3 in 2015 |

service) was assigned to assist PSW3. The commissioning letter from Mananger1 to the reviewers referred to the fact that "while recognising there were alternative views mooted as to whether or not the continuation of this placement was in the interest of [Mary] no formal review or assessment of the evidence to hand was made to underpin the decision to leave [Mary] in her current placement". The terms of reference for the review were to "...assess whether this placement safeguards and best meets the needs of [Mary] recognising that this vulnerable adult may need on-going and life-long care". The correspondence further stated that Manager 1 had "notified our colleagues in Disability Services that we have a vulnerable adult in our aftercare provision that may need alternative care should her needs not best be safeguarded or met within her current placement".

Manager1 requested that the review would be completed by the end of March 2015. The draft report was submitted to him in January 2016. In discussing this time frame Manager1 clarified the context whereby the social worker originally identified to assist PSW3 with the placement review had to go on long-term leave, and an additional member of staff was on long-term sick leave, thereby contributing to delays which could not have been anticipated.

In interview PSW3 related having received regular queries from Manager1 as to why the report was not forthcoming within the agreed time frame, but that delays were due to the reluctance of the voluntary organisation to give feedback on Mary's disposition or comment on her placement. However, the voluntary organisation principal social worker responded to the review that she and her colleague had no recollection of such requests being made, and that the first record they have of such a request is from August 2015.

While acknowledging the lengthy period of the review, Social Worker2 indicated at interview that she and her colleague were not concerned about any delay, as they had concluded in July, after having made home visits, that Mary was not at risk, and therefore saw no urgency in producing a final report. Had they had any concerns, they would have communicated these to their manager.

Social Worker2 indicated that she and PSW3 had not considered escalating the case to their manager when they felt they were not receiving timely cooperation from the voluntary organisation. The reviewers had made a telephone request for an assessment of Mary from the voluntary organisation in August 2015; the report records also that they made a written request for the assessment later that month. Social Worker2 informed the review that this request reflected their position that any report they might compile would be incomplete unless they were able to reflect Mary's views insofar as that was

| | |
|---|---|
| possible.<br><br>A loose leaf note from the records of Case Manager A, dated Feb/March 2015 contained the entry "[Mary] not at risk". This note includes the initials of PSW2, suggesting him as the source of the information. In clarifying to the review why he should still have a concern when he had been in attendance at the meeting on Feb 4th where Tusla had expressed their intention to undertake a review of the placement, Case Manager A did not recall the contents of this meeting referring to Mary. | |

| April 2015 | Participants |
|---|---|
| Notes of a management meeting held between HSE Disability Services and the voluntary organisation indicate that the principal social worker from the voluntary organisation and a Tusla social worker were "to do an assessment" and report back to the director of the voluntary organisation. However, neither of these social workers was present at that meeting – which was a management meeting – and it is therefore not clear if the Tusla social worker referred to is one of the team commissioned by Manager1 to do the review of the placement. This is referred to further in May 2015 (below). The principal social worker from the voluntary organisation responded to this review that she had received no request either verbally or in writing. | Case Manager A:<br>Manager in HSE Disability Services<br><br>Director voluntary organisation |

| May 2015 | Participants |
|---|---|
| In May 2015 there is a record in the HSE Disability Services file of a proposed visit by the voluntary organisation principal social worker and a Tusla social worker (see April above) which had not yet occurred as the voluntary organisation principal social worker was waiting to hear from Case Manager A, who was to make contact with PSW2 (not the assigned PSW) about how to proceed. There is a lack of clarity in the combined records about these events and it is difficult to establish to what precisely these entries refer.<br><br>In responding to this review Case Manager A indicated that events at this point had in any case been overtaken by the review of the placement initiated by Tusla. | Case Manager A:<br>Manager in HSE Disability Services<br><br>PSW2 principal social worker/colleague of PSW1 |

| June 2015 | Participants |
|---|---|
| In an email from the voluntary organisation's principal social worker to the director of the voluntary organisation in June 2015, the principal social worker indicated that she not heard further from Case Manager A up to the time of writing in June 2015, since their last discussion in January 2015 (see January 2015 above). | Principal Social Worker voluntary organisation<br><br>Director voluntary organisation |

| | |
|---|---|
| In responding to this review Case Manager A indicated again that events at this point had been overtaken by the review of the placement initiated by Tusla. | Case Manager A: Manager in HSE Disability Services |

| July 2015 | Participants |
|---|---|
| In a retrospective account of events (written in 2016) Case Manager A indicates that he had followed up with Tusla with regard to Mary in July 2015, but Tusla had had no concerns. Case Manager A informed this review team that the source of this information was PSW2. | Team Leader3<br><br>Case Manager A: Manager in HSE Disability Services |

| August 2015 | Participants |
|---|---|
| In an email to the voluntary organisation's principal social worker in August 2015, Case Manager A wrote that he had been assured in conversation with PSW2 (the record does not state when), that Tusla had no concerns about any risk to Mary in her placement with the former foster carers. At interview PSW2 accepted in good faith the veracity of the version of events outlined by Case Manager A, but could not recall the context of the discussion. | Case Manager A: Manager in HSE Disability Services<br><br>PSW2 principal social worker/colleague of PSW1 |

| September 2015 | Participants |
|---|---|
| On September 5th the principal social worker in the voluntary organisation wrote to Social Worker1 stating that the case had been referred by them to HSE Disability Services.<br><br>A file entry refers to contact being made by the voluntary organisation with Social Worker2 advising on the need for staff to be sensitive to Mary in trying to establish any details around her experience of life with Mr. and Mrs. A. The voluntary organisation's principal social worker reiterated to this review her ongoing input into the case in terms of being mindful of the need to consider the impact of any actions on Mary, and the need to make decisions that would be compatible with her capacity to cope with change. | Social Worker1 who had been Mary's social worker while she was in care<br><br>Social Worker2: Social Worker who participated in the review with PSW3 in 2015<br><br>Principal Social Worker voluntary organisation |

| January 2016 | Participants |
|---|---|
| In January a draft of the review of the placement was received by Manager1. The review made 8 recommendations of which the first four are outlined below (the others refer to personal issues of Mr. and Mrs. A).<br>1) that Mary should remain within the placement<br>2) that Mary's legal status should be clarified<br>3) that an aftercare worker should be appointed to Mary | Manager1: Manager in Tusla who commissioned a review of Mary's placement in 2015<br><br>PSW3: Principal social |

| | |
|---|---|
| 4) that Mary's case should be referred to the Aftercare Steering Committee to determine what supports she would require and the agencies responsible, and that the role of the Disability Services with respect to her future care should be clarified.<br><br>On receipt of the draft report Manager1 noted his response to the recommendations, which included his intention to follow up with the Aftercare Steering Committee.<br><br>Mr. and Mrs. A had sight of the final draft with the recommendation that Mary would remain with them.<br><br>Tusla was now in possession of a 2014 report which assessed that there was a risk, and a draft report from 2016 that recommended that there were sufficient safeguards in place to mitigate that risk.<br><br>Case Manager A advised this review that a copy of this report received by HSE Disability Services (at what point is not clear) did not have "Draft" written on it, so it was considered by him to be a final document at the time. However, there is no copy on the HSE Disability Services file. | worker who undertook the review of Mary's placement in 2015<br><br>Social Worker2: Social Worker who participated in the review with PSW3 in 2015<br><br>Senior Manager1: Senior Manager in Tusla with overall responsibility for services in the area |

| February 2016 | Participants |
|---|---|
| Email correspondence between Manager1 and PSW3 indicates that they were in agreement – because of the outstanding issue of risk – on the need for a complex case management meeting, to include HSE Disability Services, in respect of Mary. In consultation with PSW1 this meeting was convened (see below).<br><br>At this time also (Feb 3rd) the Tusla file records that a relative of the persons making the original allegations had been prompted by media exposure of a case elsewhere in the country to make renewed contact with Tusla, expressing concerns that Mary was still in the placement.<br><br><u>Disability Services Meeting February 5th</u><br><br>In an account written by Case Manager A (undated but after March 2016) he refers to a meeting convened at the request of Disability Services on 5th February 2016, attended by Case Manager A and Case Manager B from Disability Services and Senior Manager1 from Tusla. In his account of that meeting Case Manager A notes that the outcome of the 2015 review of the placement (which he describes as "A Risk Assessment") was consistent with the advice the Disability Services had received | Manager1: Manager in Tusla who commissioned a review of Mary's placement in 2015<br><br>PSW3: Principal social worker who undertook the review of Mary's placement in 2015<br><br>PSW1: Responsible for oversight of the case while Mary was in care<br><br><u>Present at the Disability Services meeting Feb. 5th</u><br>Case Manager A: Manager in HSE Disability Services and colleague<br><br>Case Manager B Disability Services |

| | |
|---|---|
| up to that point that it was safe for Mary to remain in the placement. At interview Case Manager A clarified that by "advice" he meant that given by Tusla to Disability Services up to that point. While this is represented in the record of HSE Disability Services as "A Meeting took place on 5th February" and the participants are then listed, Senior Manager1 recalled it as an opportunistic meeting when he was waiting for another appointment. However, the content is not disputed by him other than to point out that notwithstanding his respect for the views of PSW2, it was PSW1 who was fully informed about the case. In combining the information available about these events, it appears that there may have been an opportunistic meeting on 4th February which then led to a scheduled meeting on 5th February.<br><br>Handwritten notes from this meeting of February 5th written by Case Manager B (but apparently not circulated as minutes) indicate that Senior Manager1 was aware of the case, was aware of the outcome of the 2015 review, and was concerned that there were now two reports (the original 2014 assessment and the 2015 review) with contrary outcomes. Senior Manager1 indicated that he would discuss the matter with PSW1. He was aware of PSW2's view expressed to Case Manager A that there was no risk to Mary, but did not concur with that view.<br><br>Additional handwritten notes by Case Manager B for that date indicate that Case Manager A may have spoken with PSW1 – the notes are unclear. The information from PSW1 was that Tusla had not had authority to remove Mary as she was an adult, Tusla would seek legal advice, and an urgent complex case meeting would be convened. A further handwritten note from the same date indicates that in discussion between Case Manager A and Senior Manager A in Disability Services, it was suggested that a referral would be made to the newly established safeguarding team.<br><br>On February 8th, Case Manager B referred Mary to the safeguarding team.<br><br><u>Complex Case Meeting February 9th</u><br>On February 9th 2016 a complex case meeting was convened by Tusla. The records of Manager1 indicate that this was triggered by the concern shared by him and PSW3 that, following the completion of the review, the issue of risk was still outstanding. The invitation to the meeting outlined the purpose as:<br>• Sharing information with regard to the concerns regarding Mr. A and the implications for Mary<br>• Sharing information with regard to the assessments completed to date<br>• Putting in place a safeguarding plan for Mary<br>• Clarifying roles and responsibilities. | Senior Manager1: Senior Manager in Tusla with overall responsibility for services in the area<br><br><u>Present at complex case meeting Feb. 9th</u><br>Senior Manager1: Senior Manager in Tusla with overall responsibility for services in the area<br><br>Manager1: Manager in Tusla who commissioned a review of Mary's placement in 2015 |

| | |
|---|---|
| The minutes (taken by PSW1) indicate that those present at that meeting were representatives from HSE Disability Services, the HSE safeguarding team and the voluntary organisation.<br><br>The meeting agreed that, in the light of all that was known, it was necessary to move Mary to a residential placement. The meeting considered how this might best be achieved and noted the ambiguity around her legal status, and whether pending legislation in relation to assisted decision-making might offer some guidance in this regard. At interview Senior Manager1 indicated that the issue of wardship proceedings had been raised by him at this meeting as a possible mechanism for addressing the dilemmas faced.<br><br>The principal social worker from the voluntary organisation advised the meeting that no place was currently available, but that the voluntary organisation could make a business case in support of creating such a placement. The option of a private provider was considered, but the meeting was concerned to keep Mary in her locality so that she could continue to avail of her day services. The principal social worker of the voluntary organisation outlined to this review her ongoing advice during this stage of the proceedings, that a planned transition into any new placement was essential for Mary's welfare.<br><br>It was anticipated that, given the nature of her disability, and the fact that she understood her home to be with Mr. and Mrs. A, Mary's transfer into another placement would be a lengthy process requiring a high level of support for her, and the cooperation or Mr. and Mrs. A.<br><br>The meeting compiled a safeguarding plan which identified two options:<br>(A) Request Mr. A to move out, and undertake a risk assessment with a view to making a decision regarding Mary's placement on receipt of the outcome of the assessment.<br>(B) Request Mr. A to move out and simultaneously engage in a parallel planning process to identify an alternative placement for Mary, and in addition to that to request him to engage in a risk assessment to assess the more global risk.<br><br>In the event that Mr. A would not agree to these measures, an emergency placement would have to be identified for Mary.<br><br>The record indicates that, while Mr. A agreed initially, he subsequently contacted PSW3 to advise that he would not move out of the family home, for reasons of ill health, and on the advice of his family and solicitor.<br><br>Notes taken by a member of the team from Disability Services | PSW3 and Social Worker2 who had undertaken the review in 2015<br><br>Aftercare coordinator and a member of the aftercare team<br><br>Principal Social Worker voluntary organisation and colleague<br><br>Case Manager A and Case manager B, Disability Services, and two colleagues<br><br>Social Worker from the Specialist Enquiry Team |

| | |
|---|---|
| (see "colleagues" referred to under "Participants" in column 2) record that a referral would be sent from Tusla to Senior Manager A's team; a notification would be sent to the Gardaí by the (Tusla) social work team; and a risk assessment would be carried out on Mr. A by Senior Manager A's safeguarding team. It further noted that a core group would reconvene on March 2nd 2016.<br><br><u>Meeting February 10th between Mr. and Mrs. A, PSW3 and Social Worker2</u><br>The purpose of this meeting was to advise Mr. and Mrs. A of the outcome of the complex case management meeting held on February 9th.<br><br>PSW3 and Social Worker2 advised Mr. and Mrs. A that the safeguarding team wished to meet with them to get their response to the outcome of the complex case meeting. PSW3 and Social Worker2 suggested that if Mr. A were to leave the family home to allow for the transition of Mary, it could be for a period of up to three months. The record states that Mr. A expressed the view that undergoing a risk assessment might be a good thing as it could help him clear his name. In addition, it is stated that Mrs. A queried why the risk assessment had not been done two years previously, and why Mary had been left with them if she was deemed to be at risk. The notes of the meeting do not indicate what arrangements were in place for Mr. A to respond to the requests made, but PSW3 clarified to this review that the agreed arrangement was that Mr. A would contact her by telephone.<br><br><u>Email February 11th from Legal advisor to PSW</u><br>Correspondence on February 11th from the legal advisor to the principal social worker of the HSE safeguarding team indicated that it would be important to impress upon Mr. A that, should he refuse to cooperate with the required safeguarding measures, the possibility existed that recourse might be sought in the High Court which would direct Mary's immediate removal elsewhere. The correspondence noted: "There is an absence of any legislative intervention which enables the HSE to take steps to actively protect vulnerable adults who are at risk. Such interventions as may exist are on foot of the Wardship Jurisdiction or the Inherent Jurisdiction of the High Court".<br><br><u>Case Teleconference Disability Services February 12th</u><br>The records of the HSE Disability Service indicate that a teleconference was held on February 12th that included Senior Manager A, Case Manager B, the principal social worker from the voluntary organisation, the director of the voluntary organisation, and the legal advisor. The outcome of this was that a residential placement was made available by the voluntary organisation from that day, into which Mary could transition. Mr. A was to be asked to vacate the family home to | <u>Present at the meeting on February 10th</u><br>PSW3 and Social Worker2 who had undertaken the review in 2015. Mr. and Mrs. A<br><br>Principal Social Worker Safeguarding Team<br><br>Legal Advisor<br><br><u>Present at Conference call Disability Services Feb 12th</u><br><br>Senior Manager A (and senior administrator from his department)<br><br>Case Manager B<br><br>Principal Social Worker voluntary organisation<br><br>Director voluntary organisation |

| | |
|---|---|
| allow for a transition, or, in the absence of his agreement, a short hotel break could be arranged for Mrs. A and Mary, whereby Mary would not be under the care of Mr. A. The availability of staff from the voluntary organisation to be placed in the family home was also identified. A capacity assessment was planned for Mary within the following days but there was no expectation that she would have informed capacity. In the absence of agreement by Mr. and Mrs. A to any of the safeguarding measures, Mary would be transferred directly from her day placement into the residential placement. The Principal Social Worker of the HSE safeguarding team informed the review team that there were a series of teleconferences over these days in order to try to resolve the situation.<br><br>The record states that Mr. A changed his mind about complying with the safeguarding measures requested of him. Therefore, some days later Mary was transferred by the HSE from her day care placement directly into a residential placement. | PSW Safeguarding Team<br><br>Legal Advisor |

# Term of Reference 2:

## To consider, in particular, issues of safeguarding and risk assessment in respect of this case

### Safeguarding

As soon as a decision was made within Tusla that the allegations against Mr. A were credible, the need to safeguard the children in foster care was identified. After carrying out an assessment, during the course of which Mr. A temporarily left the family home, alternative arrangements were made for these children. The conclusion reached in respect of Mary was that a legal dilemma existed because her placement was no longer a foster care placement, and that there was a need for HSE Disability Services to engage in her care. The issue of safeguarding, therefore, was influenced by a concern to respect her status as an adult, and the lack of any authority on the part of Tusla to move her from a placement where, all the indications were, she was very content.

From 2014, the safeguards in place were the undertakings given to Tusla by Mrs. A that she would protect Mary. The record indicates that Mr. A also agreed to discontinue administering any personal care to Mary and, on occasions when Mrs. A would be away from the family home, a female relative would stay in the house. Tusla had no authority to "spot check" these arrangements, and was dependent on Mr. and Mrs. A and their family for assurance that they were in place.

In 2015 a review of the placement, commissioned by Tusla, came about when the aftercare coordinator made reference to it at a meeting with Manager1, to whom she reported. Manager1 was concerned that the issue of Mary's continued residence had drifted, and took steps to seek clarification by way of a placement review. The terms of reference stated that the review was intended to "…assess whether this placement safeguards and meets the needs of [Mary] recognising that this vulnerable adult may need on-going and life-long care." This review did not set out, therefore, to "second guess" the assessment that the allegations against Mr. A were credible. Rather, as outlined at interview (with Manager1, PSW3 and Social Worker2), it sought to identify the protective factors that might allow Mary to remain safely in the placement. So, for example, the review described protective factors in terms of Mr. A's family cooperating with safeguarding measures. However, the report does not reflect any authority the reviewers may have felt to challenge this, in the light of the complete faith Mrs. A and her family placed in Mr. A's denial: the necessity to place such a high level of trust in Mrs. A as a safeguard was a weakness already identified in 2014.

Having completed two home visits and collaborated with the voluntary organisation providing Mary's day placement, the placement reviewers recommended allowing Mary to remain, on the basis of safeguarding factors balanced against risk factors. As it transpired, reflecting on the draft report when it was submitted to him, Manager1 agreed with PSW3 (who had undertaken the placement review with Social Worker2) that the whole case needed to be revisited by way of a complex case meeting.

The length of time it took to complete the review was considerable. One of the contributory factors put forward at interview by the reviewers of the placement was the lack of timely cooperation from the voluntary organisation. The placement reviewers were conscious of the

need not to alarm Mary and had observed, on calling to the home of Mr. and Mrs. A, that Mary became upset by any attempts on their part to engage her. Therefore, they sought the support of the day care service, from people who were familiar with Mary, in trying to establish if she was happy in her placement, or showed any signs of upset in relation to particular events or people. The experience of the placement reviewers was that the voluntary organisation, while expressing a willingness to assist, was slow in responding. However, the voluntary organisation does not accept this version of events, and points to the first contact made with them in respect of the placement review, as being in August 2015.

There were opportunities available to the placement review team to escalate the case to senior management in order to secure more timely cooperation by the voluntary organisation if this was an issue. At interview the reviewers related they had not considered this, but had they developed any concerns about Mary's safety they would not have hesitated in bringing them to notice. Social Worker2 indicated that the reviewers formed the opinion at an early stage (July 2015) that there were sufficient safeguards in place for Mary, and that therefore they would be recommending her continuation in the placement. Therefore, they did not feel any pressure to bring the review to a speedy conclusion.

The merits of undertaking a review as opposed to taking alternative action (such as, for example, initiating a complex case meeting) are open to debate. In a context whereby the original assessment of risk was not being challenged, a complex case meeting would have been a reasonable course of action. A benefit of the draft placement review report, however, was that in coming to a conclusion somewhat inconsistent the original 2014 assessment, it precipitated the complex case meeting in early 2016, in order to advance a decision about Mary's welfare.

With regard to safeguarding measures at a later stage, in early 2016 when it had been agreed between Tusla, the HSE and the voluntary organisation that Mary should be removed, an attempt was made to safeguard her by having a planned phased arrangement whereby Mr. A would move out of the family home, to facilitate her gradual move into a residential placement. Having done so once, in 2014, Mr. A agreed to move out again. However, the record indicates that he changed his mind, one reason being that Mary had been left in the placement for over a year after the allegations were made. Therefore, in terms of what safeguards might be imposed within the family home, that option was no longer available.

With regard to safeguards outside of the home placement, staff in the day care service attended by Mary were alerted by Tusla to the need to be watchful of any particular signs of upset, or anything that would point to Mary being unhappy at home. Therefore, the position of the voluntary organisation was that she was safeguarded while in their care, for the 30 hours per week they were contracted by the HSE Disability Services to provide, and they were watchful for signs or behavioural changes that would give rise to concern.

The decision to remove Mary from the placement in 2016 represents an acknowledgement that the safeguarding measures in place in the home of Mr. and Mrs. A were not sufficient to guarantee her protection. The three agencies involved had endeavoured to implement a phased transition for Mary with the requisite safeguards in place. When this could not be guaranteed further, and on receipt of legal advice, the HSE made a decision to move her.

## Risk

While the term of reference to which this section refers identifies risk assessment only, to avoid repetition throughout the report this section will also make reference to risk management and risk escalation.

## Risk Assessment

From the time the retrospective allegations were considered credible, Tusla was satisfied that a risk had been established in respect of the children in the care or Mr. and Mrs. A. Mary might reasonably have been expected to be at higher risk because of her limited capacity to communicate information about her life.

Having established the risk, Tusla acted on it by removing the other children from the placement. The most preferable solution from their point of view was to have Mary transfer to a residential placement in a voluntary organisation where she was already well known, and which would be best placed to understand and meet her needs. Such a placement would not necessarily have severed her relationship with members of her former foster family or her siblings, but would have removed her from any potential risk from Mr. A. Therefore, from the point of view of person-centred care, it was a well-intentioned course of action. There is no evidence that placements were pursued in any other part of the country, or that Tusla took the view that any residential placement should be secured at any cost. More critically, given that they did not have any statutory authority to effect a transfer from her home with Mr. and Mrs. A, a graduated transfer with the cooperation of Mr. and Mrs. A, into a facility with which Mary was already connected, appeared to be the option likely to cause least upset to her.

At the point when the other children were removed from the placement, Tusla sought a residential placement for Mary with the voluntary organisation. They had formed the view that such a placement would be forthcoming, based on the meeting in March 2013 when the voluntary organisation had given assurances about retaining long-term oversight over Mary's needs. However, at that point in 2013 there had been every reason to believe that Mr. and Mrs. A would provide lifelong care to Mary, and the minutes of that meeting indicate that the voluntary organisation would step in if the need arose. This was interpreted by Tusla as meaning that the voluntary organisation would and could provide a long-term residential placement if required. Those minutes were later contested by the voluntary organisation. This contrary understanding of the outcome of that meeting, was communicated to this review by the director of the voluntary organisation at interview. Case Manager A (HSE Disability Services) also indicated at interview that it was a mistaken assumption to anticipate that a placement could be provided, and that the minutes were therefore not an accurate account. It appears, therefore, that when difficulties arose as a result of the allegations, Tusla took some comfort in the assumption that, pursuant to that meeting, a place would be made available to Mary. Therefore, while the agencies were intended to complement each other, there was a lack of clarity about the boundaries of responsibility, and service provision in the form of a residential placement. So, for example, Tusla undertook responsibility to seek out a placement for Mary, in a context whereby Team

Leader3 expressed the view at interview that the case had already been transferred to HSE Disability Services in 2013 and was not, therefore, their responsibility.

## Risk Management

The record of the legal consultation of 2014 suggests that the advice to Tusla was that the voluntary organisation had a duty of care to Mary. The record indicates that the advice sought referred to the voluntary organisation only. It is not recorded as having addressed any duty of care in respect of the HSE Disability Services, which would not have been unreasonable given that Mary had been in the care of the State, and was now an adult who would come under the auspices of the HSE Disability Services

The expectation within Tusla supported by legal advice, that the voluntary organisation could undertake a risk assessment on the basis that they had a duty of care to Mary, given that she was a participant in their day care services, is not supported by any compelling argument. Even though the voluntary organisation was involved in delivering a service to her, this was for 30 hours per week only, and she was not resident there. It would not be unreasonable, given the circumstances of the case, to expect that such a request would be specific as to what terms of risk assessment would apply, and what it would address, given the complications of Mary's adult status and the fact that she was living in a private arrangement. The response of the voluntary organisation to this request was to point out that they had no authority to undertake such a process. With regard to the potential for HSE Disability Services to initiate a risk assessment themselves, at interview Case Manager B informed the reviewer that HSE Disability Services was an administrative service only, and therefore would not engage in clinical assessments itself, but would refer clinical matters to partners in the voluntary sector. This is reflected in the exchanges between HSE Disability Services and the voluntary organisation, whereby when the voluntary organisation referred the case to the HSE Disability Services, it was referred back by the HSE, with the request that the voluntary organisation should give instructions to the HSE as to how to proceed. This indicates a somewhat confused relationship between the HSE Disability Services and the voluntary organisation, as to where the boundaries of their relationships and responsibilities lay.

## Risk Escalation

Within an area-wide context encompassing a number of disciplines, it is standard practice that direct accountability and responsibility for incident management remains at operational level, with risk management structures in place for that particular discipline. In practice where issues become critical, these are escalated immediately in the context of the urgency of the response required.

The point at which Manager1 initiated the review into the placement in early 2015 was also the point at which senior managers in Tusla and the HSE are on record as being present at a meeting when the case was mentioned. The notes of Manager1 indicate that at such a meeting in February 2015, he alerted his colleagues to his intention to initiate a placement review. The notes also indicate that Case Manager A, being present at that meeting, stated

that he was familiar with the circumstances of the case. However, while willing to accept the notes of the meeting of Manager1 in good faith, the HSE managers present informed the reviewer that they had no recollection of that case being discussed at the meeting. This meeting does, however, constitute some evidence of escalation of concerns, Senior Manager1 and Senior Manager A being present. While the notes of Manager1 indicate that those present at the meeting asked to be kept updated, there is no further reference to this on the minutes of two subsequent meetings for 2015. However, Manager1 did indicate that formal minutes would not routinely make reference to individual cases, and the agendas were concerned with more generic and high level issues.

## Tusla Standard Operational Procedures for Risk Escalation

Within Tusla there are standard operational procedures for the escalation of risk from local to national level, and clear criteria are available to make an assessment as to the appropriateness of escalation. Among those criteria are:

- Where the event has the potential to set legal precedent as determined by legal review
- Where the event is deemed to have potential impact on national policy and procedures (Tusla, 2015).

Either criterion might reasonably be expected to apply to the case under discussion, given the concerns around Mary's legal status and the implications should similar cases arise. There was no requirement for practitioners on the ground to make that decision: there was potential to escalate to senior management at area level. However, what emerges from the material available and from interviews, is a willingness to hold on to risk. Child protection and welfare, by its nature, is fraught with risk; therefore the threshold of what is considered "risky" may be high by comparison to other social care environments. Social workers have become adept at assessing and carrying risk, which is part of their everyday work. However, at interview, PSW1 agreed that, in hindsight, it would have been beneficial to escalate Mary's case to senior management at an earlier stage.

## HSE Disability Services Standard Operating Procedures for Risk Escalation

Within the HSE Disability Services there are standard procedures for identifying risk, and these are identified on risk registers. However, the type of risks that find their way into the system are relatively generic. For example, a risk identified in 2015 refers to:

- Risk of harm to service users and their families and/or members of the public associated with the inability to meet the needs for residential placements in particular in emergency situations (HSE Risk Assessment Form, June 2015).

The risk register is not, therefore, used as a mechanism for identifying and addressing risk in relation to individuals, and does not lend itself to supporting resolution of risks such as that which applied in Mary's case.

# Term of Reference 3:

## To set out findings in this case with regard to risk, safeguarding and best practice

### Findings in respect of Risk

In terms of the assessment of risk, the review finds that this was done in a considered manner as reflected in the assessment report of the allegations of abuse in 2014. Consideration was given to the effect the allegations might have on Mr. A, and every precaution was taken by Tusla to ensure that the allegations were put to him in a supportive environment. With regard to bringing informed opinion to bear on the issues of concern, Tusla team leaders consulted and collaborated with colleagues appropriately in order to apply the best expertise available to the case. There was no ambiguity, therefore, around the identification of risk after the retrospective disclosures. Tusla acted on that risk in terms of children in care in the placement by removing them.

With regard to the management of risk in respect of Mary, it was not escalated to a senior level in Tusla, but held at a middle managerial level where powers were not available to address it. The finding of the review, therefore, is that having identified a risk, and that risk being compounded by the legal lacunae around Mary's status in terms of autonomy and decision-making capacity, it would have been proportionate to escalate it to senior management as soon as it became clear that any potential move by Mary from the placement would be fraught with complications. An additional feature contributing to poor risk management was the lack of agreed and clear procedures whereby the Tusla child protection social work department would close the case and transfer it to the HSE Disability Services.

Finding 1:

The dilemma experienced within Tusla with regard to what action might be taken legally in respect of an adult with intellectual disability not under statutory care order contributed to Mary remaining in her placement.

Finding 2:

Deviation from procedures available to escalate the case to senior management in Tusla before 2016 contributed to Mary's continued presence in the placement.

### Findings in respect of Safeguarding

After the allegations were made in 2014 some safeguarding measures were put in place. Mr. A was asked to temporarily vacate the family home in order to allow time for the assessment of the needs of the foster children, and for arrangements to be made for their removal if necessary. The record indicates that Tusla had evidence that he complied with these safeguarding measures.

Mrs. A was identified as a protective factor, but assigning her to this role was questionable given that she expressed complete confidence in her husband, believed him to have been unjustly accused, and was concerned about the impact of the allegations on his health. It does not seem reasonable, therefore, under those circumstances, to expect her to act as a gatekeeper for her husband's access to anyone in their care.

Finding 3:

Reliable safeguarding measures were not in place for Mary despite the fact that, in the initial phase of the period under review, Tusla responded comprehensively in terms of risk assessment when the allegations were first brought to their notice.

The specific focus of the placement review in 2015 (see opening piece in Term of Reference 2 above) was on testing the safeguards in place. The draft report of that review recommended that there were sufficient safeguards in place and that, therefore, Mary should remain in the placement. However, ultimately these safeguards were judged not to be sufficiently robust.

Finding 4:

The review undertaken by Tusla of the safeguarding measures in place for Mary in 2015 was not completed within an appropriate time frame.

## Findings in respect of Best Practice

The Terms of Reference do not specify on what areas of best practice this review should focus. There are many areas of best practice which a review such as this might interrogate, for example case management, record keeping, social work practice and interagency collaboration; some of these have been discussed in the body of this report. In the section below, the reviewer draws on the material available to highlight areas of best practice within the general scope of activity around the case.

The findings in respect of best practice are that it was inconsistent as outlined in some of the discussion above. However, in terms of best practice in person-centred care, individuals attached to the case demonstrated a clear desire to follow best practice and abide by their own professional code of practice, and to respect Mary's rights as an adult. Social Worker1 continued to be involved in the case with the best intentions, even after she was no longer the allocated social worker, after Mary had aged out of care. In addition, Team Leader1 pursued the matter on a number of occasions alerting her senior colleagues about the need to address the placement issue. Similarly, the aftercare coordinator prompted the placement review in 2015, as a result of identifying the lack of clarity around Mary's continued presence in the placement since the allegations were deemed credible. Manager1 took the initiative to establish the review when the case had been dormant for some time. The voluntary organisation principal social worker made representations to the HSE Disability Services in Mary's best interest. Those undertaking the review of the placement were mindful of the need to ensure that Mary's voice was heard and included in their

deliberations. Therefore, while there may have been a lack of coordination between agencies, there was considerable professional integrity practiced by individual practitioners.

While the transfer of Mary into the residential placement by the HSE does not fall within the remit of this review, it would be remiss not to acknowledge that several interviewees referred to the transfer of Mary into her residential placement as having fallen below the standard of what they would consider best practice.

Tusla exercised best practice in being mindful of Mary's rights as an adult, and not wishing to abuse their authority in acting unilaterally. However, this rights-based approach, which reflects positively on the attitude of Tusla to persons with disabilities, is compromised by their inattention to her status as a vulnerable adult, which would have warranted a complex case meeting at an earlier stage. When it became apparent that a residential placement was not forthcoming in 2014, and the participation by the voluntary organisation was not what was expected by Tusla, opportunities could have been taken to convene such a meeting, and clarify the responsibilities and expectations of the service that HSE Disability Services would be obliged to make available. In the event when it did occur in February 2016, the complex case meeting was efficient in reaching a conclusion.

Had the safeguarding team for the protection of vulnerable adults been developed at the time in line with the policy, this might have provided an unambiguous pathway for Tusla to refer Mary's case specifically to a HSE safeguarding team responsible for protecting vulnerable adults. These teams did not come into place until early 2016. However, the policy framework was in place for formulating thinking around how best to approach concerns about vulnerable adults. Manager1 was aware of the policy and its potential to guide thinking on how best to consider Mary's need for safeguarding. This was something he flagged to those reviewing the placement in 2015 and represents an attempt to apply best contemporary practice to the case.

Finding 5:

Individual staff demonstrated a clear desire to apply a person-centred care approach with respect to Mary's welfare.

Finding 6:

Coordination of service delivery between the HSE Disability Services and the voluntary organisation was ineffective.

Finding 7:

A clear and formal written communication from Tusla to the HSE in 2014 could have contributed to progressing the case and bringing clarity to the roles of both organisations.

Finding 8:

When interagency cooperation was formalised in 2016 via the complex case meeting mechanism, it was efficient in making decisions.

# Term of Reference 4:

## To identify specific and general issues to inform any necessary learning, having regard to best practice in managing risk and interagency engagement

The management of risk has been addressed above under Term of Reference 3. The issues identified below emerge from the body of written material and information given at interview. Findings are included which follow on from the issues identified in this section.

### Status and Capacity

Practitioners in the field of social work and disability are not blind to the dilemmas posed by issues of client capacity, and such dilemmas have been publicly debated in the context of the development of the Assisted Decision-Making (Capacity) Act (2015). The confusion around this issue was a recurring feature in the management of the case by Tusla, insofar as while the case was in effect closed, they continued to make efforts to advance Mary's welfare, and it was reactivated in 2015 for the purpose of the placement review. The issue of Mary's capacity to make a decision, therefore, and the authority of the State to intervene in her best interests, was at the heart of the dilemma experienced by Tusla at middle management level.

There were grounds at any point for an interdepartmental meeting between Tusla, the HSE and the voluntary organisation, at which a legal advisor might present options. In the event, after the legal consultation in May 2014 (which did not just concern Mary but other children in the placement) there is no evidence of any further attempt by Tusla to solicit legal opinion while they continued to remain involved in the case, or to use legal advice to oblige the HSE Disability Services to honour their obligations. Indeed, when the option emanating from that consultation did not succeed – that the voluntary organisation would undertake a risk assessment – there is no evidence of reverting for further legal direction in the case. It is not until February 2016 that the record indicates that further legal advice was sought when Tusla and the HSE collaborated closely on the case. That advice referred to the options of wardship or the inherent jurisdiction of the High Court, options that might well have been identified and would also have been available at a much earlier stage.

### Interagency Cooperation and Collaboration

> *"Meaningful communication is key to effective multi-disciplinary working. Effective practice is most likely to occur when organisations have systems in place that support collaborative practice. Practitioners should identify and address the barriers that have an impact on practice when working together on a particular case…. However, multi-disciplinary practice is complex. Issues of lack of ownership, communication problems, poor understanding of roles and responsibilities, mistrust amongst practitioners and status issues all act as barriers to effective collaboration"* (Howarth, 2009).

While Howarth's (2009) reference is to multi-disciplinary as opposed to interagency practice, the issues she identifies have resonance for this case.

This review did not detect any reluctance among interviewees to work collaboratively. Rather what emerged was a lack of clarity about what agency and what professional had a lead role in progressing actions to promote Mary's welfare, and to protect her from any potential risk within the placement. The network of informal relationships of collegiality between agencies that often facilitates the good management of cases, appears not to have worked to the benefit of this case. The familiarity enjoyed between social workers in Tusla and their colleagues in HSE Disability Services did not promote an unambiguous referral of this case from Tusla to the HSE. This is also reflected in the meetings between HSE Disability Services and Tusla as described by Case Manager A and Team Leader 3, where a number of cases would be discussed between colleagues from both services. This occurred in a context which does not appear to have been formalised as, for example, scheduled interdepartmental meetings. The structures around transfer of cases from one department to another, therefore, were not sufficiently robust to overcome confusion around which agency was holding the case and who the identified lead case holder was. In the absence of such structures, and given that the historical processes of custom and practice between the HSE Disability Services, the voluntary organisation, and Tusla, were not advancing an alternative placement, it was still possible to send a formal communication to the HSE clearly outlining that Tusla now had no further engagement; that they were formally - or had already - referring the case to the HSE; that a residential placement was required; that the inaction of the HSE Disability Services was unacceptable. This is not to suggest any desire on the part of Tusla to *offload* the case, as the possibility still existed of eliciting the support of the Aftercare Service. In the absence of such a process, however, the lines of responsibility, which were already unclear, continued to be blurred. In the case of Mary there is, therefore, to some extent a *mixed message* involved in pursuing a placement with the voluntary organisation if the position was that the case had already been transferred to the HSE Disability Services in 2013. This was further exacerbated by Tusla taking up the case again in 2015 – in the form of the placement review – compounding the message that they were still involved in an aftercare capacity, when so much energy had previously been expended on trying to solicit the voluntary organisation to take responsibility. While one has to allow that this continued involvement was done in a spirit of goodwill, there is no evidence that it emerged from any combined and structured discussion between the HSE Disability Services, Tusla, and the voluntary organisation, as to who would take a lead in the case, at what stage, for how long, and what arrangements for reporting and for cross-departmental collaboration would be put in place.

The management meeting held between Tusla and the HSE in February 2015 did not provide a forum for agreeing action on cases of high concern at a senior level. The shared view between the HSE and Tusla at that meeting (as reported in the notes of Manager1) that there would be feedback to that group, is not referenced further in the minutes of these meetings, nor were the meetings intended for the purpose of case review.

It was suggested by some interviewees that better interagency cooperation might have avoided the case developing to the point where Mary was transferred into a residential placement without the preferred level of forward planning. However, the literature on the subject advises caution in this regard. In an international literature review undertaken for the Department of Children and Youth Affairs and published in 2011, the matter is stated thus:

> *"…most evaluations of the outcomes of interagency working do not report substantial measurable impact for service users themselves (i.e. for children and families). They*

*report findings such as positive changes in the accessibility of services to users and an improved experience of service use, but not, in general, changes in the 'holy grails' that all enlightened administrations want to see – for example, measurably improved child health and well-being, reduced behavioural and emotional problems, better parenting, reduced child abuse and neglect*." (Statham, J. 2011).

From the evidence available in the form of files and interviews, the issue of a shared understanding of referral processes appears to have been at least as significant as the more generic issue of interagency cooperation.

## Referral Pathways

The Service Arrangement between the HSE and the voluntary organisation does not specify any process by which the HSE, as the funding agency, acts as a clearing house for some or all referrals. The voluntary organisation accepts referrals directly from a number of sources in the community, and undertakes its own assessment as to the needs of the potential resident and the capacity of the agency to meet those needs. Therefore, as it had its own longstanding relationships with a range of community services, HSE Disability Services were not perceived by Tusla as a gatekeeper for access to residential placements. Tusla, therefore, made direct contact with the voluntary organisation in order to try to secure a placement for Mary. The issue of accessing disability service placements for children in care (Mary was not in care at this point) had been a longstanding difficulty for Tusla, to the extent that they had placed it on their risk register.

The situation with regard to the referral pathway as described by interviewees to this review, is one that reflects historical relationships rather than any planned streamlining of case referral. The referral process is therefore from discipline to discipline, from one social work department to another. Tusla interviewees indicated that this was part of their relationships of interagency collegiality and the manner in which they would normally effect referrals. The team leader in the case (Team Leader3) expressed the belief that her understanding was that the professionals' meeting in March 2013 constituted a referral to HSE Disability Services. This assumption, made in good faith, compounds the message of the lack of a clear shared understanding between the agencies of what constitutes a referral, and what processes are in place to respond to it.

Given the somewhat chaotic situation that arose around the referral of Mary for a residential placement, and despite its well documented belief that the voluntary organisation had a responsibility in terms of providing a place, there is no written application by Tusla for a residential placement for Mary on record. There is a record of enquiries made by telephone, which elicited the response that no place was available. Interviewees pointed out that standard application forms were not in use. However, the admissions policy of the voluntary organisation outlines an application process available for all referrals to their service. While Tusla may not have felt it had any authority to make an application on behalf of an adult who had not expressed any wish for a placement, such a mechanism of formal application may have proved useful. The voluntary organisation operates an adult forum at which all referrals for adult admissions are discussed. Even in the absence of an existing residential place, this forum may have provided an opportunity to discuss the complexities attached to

the case, possibly identify a key case holder to act in Mary's interests, and underline the role and responsibility of the HSE Disability Services in the case.

Finding 9:

There was a lack of a shared understanding among all the agencies involved with regard to referral pathways between Tusla, HSE Disability Services and the voluntary organisation.

## Roles and Responsibilities

The lack of clarity and agreement, reflected in the chronology, around what constituted a referral, or where the obligation lay to identify a residential placement, is reflected in the confusion around roles and responsibilities within Tusla and the HSE Disability Services.

In the case of operational relationships between Tusla and the HSE Disability Services, as related at interview, there was confusion about which principal social worker (PSW) had responsibility for the case. Case Manager A (HSE Disability Services) was of the belief up until early 2016 that PSW2 had oversight, and therefore consulted him as to whether the social work department had any concerns about Mary's continued residence with Mr. and Mrs. A. When PSW2 responded that he had no concerns, this was based on a less informed knowledge of the case than his colleague PSW1. Therefore, while HSE Disability Services believed PSW2 to be the relevant principal social worker, both PSWs agreed at interview that PSW2 would not have been as familiar with the case as PSW1.

In terms of the role either organisation played in addressing Mary's needs, there emerges from the files and interviews a perception within Tusla that HSE Disability Services and the voluntary organisation were somewhat interchangeable. Therefore, they are sometimes conflated as "adult services" in the records without specification as to which is being identified. This may account for the degree of somewhat unclear exchanges noted in the chronology between Tusla and the "adult services" and between the two "adult services" themselves (the HSE Disability Services and the voluntary organisation).

As identified in the chronology, HSE Disability Services were aware of the case from 2013, and there are undisputed records of their engagement in some meetings, phone calls and discussions about Mary.

It seems reasonable to enquire to what extent the HSE might be expected to actively pursue a referral of a case which was on their *radar*, but was not the subject of an unambiguous written referral, or notification of concern by Tusla that the HSE, having had the case referred to them, was not fulfilling its obligations in respect of their duty to Mary. This may have been particularly opportune at the management meeting in early 2015 which, while it was not designed to address individual cases, presented an opportunity to Tusla if they perceived that HSE was neglecting their duty, to make that clear at a senior level.

Finding 10:

The lack of clarity around role and function of post holders had a negative impact on the overall management of the case.

## Aftercare

A court report from April 2013 states that Mary had been "formally referred to the HSE Aftercare Service" (prior to Tusla) but would not be in receipt of aftercare services. Instead, she would have her needs catered for within adult disability services.

The Leaving and Aftercare Services National Policy and Procedures Document (HSE, 2011b) has a section entitled Special Consideration which outlines the case with regard to intellectual, physical and sensory disability as follows:

> *"Young people with disabilities may well face more barriers than other young people… Co-operation between the various agencies involved in providing services for young people with an intellectual, physical or sensory disability is crucial. Good care and placement planning, and review processes, should ensure that the relevant agencies are involved at an early stage of such children's placement, hence ensuring that the transfer of lead agency support is as seamless as possible"* (HSE, 2011b:20).

The document further states:

> *"There are many young people in the care of the HSE[4] who present with complex needs and who fall between services… It is imperative that an assessment is multi-disciplinary to ensure that appropriate personnel are involved and supports and resources are identified and in place. The assessment may include input from Psychology Services, Disability Services, Education/Training Services, Mental Health, Housing, Community Welfare, etc."* (HSE, 2011b:21).

Therefore, there is no exclusion applied to young people with intellectual disability. Indeed, the position of the aftercare service as outlined above is to recognise the particular needs of persons with disabilities. While the referral process for aftercare indicates that a referral should be made by a social worker once the child has reached 16 years – as was done in this case – it does not state that referrals will not be accepted after that milestone, and the core period of eligibility is identified as 18 to 21 years (HSE, 2011b:14). However, the local aftercare guidelines for Mary's area state that: "*The aftercare service is principally aimed at young adults who have the capacity to live independently, and the service cannot provide specialist support to young adults who have:*

- *Moderate or severe learning disability*
- *Physical or sensory disability*
- *Diagnosed severe mental health difficulties*

(Leaving & Aftercare Service - Referral Guidance Notes: circa 2013)

[4] Predating the establishment of Tusla

While Social Worker1 had initially referred Mary to the aftercare service, she did not meet the local criteria. When Social Worker1 did revert to the aftercare service later in 2014 they responded very positively, and it had been the aftercare coordinator who brought the matter of Mary's continued residence in her placement to the attention of Manager1.

Aftercare did not respond to the initial referral in 2013 by offering Mary a service even though they did follow up the referral. At interview, the aftercare coordinator stated that this was based partly on Mary's lack of capacity to engage and express her own wishes about what an aftercare service might offer her. The aftercare coordinator visited the home of Mr. and Mrs. A with a view to assessing Mary for the service, and was in agreement with her colleagues in Tusla (child protection and foster care) that Mary was receiving a high quality of care. The expectation at that time was that she would live out her life with Mr. and Mrs. A. In addition, the availability of support from the voluntary organisation offered reassurance, and the aftercare coordinator was conscious of the fact that staff there had a better understanding of her needs, and some capacity to communicate with a person of her level of disability, which the aftercare workers did not. The aftercare coordinator was clear at interview, therefore, that it was not shortage of resources or any other concern that prompted the decision not to engage with Mary, but a combination of her lack of capacity, and the perception that she was already receiving a high level of care both in terms of home care and day care.

It could be argued that it was precisely her lack of capacity that might prompt the provision of an aftercare service, even at a level of oversight, without the need to directly engage with Mary. The recognition of the potential value of such support was reflected in Social Worker1 contacting the Citizens Information Board, to determine if an advocacy service could be made available to Mary. However, this option had not been progressed by the time Mary was transferred into residential care.

## Record-Keeping and Documentation

Legible, timely and complete service user records are a critical component of communication between and across members of the multi-disciplinary teams, and professionals rely upon thorough records to ensure that they are properly informed prior to making their own clinical intervention.

The HSE Standards and Recommended Practices for Healthcare Records (May 2011) clearly outline the requisite standards expected of documentation. The quality of some records available in this case from the HSE Disability Services was not always of a high standard, in that it was sometimes difficult to decipher handwritten notes, and it was not always clear who had written them. In addition, while the reviewer was informed by HSE Disability Services that a copy of the placement review undertaken in 2015 was made available which was not marked as a draft, this does not appear on the HSE Disability Services file. Records held in Tusla with regard to phone calls made to HSE Disability Services are not reflected in the HSE Disability Services file. In addition, in respect of both the Tusla and HSE Disability Services files, where meetings or participation in meetings had taken place that were not recalled at interview by some parties to the exchanges, the practice of contemporaneous recording across the services would have assisted any "look back" process. However, there was sufficient information on files to compile a chronology that was – according to the feedback from interviewees – largely consistent with events as they experienced and

recorded them. Where amendments were made to the chronology on foot of feedback from interviewees, this was based on clear grounds provided by them.

The availability of an integrated IT system may have assisted in the management of this case insofar as, for example, Manager1 and PSW1 in Tusla were not fully *au fait* with the extent to which the other was involved in the case. While Manager1 (who oversaw the aftercare service) was aware that Mary had been known to his colleagues in the child protection department, he was not fully conversant with the history of engagement between Tusla and HSE Disability Services. At interview, PSW1 indicated that she was not aware of the review of the placement being undertaken in 2015 until it was at an advanced stage. However, it must be acknowledged that from her point of view, there was nothing to prompt her seeking out such information. Had each party had access to a shared IT information bank in the case, it may have promoted a more comprehensively shared understanding of the case.

# Conclusion

Findings from the review have been identified in the opening section of this report. In addition, outlined below are some generic issues emerging from the body of the report, which may promote learning.

A. Promotion of a shared awareness of intersecting policies and procedures for interagency working including the HSE Safeguarding Policy and the Tusla Aftercare Policy will facilitate a mutual understanding of roles, responsibilities and referral pathways, which would assist the management of complex cases

B. Formal arrangements to include meetings to address complex cases pertaining to people with disabilities with multi agency involvement would facilitate improved management, or shared management of specific cases

C. Requirements with regard to record keeping standards are an identified deficit requiring attention. Clear guidance needs to be provided to staff in relation to good record keeping practices

In conclusion, the question emerges as to what would have been a proportionate response to the acceptance of the allegations in 2014. Notwithstanding the concerns and dilemmas identified throughout this report, and the lack of evidence of any unhappiness on Mary's part in her placement, the overriding issue was that Mary was not in a position to protect herself, and was therefore dependent on others to do it for her. Reassurance regarding Mary's safety and wellbeing might have been achieved by reference to some of the issues identified in the key findings.

# References


Comhairle (2005) *Guiding Principles and Operating Procedures for the Delivery of Advocacy Services through Community and Voluntary Organisations.* Dublin: Comhairle

Tusla (2015) Standard Operational Procedures Risk Systems Administration

Tusla (2016) *Guidance Document for the Implementation of the Standardised Aftercare Allowance.* Available from: http://www.tusla.ie/uploads/content/Final_Statement_Foster_Care_Version_17th September_2015.pdf

Health Service Executive (2011a) *Child Protection and Welfare Practice Handbook.* Available from: http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf

Health Service Executive (2011b) *Leaving and Aftercare Services National Policy and Procedures Document.* Available from: http://www.ifca.ie/files/4414/3324/2639/HSE_Leaving_Aftercare_Services_National Policy_and_Procedure_Document_22_12_11SM_FINAL_VERSION.pdf

Health Service Executive (2014a) *Safety Incident Management Policy.* Available from: https://www.hse.ie/eng/about/Who/qualityandpatientsafety/MeasuringandLearning/SCDQIDQIProgramme/Safety_Incident_Management_Policy.pdf

Health Service Executive (2014b) *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures.* Available from: http://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf

Health Service Executive (2015) *Guidelines for Systems Analysis Investigation of Incidents and Complaints.* Available from: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/QPSDGL5211.pdf

Howarth, J. (2009) in Cleaver et al. *Safeguarding Children*. New York: John Wiley & Sons Ltd.

Statham, J. (2011) *Working Together for Children: A review of international evidence on interagency working, to inform the development of Children's Services Committees in Ireland*. Dublin: Department of Children and Youth Affairs.

Tusla (2016) Annual Report 2015

# Appendices

**Appendix 1** Terms of Reference

**Terms of Reference for Case Review Jointly commissioned by Tusla and HSE**
**Cork Former Foster Home Case**

**Introduction**

These are the terms of reference for a case review jointly commissioned by the HSE and Tusla into the circumstances where a vulnerable young adult ("Mary") with an intellectual disability, in receipt of services from both Agencies, continued to reside with a former foster family following a report being received of a retrospective allegation, which did not relate to residents in the foster home.

**Purpose**

The purpose of this review is:

1. To establish the full facts of the case;
2. To consider, in particular, issues of safeguarding and risk assessment in respect of this case;
3. To set out findings in this case with regard to risk, safeguarding and best practice;
4. To identify specific and general issues to inform any necessary learning, having regard to best practice in managing risk and interagency engagement.
   .

**Scope of the Review**

The scope of the review should examine all relevant available reports and interview all relevant parties as deemed appropriate by the Independent Reviewer.

The time frame of this review will have particular reference to the period from January 2014 (when an allegation of abuse was brought to Tusla's attention) to February 2016 when the decision was made to remove the service user from the former foster family home to a full-time residential placement.

The case review will be undertaken by Dr. Cathleen Callanan, Independent Reviewer, with the support of a senior professional from both agencies. The staff of both agencies will fully cooperate with the case review.

The case review report is to be submitted to both agencies within six weeks of commencement. The report will be published in full.

**Investigation Method**

The review will follow the HSE Guidance for Systems Analysis Investigation of Incidents and Complaints (QPSD November 2012), the Safety Incident Management Policy (QPSD May 2014) and will be cognisant of the recently launched National Policy and Procedure for Vulnerable Adults (December 2014) and recognising the rights of all involved to privacy and confidentiality; dignity and respect; due process; and natural and constitutional justice.

Reference:

Guidelines for Systems Analysis Investigation of Incidents and Complaints (HSE 2012)

Safety incident Management Policy (HSE May 2014)

**Appendix 2** List of files and additional material available to the review team

| Organisation | Number and type of files |
|---|---|
| Child and Family Agency (Tusla) | Social Work Files x2 (2013–2016) containing correspondence, case notes and reports<br><br>Message Books for Tusla social work department x31 (2013–2015)<br><br>Manager1 File x1 (2016) correspondence and reports<br><br>Interview transcripts of this review x11 (2016) (one interview was by telephone)<br><br>Risk Register<br>Aftercare Policies (national and local)<br>Child Protection Handbook<br>Children First<br>Need to Know Procedure<br>Need to Know Notification<br>Protocol for Complex Cases<br>Aftercare Policy (short version)<br>Aftercare Policy (long version)<br>TOR Aftercare Steering Group<br>Regulations for Children in Care |
| Child and Family Agency Foster Care | Foster Care Files x3 (2002–2016) containing correspondence, case notes and foster carer assessment<br><br>National Standards for Foster Care |
| Health Service Executive (HSE) | Safety and Protection Team File x1 (2016) containing correspondence and historical information as well as standardised procedures and assessments<br><br>Interview transcripts of this review x3 (2016)<br><br>Minutes of Management Meetings with Tusla 2015 x3<br><br>HSE Safeguarding Policy<br>HSE Safety Incident Management Policy<br>Records of launch and communication regarding dissemination of Safeguarding Policy |
| HSE Disability Service | Adult Disability Services File x1 (2013-2016) containing correspondence, case notes and reports<br><br>Correspondence File x1 (2013-2016) containing |

| | |
|---|---|
| | copies of correspondence and reports<br><br>Office of Chief Officer File x1 (2016) containing copies of correspondence and reports<br><br>Interview transcripts of this review x3 (2016)<br><br>Risk Register<br><br>Protocol for dealing with Disability Services Emergency Cases/Complex Cases |
| Voluntary organisation | Social Work File x1 (2014-2016) containing correspondence, case notes and assessments<br><br>Interview transcripts of this review x2 (2016)<br><br>General File x1 (2012-2016) containing correspondence<br><br>Admission, Transition and Discharge Policy<br><br>Service Arrangement |
| General | Assisted Decision Making Bill (2013)<br><br>Emergency Funding Application Forms |

## **Appendix 3** List of Interviewees

Tusla

| **Organisation** | **Staff** | **Role** |
|---|---|---|
| Tusla: Child Protection and Welfare | Team Leader1 | The team leader who met with the complainants in 2014, and completed the assessment of the retrospective allegations with Team Leader2 |
| Tusla: Foster Care Team | Team Leader2 | Completed assessment of the retrospective allegations with Team Leader1 |
| Tusla: Child Protection and Welfare | Social Worker1 | Case holder while Mary was in care up to 2013 |
| Tusla: Child Protection and Welfare | Team Leader3 | Team leader who was line manager to Social Worker1 and reported to PSW1 |
| Tusla: Child Protection and Welfare | Principal Social Worker 1 PSW1 | Principal social worker responsible for oversight of the case |
| Tusla: Child Protection and Welfare | Principal Social Worker 2 PSW2 | Principal social worker with duties not including this case |
| Tusla: Aftercare and Foster Care Team | Manager1 | Manager in Tusla who commissioned a review of Mary's placement in 2015 |
| Tusla: Foster Care Team | Principal Social Worker 3 PSW3 | Principal social worker who undertook the review of Mary's placement in 2015 |
| Tusla: Team for young people out of home | Social Worker2 | Social worker who participated in the review with PSW3 in 2015 |
| Tusla | Senior Manager1 | Senior manager in Tusla with overall responsibility for services in the area |
| Tusla | Aftercare Coordinator (telephone interview) | Principal social worker responsible for the coordination of aftercare services |
| Tusla | Social Worker | Social Worker whose name was assigned to the case but who had no involvement in it |

HSE

| **Organisation** | **Staff** | **Role** |
|---|---|---|
| HSE Disability Services | Case Manager A | Manager in HSE Disability Services |
| HSE Disability Services | Case Manager B | Manager in HSE Disability Services |
| HSE | Principal Social Worker A | Principal social worker for the adult safeguarding team rolled out in January 2016 |

Voluntary Organisation

| **Organisation** | **Staff** | **Role** |
|---|---|---|
| Voluntary Organisation | Director | Responsible for overall delivery of services |
| Voluntary Organisation | Principal Social Worker voluntary organisation | Responsible for delivery of social work services |